Charity Care
Tools to Manage the Uninsured Population

Sandra J. Wolfskill, FHFMA

Your hospital doesn’t have to lose millions of dollars every year providing care to the uninsured.

Charity Care: Tools for Managing the Uninsured Population provides strategies and case studies you can use to meet the challenges inherent in providing charity care. This comprehensive resource will help you assess risk and develop appropriate policies and procedures to educate your revenue cycle team.

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Introduction to charity care issues
Healthcare billing and collections practices are complex. Until recently, the term “patient friendly” applied to clinicians and registration representatives, not the patient billing process. The collections side of the process was all about collecting the most dollars possible and holding bad debts and charity deductions to the lowest possible levels. Few patient financial services directors and chief financial officers became involved in the human side of the equation and the patients with little or no health insurance were caught in a system they did not understand and in which they were unable to obtain the help they needed.

Listen to one family’s story, as reported in *The New York Times*, December 19, 2004:

Mrs. X was about to leave her trailer home in Somewhere, USA, one April morning in 2003 when she noticed her 49-year-old husband, Mr. X, hunched over the side of the bed and coughing up fluid. Although he had battled a variety of lung and liver ailments for years, he seemed worse than usual, Mrs. X recalled not long ago—bad enough, she thought, that he should get to the emergency room (ER).
The nearest ER was at ABC Medical Center, four miles away in Anywhere, a mostly working-class suburb. Both adults had been admitted and treated there before; a few months earlier, doctors performed emergency surgery on Mr. X’s lungs. The adults were satisfied with the treatment at ABC Medical, as it is known. Their problem was that they already owed the hospital more than $40,000. Mr. X, who for years had been too sick to work, had no health insurance, and Mrs. X had acquired hers only a few months before. Her salary as a Wal-Mart cashier was barely enough to support the couple and their two children—a 17-year-old daughter at home and a 22-year-old daughter away at college. It left no money for adding Mr. X and the kids to her health plan, let alone for paying a five-figure hospital bill.

During Mr. X’s past admissions to the hospital, Mrs. X says, she asked staff members if there was some way to discount or waive the charges—figuring that ABC Medical, a nonprofit institution sponsored by religious organizations, might be inclined to help. But the answer, she says, was always no. So, as the hospital bills piled up on the dining table, Mrs. X lay awake at night, wondering how the family would crawl out from under the debt. On that April morning, as Mr. X kept insisting that it was “just the flu,” she suspected that it was something more serious. But Mr. X wouldn’t let her take him to the ER, and eventually Mrs. X headed to work. When she returned that night, she found him on the floor, dead.

Mrs. X had Mr. X’s body cremated a few days later. But the family’s dealings with ABC Medical were not over. That July, Mrs. X learned that the hospital had sued her over part of their debt, winning a judgment allowing it to garnish her wages. (Mrs. X says she never received summons papers before the wage-garnishment hearing.) Soon the hospital was taking the maximum amount from Mrs. X’s salary that state law allowed, or about $100 of the $680 in gross pay she earned every other week. Mrs. X says that this left her with no money for repairs when the furnace in her trailer broke down the following winter. She and her younger daughter moved to an apartment, which Mrs. X says she could afford only by skipping the medications she took for her asthma and high blood pressure.

That fall, researchers from the labor union trying to organize ABC Health Care, the parent company that owns ABC Medical, came across the X’s file while investigating the company’s treatment of uninsured patients. With the help of the union’s attorneys, Mrs. X eventually persuaded a judge to overturn the garnishment order based on her testimony that she had never received the summons to that hearing. In April 2004, the judge ordered ABC Medical to repay the money it had taken, some $1,800 in all, although ABC complied only after several months. Mrs. X still had other unpaid...
medical bills at ABC Medical—from separate hospitalizations not included in the initial lawsuit. At one point, according to her attorneys, ABC’s collection agent threatened to pursue those debts if Mrs. X continued to demand that her garnished wages be returned. (ABC denies ever making such a threat, but a spokesman acknowledged that it couldn’t vouch for the behavior of the bill collector, an outside contractor.)

Was this an isolated case or a common pattern of patient and hospital interaction? Until the lawsuits filed in 2004 against over 400 hospitals and the American Hospital Association (AHA), public attention to the issues surrounding uncompensated care and hospital billing and collection practices was limited. However, as the number of uninsured individuals continues to rise, and as managed care plans are being redesigned to move more first dollar responsibility (i.e., the amounts patients are required to pay before their healthcare insurance begins making payments-deductibles) to patients, hospitals are facing increased pressure to revise their policies and procedures, especially their charity-care practices.

No one will argue that hospitals, even nonprofit hospitals, should operate at a loss. To do so long-term could result in the collapse of the healthcare system. The balancing act involves hospitals’ need to generate operating margins (profits) in order to expand and update capital and programs v. the need to care for those who cannot afford the services they require. Each hospital looks at charity care in light of its mission and value statements; the challenge is to operationally comply with the mission and, at the same time, support the financial viability of the organization.

Uncompensated care

Healthcare financial managers face the increasing challenge of managing not only revenue and expenses, but also uncompensated care. Uncompensated care represents services provided to patients for which the provider receives no payment. There are two classifications of uncompensated care:

• **Bad debt** accounts are defined as accounts where the responsible party has the ability to pay, but does not do so in a timely manner or without intervention from an external collection agency.

• **Charity** accounts are accounts where the responsible party does not have the ability to pay based on a defined set of income and asset criteria. Providers may discount charity accounts fully or partially, based on income qualification guidelines.
Uncompensated care by the numbers

Hospitals have traditionally structured their charity programs to the Federal Poverty Levels (FPL), which the government updates annually. However, in the past few years there has been a trend to expand the charity eligibility to greater percentages of the FPL.

Uncompensated care as a percentage of expenditures has remained relatively constant, ranging from a high of 5.8% in 2000 to a low of 5.1% in 2002 (Figure 1.1).

<table>
<thead>
<tr>
<th>% of FPL</th>
<th>Single scale</th>
<th>Complex scale</th>
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<tr>
<td>100 %</td>
<td>Base scale only</td>
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<tr>
<td>150%</td>
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<td>200%</td>
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<tr>
<td>600%</td>
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With the ability to offer discounts to uninsured and underinsured patients, sliding scales are becoming a common tool for determining eligibility.

Uncompensated care as a percentage of expenditures has remained relatively constant, ranging from a high of 5.8% in 2000 to a low of 5.1% in 2002 (Figure 1.1).
At the same time, the amount of uncompensated care provided has increased from a low of $21.5 billion dollars in 2001 to $24.9 billion dollars in 2003 (Figure 1.2).

On an adjusted patient day basis, the cost to healthcare providers has followed a similar pattern, ranging from a low of $69.51 per adjusted patient day in 2001 to $78.75 per adjusted patient day in 2003 (Figure 1.3).
With hospital operating margins in 2003-2004 ranging from -1.84% to 4.1%, the incorporation of contemporary uncompensated care processing is an important aspect of healthcare financial management.

**Reasons for increased uncompensated care**

Why has uncompensated care become a major issue confronting American hospitals? One indicator that directly parallels the uncompensated care dollars is the number of individuals in poverty, which peaked in the early 1990s, only to increase again as the recession of 2000-2001 unfolded. According to the most recent Census data, in 2003, 35.9 million people lived in poverty, an increase of 1.3 million from the 2002 level.

The second measure of poverty in the United States is the FPL, which the Department of Health and Human Services (HHS) publishes annually. The government and other organizations use these guidelines for administrative purposes, typically for determining eligibility for certain federal programs and provider charity discounts. Programs, including charity policies, may use percentage multiples of the guidelines (e.g., 200% of the guidelines) for determining full and partial eligibility. As Figure 1.4 illustrates, the FPL for a family of four has risen in each of the last four years.

At the same time as the increased FPL, the number of Americans without health insurance rose to an all-time high of 45 million people in 2003. This represents a 1.4 million increase in uninsured individuals in just one year.

**How hospital charges impact uninsured patients**

What does this increase in the poverty guidelines and the number of uninsured Americans mean to patients without insurance?

The charge structures that hospitals developed during the “lesser of cost or charges” era, when government and commercial payer contracts penalized providers if their charges were less than the actual costs, has directly impacted uninsured individuals. Therefore, mark ups eventually exaggerated the true cost of any service or supply.

In an effort to control healthcare costs, government payers imposed prospective payment systems on providers, which further negated the value of charge structures as a true representation of cost. At the same time, commercial payers negotiated a variety of payment methodologies, all based on some form of discounting. In the end, hospitals only billed the patients without insurance for their full charges.
Changes in the charity-care arena

Until 2004, hospitals maintained that certain provisions of the Medicare program prohibited the use of discounts for self-pay patients. On December 16, 2003, Richard Davidson, president of the AHA, sent a letter to HHS Secretary Tommy Thompson in which the AHA maintained that Medicare program rules, as well as restrictions set out by the Office of Inspector General (OIG), made it virtually impossible for hospitals to offer discounts to low-income or medically indigent patients.

Secretary Thompson responded on February 19, 2004, refuting the AHA’s charges and opening the door to major revisions in hospital charity policies and procedures. The Secretary directed the Centers for Medicare & Medicaid Services (CMS) and the OIG to provide guidance to hospitals on the topics of discounting and billing requirements for uninsured and underinsured patients:

Your letter suggests that HHS regulations require hospitals to bill all patients using the same schedule of charges and suggests that as a result, the uninsured are forced to pay “full price” for their care. That suggestion is not correct and certainly does not accurately reflect my policy. The advice you have been given regarding this issue is not consistent with my understanding of Medicare’s billing rules. To be sure that there will be no further confusion on this matter, at my direction, the Centers for Medicare & Medicaid Services and the Office of Inspector General have prepared summaries of our policy that hospitals can use to assist the uninsured and underinsured. This guidance shows that hospitals can provide discounts to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing obligations. Nothing in the Medicare program rules or regulations prohibit such discounts. In addition, the Office of Inspector General informs me that hospitals have the ability to offer discounts to uninsured and underinsured individuals and cost-sharing waivers to financially needy Medicare beneficiaries.

Source: Text of letter from Tommy G. Thompson, secretary of HHS to Richard J. Davidson, president, AHA. This can be found at www.dhhs.gov/news/press/2004pres/20040219.html.

Thus, the secretary and HHS went on record as allowing discounts to uninsured patients and underinsured patients. In addition, the waiver of cost-sharing payments from Medicare patients who were unable to pay and the determination of medical indigence paved the way for major revisions in hospital charity policies and practices. We present the discounting issue in greater detail in Chapter 3.
Charity-care policies and procedures

As a result of the position statements issued by HHS and the OIG, hospitals have updated their charity-care policies and procedures. A recent HCPro survey indicated that 65% of the respondents revised their charity processes within the last six months. In the same survey, 69% of the respondents indicated that the most recent revision of their charity policy has resulted in an increase in the charity dollars approved in their institutions.

Recently, a three-hospital system in Massachusetts announced a significant change in its charity policy and procedures. It plans to offer patients who do not qualify for public assistance but whose income falls between 401% and 600% of the federal poverty level guidelines a discount of 35%.

Comparing charity dollars v. bad debt dollars as a percentage of net revenue confirms that bad debt write-offs continue to exceed charity write-offs by significant numbers. The HCPro survey provided the following comparison:

In fact, 73% of the charity write-offs are valued at less than 3% of net revenue, whereas only 53% of the bad debt write-offs are in the same range. Charity and bad debt percentages appear to be inversely related; thus, charity write-offs tend to decrease as the value of bad debt placements increase. This data suggests that either more patients who can pay are not doing so, thus the bad debt placements, or hospitals are quicker to send accounts to collection than to approve charity write-offs.

Budget limitations do not appear to be driving charity approval decisions. In the HCPro survey, 78% of the hospitals reported that write-offs are not limited by an approved budget amount. This lack of limitation is consistent with the definition of charity care, which speaks to the patient’s inability to pay for the services provided.

Public education for charity services

Hospitals are increasingly using the media, including the Internet, to educate the public and provide information about their charity funding. According to one hospital Web site:

In fiscal year 1998 alone, East Texas Medical Center (ETMC) provided $95 million in charity and uncompensated care. That’s an average of $260,000 a day benefiting the people and communities of East Texas.
Obviously, the need for care is great, and it is growing. It is up to all of us to answer that need. Across the nation, the cost of medical care continues to increase, while governmental health reform and managed care further decrease reimbursement for health services. In addition, East Texas’ projected growth and aging population will continue to increase the demand for medical services and charitable care.

It is our mission to serve all members of the community, regardless of race, creed, sex, national origin, handicap or ability to pay. That is why each year ETMC significantly exceeds the charity care requirement mandated for not-for-profit health organizations under state law.\(^2\)

Another provider’s Web site disclosed the following:

As a nonprofit health care company, charity care is an important component of our service. In 2003, Banner provided $49.8 million in charity care to disadvantaged patients.\(^3\)

However, other providers make no mention of charity care or free care on their Web sites. A few provider Web sites provided telephone numbers for patients to call and request financial assistance. The industry is all over the map when it comes to reporting charity care, publicly disclosing the availability of charity care, and clearly identifying how charity care impacts individual institutions.
Patient awareness of charity care

Patient awareness of the availability of charity care is also not universal. A recent study by the Center for Studying Health System Change (HSC) asked the uninsured about their awareness and use of healthcare providers offering lower cost and affordable care. Specifically, the study asked uninsured patients the following questions:

“At this place, do you pay full price for medical care or do you pay a lower amount based on what you can afford to pay?” and “Thinking of the area where you live, is there a place that offers affordable medical care for people without insurance?”

Combining these questions, the responses indicate that over half of the uninsured (52%) are not aware of nor use providers who provide such assistance in their communities. This also suggests that this significant portion of the population may be at increased risk of not pursuing needed medical services.

Survey participants did not identify hospitals as the primary safety net for the uninsured. In general, participants most often identified physicians, clinics, and health centers as sources of low-cost care. Specifically, 45% of the uninsured received healthcare from clinics or health centers and 26% identified a physician office as their main source of healthcare. Only 8% of those surveyed identified the hospital emergency department (ED) as their primary healthcare safety net. However, other HSC research has shown that, in general, the uninsured receive over half of their outpatient care from hospital-based facilities. In addition, typically 25% of all outpatient visits to hospitals by the uninsured are ED visits.

The HSC survey report concluded with the following observations:

That more than half of the uninsured are unaware of safety net providers in the communities may also reflect the fact that so few identify hospital-based outpatient settings as sources of lower-cost care. While visits to hospital outpatient and emergency departments make up more than half of all outpatient visits by uninsured people, a comparatively smaller number of uninsured identified hospital-based facilities as safety net providers. Since services received in hospital-based settings are usually more expensive than in clinics or private physician offices, the uninsured may not perceive that hospitals are lower-cost sources of care, even if the services are provided at a discounted rate.
Concerns have also been raised about some hospitals charging uninsured patients more than insured patients, implementing stringent eligibility standards for uncompensated care, and using aggressive bill collection practices as a way to discourage future use, all of which may add to the perception among many uninsured people that hospitals are not sources of lower-cost medical care.  

How EMTALA impacts charity-care policies  
All hospitals, not just hospitals that participate in Medicare, must comply with the Emergency Medical Treatment and Labor Act (EMTALA). Passed by Congress in 1986, this act ensures access to emergency services regardless of an individual’s ability to pay. Hospitals with EDs must provide a medical screening examination whenever a patient arrives in the ED and requests the examination or is in labor, regardless of the individual’s ability to pay. Thereafter, hospitals are required to provide stabilizing treatment or appropriate transfer if the patient requests the transfer or if the hospital is unable to stabilize the patient within its capability.  

How do the EMTALA rules impact hospital charity-care practices? Patient access staff must be careful that there is no suggestion of a link between the patient’s ability to pay and the hospital’s provision of service. To this end, many providers have implemented abbreviated initial registration activities, followed by a comprehensive patient discharge process upon completion of the ED services.  

The 2003 EMTALA regulations permit hospitals to follow a reasonable registration process, including asking for demographic, insurance, and emergency contact information, as long as that inquiry does not delay screening or treatment. However, there is also the caveat that the registration process may not unduly discourage patients from remaining for additional evaluation and treatment.  

Tax exempt status—federal level  
A significant issue for many nonprofit hospitals is their federal, state, and local tax-exempt status. For federal purposes, status as a 501(c)(3) organization requires that the organization meet specific regulatory and statutory requirements. Beginning with the articles of incorporation and bylaws, the organization must establish its existence as an exclusively charitable organization. The organization should prohibit substantial unrelated business activity not associated with the organization’s exempt purposes.  

The organization may participate in a limited number of unrelated business activities, as long as those activities are an insignificant part of the organization’s total activities. The government then taxes revenue from the unrelated activities as unrelated business income.
To qualify for tax-exempt status, the organization must provide a public service or serve the public interest. The organization must also prove that it does not benefit private individuals. In order words, profits may not accrue to private individuals, only to the corporation as a whole.

**Criteria for tax-exempt status**

The Community Benefit Standard Test (Rev Rul.69-545) looks at the following factors in relation to a hospital’s tax-exempt status:

- Does the hospital offer emergency services to all individuals without regard to the patient’s ability to pay for those services? *Note: The EMTALA regulations require this of all hospitals with dedicated EDs.*

- Does a community board govern the hospital?

- Does the hospital maintain an open medical staff?

- Does the hospital provide nondiscriminatory treatment for Medicare and Medicaid patients?

- Does the hospital serve a broad spectrum of the community such that the community obtains a benefit from the hospital’s existence? If the organization uses charity care write-offs to meet the community benefit standard, it must document the amount of charity care provided.

There has been a presumption by the Internal Revenue Service (IRS) that collection efforts may undercut the status of charity care for nonprofit hospitals. However, in the St. David’s Health Care System case, the federal court held that “charitable services may include collection attempts as long as patients who were found unable to pay their bills often had them reduced or entirely canceled.”

For the majority of nonprofit hospitals, the issue is not *meeting* these requirements, but rather providing the public and governmental agencies with sufficient information to *demonstrate* meaningful compliance. The IRS 990 reporting requirement is important because, under IRS regulations, tax-exempt organizations are required to make available the community benefit information to anyone requesting that information.
Disclosure of charity-care dollars
Nonprofit hospitals derive their tax-exempt status in part from the provision of charity care. But how much charity care do hospitals provide? That is a fundamental question driving the discussion on this issue. Hospitals typically track the amount of charity care provided, but disclosing the basis for the total dollars reported and publicly reporting total dollars are different issues.

According to a Modern Healthcare survey in June 2004, most hospitals do not report charity care in their public disclosures, even though the IRS requires “complete” disclosure of charity provided. Even when the hospital reports the dollars of charity care, there is no standard reporting criteria to enable the reader to know whether the figures provided are gross charges or the actual cost of the charity care provided. According to the HCPro survey, only 78% of the respondents indicated that their facilities report charity dollars on the annual IRS 990 forms.

The issue of a lack of standardized reporting is highlighted by the following data from the HCPro survey:

What is included in your facility’s definition of charity for tax reporting purposes?

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<td>Volunteer hours</td>
<td>13%</td>
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<tr>
<td>Health screenings</td>
<td>39%</td>
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<td>Community service hours</td>
<td>35%</td>
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<tr>
<td>Charity deductions from revenue</td>
<td>94%</td>
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<tr>
<td>Other</td>
<td>10%</td>
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Congressional hearings for charity care
In 2004, several congressional committees began investigating hospital billing and collection practices as well as hospital charging practices and the tax-exemption issue. First, on June 22, 2004, the House Ways and Means Subcommittee on Oversight held hearings on the tax-exemption issue. Although there are more than 300,000 tax-exempt 501(c)(3) entities, hospitals represent only 1.9% of this total number of entities. However, hospitals account for 41% of the total expenditures. Industry estimates place 80-85% of all hospitals into the tax-exempt category. Citing this data, the chairman opened hearings on two topics: healthcare charity practices and hospital pricing practices.

A key question posed by the committee chairman related to the ability to differentiate between the for-profit and nonprofit hospitals. Testimony from several experts agreed that the market practices of the nonprofit
hospitals are different from that of the for-profit institutions. There was also consensus that the determining factors of a hospital’s qualification as nonprofit should go beyond the issue of charity care or uncompensated care to include the institution’s role in the community, community service, etc. Finally, the panel agreed that more information made available to the public in understandable ways involving cost, and more importantly, cost and quality, would be valuable.

Healthcare industry representatives provided testimony concerning costs and pricing strategies, noting that charges are often a byproduct of negotiated discount and fee arrangements. Also, charges only distantly relate to cost. Thus, nonprofit providers have developed mechanisms to deal with uninsured and underinsured patients. Aggressive discounting to this group of patients was cited by Richard Morrison from Adventist Health System as one solution to the cost/charge dilemma.

The initial hearing was basically a fact-finding effort, which also highlighted the fact that individual nonprofit hospitals have vastly different charity-care practices.

Two days later, on June 24, 2004, the House Committee on Energy and Commerce Subcommittee on Oversight and Investigations opened hearings to follow up on letters sent in July 2003 to 20 of the largest hospital systems. In the fact-finding request letter, the committee indicated that they are “conducting an investigation into the billing practices of certain medical providers under which the uninsured are expected to pay substantially higher amounts for medical services than third party health plans such as medical insurers, health maintenance organizations and preferred provider organizations (collectively, “third party health plans”), or government health care programs. These practices raise significant public health and consumer protection issues. The uninsured seem caught in the middle of the sophisticated and complicated forces driving health care financing including government entitlements, managed care, rising costs and shrinking public funds.”

The letter went on to discuss the uniform chargemaster requirement, the inflation of charges above costs, and the lack of discounting to uninsured patients. The 20 items requested by the committee represent a substantial data collection effort. The committee had not published the complete transcript and data analysis as of January 3, 2005.

The stated purpose of the committee was to reduce the rates charged to uninsured patients. The committee recommended tying rates charged to the uninsured to the discounted rates given to managed care payers. Testimony from Herb Kuhn, director for the Center for Medicare Management for CMS, repeated CMS’
position that Medicare program rules and billing requirements do not prohibit discounts as long as the provider reports full charges on the cost report and maintains records, as in any business. Further, indigency rules do not prevent discounting to uninsured, and providers can make medical indigency determinations. Finally, he reconfirmed that the Medicare rules do not require providers to be aggressive in the collection of accounts. However, the regulations do require similar treatment of Medicare and non-Medicare accounts.

Other testimony suggested that Congress could require hospitals to provide patients with information about payment options when admitted, which should benefit the uninsured. Mark Rukavina, executive director of the Access Project, stated his group’s frustration at the lack of written information available from providers to patients about payment options, collection processes, and discounts.

**Summary**
The number of uninsured individuals as well as the steady increase in the federal poverty levels evidences the need for charity care. Nonprofit hospitals have a huge incentive to provide charity care as part of their efforts to meet the community benefit standard for maintaining their tax-exempt status. The 2004 CMS clarifications concerning discounting to uninsured and underinsured patients has opened the door for significant revisions to charity and discounting practices; the challenge for providers is to implement meaningful change while protecting the financial viability of their organizations.

**Notes**

1. The names of the family members, communities and the hospital have been eliminated.
6. Source: 349 F.3d 232, 236n3 (5th Cir. 2003)
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