

The Methodist Le Bonheur Center for Healthcare Economics
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UNCOMPENSATED HEALTH CARE IN TENNESSEE: WHAT ARE THE COSTS?

I. WHAT IS THE ISSUE?

Uncompensated care (UCC) is health care provided by hospitals, clinics, physicians, and other providers for which no specific reimbursement is received from either the patient or the patient's insurer. The amount of UCC provided has been rising continuously over recent decades. In 2013, the value of this care in the nation as a whole was estimated to be \$84.9 billion.¹ Most of the care is provided to patients who are uninsured either throughout or during part of a year; in 2013, approximately 70.0 percent of all medical expenses for the uninsured were uncompensated, and over three-fourths of all UCC delivered was for the uninsured.²

The cost of UCC presents critical challenges to the healthcare delivery and finance systems. Hospitals absorb some of the costs of uncompensated care and seek to cover the rest from other payers, raising expenditures for payers and, often, insurance premiums for the insured. Governments cover some of the costs from public funds, either directly through government-owned facilities or indirectly through a complex web of funding streams to hospitals. Individual providers commonly resort to

¹ T. A. Coughlin, J. Holahan, K. Caswell, and M. McGrath, "An Estimated \$84.9 Billion in Uncompensated Care Was Provided in 2013: ACA Payment Cuts Could Challenge Providers," *Health Affairs* 33(5): 807-814, 2015.

² Coughlin et al., "An Estimated \$84.9 Billion in Uncompensated Care Was Provided in 2013."

not accepting new patients who do not have well-paying insurance coverage.³ The challenges created by UCC are greatest in rural areas that have a higher prevalence of uninsured, placing rural providers at greater financial vulnerability than their urban counterparts.⁴

In this report, the levels and growth of uncompensated care in Tennessee during the three-year period from 2012 to 2014 will be examined. Specific issues to be explored include (a) how much uncompensated care is provided in Tennessee, (b) what the recent trend in this care has been, and (c) what the implications of these costs are.

II. WHAT IS THE BACKGROUND?

Uncompensated care is commonly considered to equal the sum of “bad debt” (that is, charges for care for which reimbursement was sought but not received) and financial assistance or “charity care” charges (that is, charges for care for which reimbursement was not expected).⁵ The two categories are usually combined in analyses because the distinctions between them vary from facility to facility and over time.⁶

³ C. Boccuti, C. Fields, G. Casillas, and L. Hamel, *Primary Care Physicians Accepting Medicare: A Snapshot* (Menlo Park, CA: The Kaiser Family Foundation, October 2015).

⁴ K. L. Reiter, M. Noles, and G. H. Pink, “Uncompensated Care Burden May Mean Vulnerability for Rural Hospitals in States That Did Not Expand Medicaid,” *Health Affairs* 34(10):1721-1729, 2015.

⁵ American Hospital Association, *Uncompensated Hospital Care Cost Fact Sheet* (Chicago: American Hospital Association, January 2015).

⁶ Some estimates of uncompensated care include other categories, such as losses from lower Medicaid payment rates (see, for example, New Mexico Legislative Finance Committee, *Uncompensated Care in New Mexico After the Affordable Care Act*, 2015), estimated to have cost hospitals \$13.2 billion in 2013 (American Hospital Association, *Underpayment by Medicare and Medicaid Fact Sheet*, 2015).

Estimates of the actual amount of UCC provided by hospitals and other providers vary depending upon the definition of UCC, the accounting methods used, and other variables. Teresa Coughlin of the Urban Institute and her associates have estimated that in 2013 the total UCC provided was between \$74.9 billion and \$84.5 billion, including \$44.6 billion provided by hospitals, \$19.8 billion provided by community clinics, and \$10.5 billion provided by office-based physicians.⁷ The American Hospital Association has reported that UCC costs have more than doubled since 2000 (although the corresponding proportion of hospital revenue from different sources has remained stable).⁸

Most of this uncompensated care is provided to the uninsured. In 2013, approximately 70.0 percent of total medical care expenditures for the uninsured was uncompensated care.⁹ And, as may be expected, the volume of uncompensated care is directly related to the number of uninsured in a region. Craig Garthwaite and his associates have estimated that the rise in the number of uninsured in Tennessee after the TennCare disenrollment effort in 2005 resulted in an increase in uncompensated care of \$1,048-\$1,678 for each newly uninsured person.¹⁰ The implications of this relationship to health insurance expansion under the Patient Protection and Affordable Care Act (ACA) may be substantial and will be considered below.

⁷ Coughlin et al., “An Estimated \$84.9 Billion in Uncompensated Care Was Provided in 2013.”

⁸ American Hospital Association, *Uncompensated Hospital Care Cost Fact Sheet*.

⁹ Coughlin et al., “An Estimated \$84.9 Billion in Uncompensated Care Was Provided in 2013.”

¹⁰ C. Garthwaite, T. Gross, and M. J. Notowidigdo, *Hospitals as Insurers of Last Resort* (Cambridge, MA: National Bureau of Economic Research, June 2015).

Hospitals, as opposed to most other types of businesses, for several reasons continue to provide UCC to patients who cannot pay. First, they are guided by a humanistic code that encourages providing care for all in need. Second, federal law requires that they do so. For example, the Emergency Medical Treatment and Labor Act (EMTALA) requires that hospitals provide care for many emergency conditions regardless of payment. Third, tax laws require that not-for-profit hospitals provide substantial “community benefit,” including providing uncompensated care, to offset the loss in local tax revenue. In 2009, for example, tax-exempt hospitals spent 7.5 percent of their operating expenses on community benefits, of which approximately 25.0 percent was allocated to charity care.¹¹ The high burden of UCC on hospitals led Garthwaite and associates to refer to hospitals as “an additional form of social insurance in that they are health insurers of last resort.”¹²

Of course, this uncompensated care is not “free.” The costs are borne by a complex system of offsetting payments from local, state, and federal governments; from donations; by cost-shifting to private payers, when feasible; and from internal hospital financial resources. Estimates have suggested that in 2013, 62.0 percent of uncompensated care was financed by governments, 12.0 percent by in-kind contributions by physicians, and 26.0 percent by cost-shifting from other sources, especially private insurers.¹³ Importantly, although governmental payments provide

¹¹ G. J. Young, C-H Chou, J. Alexander, S-Y D. Lee, and E. Raver, “Provision of Community Benefits by Tax-exempt U.S. Hospitals,” *New England Journal of Medicine* 368:1519-1527, 2013.

¹² Garthwaite et al., *Hospitals as Insurers of Last Resort*.

¹³ Coughlin et al., “An Estimated \$84.9 Billion in Uncompensated Care Was Provided in 2013.”

substantial funds to support UCC, these payments are largely indirect and are poorly aligned with UCC provided at individual hospitals.

III. HOW MUCH UNCOMPENSATED CARE IS PROVIDED IN TENNESSEE?

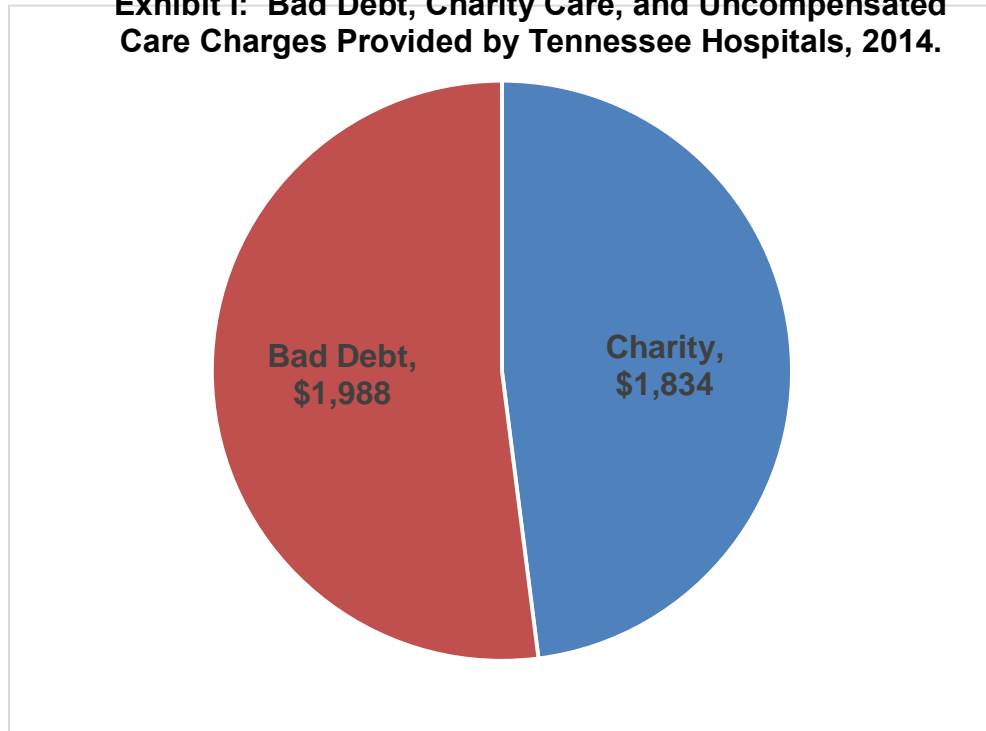
This report focuses on the uncompensated care burden in Tennessee. Data were examined for all non-federal, short-term, general medical/surgical hospitals (that is, excluding, for example, behavioral health and specialty hospitals) from the most recent and previous releases (2014, 2013, and 2012) of the Tennessee *Joint Annual Report of Hospitals (JAR)*.^{14,15} These reports include data provided by each Tennessee hospital, including information on governance, utilization, and financing. Hospitals were excluded (seven hospitals) if the data were not reported for each of the three years or if the reported data seemed implausible (e.g., negative values for bad debt or revenue).

Data presented in Exhibit I show the level of uncompensated hospital care (including both inpatient and outpatient services) and its components for the 123 general medical/surgical hospitals furnishing complete information. Total uncompensated care provided by hospitals equaled \$3,822 million in 2014, the latest year for which *JAR* data are available. Of this total, 52.0 percent (\$1,988 million) was bad debt and the remaining 48.0 percent (\$1,834 million) was charity care. The total represented 7.24 percent of gross patient care charges billed for reimbursement by these hospitals.

¹⁴ Available at <https://www.tn.gov/health/article/statistics-jar>.

¹⁵ The years correspond to the year of the release of the *Joint Annual Report* and do not necessarily correspond to data for that calendar year for each hospital.

Exhibit I: Bad Debt, Charity Care, and Uncompensated Care Charges Provided by Tennessee Hospitals, 2014.

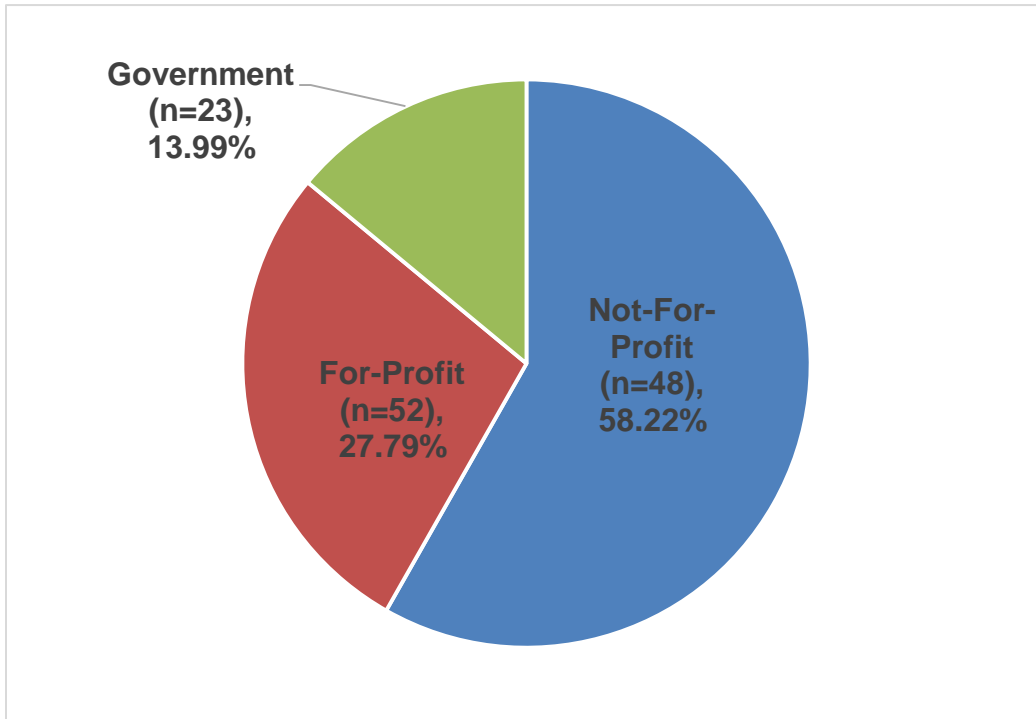


Source: Authors' analysis of the *Tennessee Joint Annual Report of Hospitals*, 2014 edition. Values include data from 123 acute care, general hospitals, as described in the text. Dollar values are in millions.

The amount of uncompensated care varied by the type of hospital ownership and governance (Exhibit II). Not-for-profit hospitals (48 hospitals) provided 58.2 percent of total uncompensated care in 2014, although they represented only 39.0 percent of all hospitals. The 18.7 percent of hospitals that were government-owned or operated (23 hospitals) provided 14.0 percent of uncompensated care. The remaining 52 facilities that were investor-owned, for-profit hospitals represented 42.3 percent of all hospitals but provided only 27.8 percent of total uncompensated care.

The proportion of uncompensated care provided by the three hospital ownership groups was also compared to the total net patient care revenue of the hospitals in the

Exhibit II: Uncompensated Care Charges by Ownership Type,



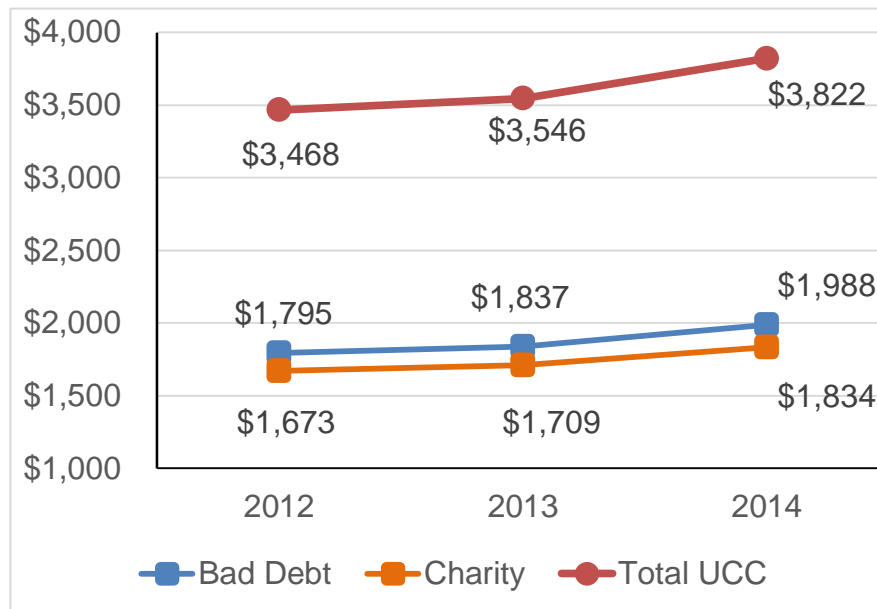
Source: Authors' analysis of the *Tennessee Joint Annual Report of Hospitals*, 2014 edition. Values include data from 123 acute care, general hospitals, as described in the text. Dollar values are in millions.

three groups (rather than the number of hospitals in each group). The proportion of all uncompensated care provided by each group was almost the same as the proportion of all net patient revenue received by that hospital group. Government-owned hospitals received 14.0 percent of net patient care revenue and provided 14.0 percent of uncompensated care, for-profit hospitals received 26.1 percent of net patient care revenue and provided 27.8 percent of uncompensated care, and not-for-profit hospitals received 59.9 percent of net patient care revenue and provided 58.2 percent of uncompensated care.

IV. WHAT ARE THE TRENDS IN UNCOMPENSATED CARE?

The trends in uncompensated hospital care as reported in the 2012-2014 *JAR* data are shown in Exhibit III. In terms of gross charges billed, the level of bad debt grew by \$193 million, from \$1,795 million to \$1,988 million (a 10.8% increase). Charity care increased by \$161 million, from \$1,673 to \$1,834 million (a 9.6% increase). Hence, overall uncompensated hospital care rose by \$354 million from \$3,468 million to \$3,822 million (a 10.2% increase) over the three-year period. When expressed as a percentage of gross patient charges, however, the level of uncompensated hospital care fell from 7.5 percent to 7.2 percent over the period, reflecting a steady rise in patient charges billed for payment by hospitals.

Exhibit III: Bad Debt, Charity Care, and Uncompensated Care Charges for Tennessee Hospitals, 2012-2014



Source: Authors' analysis of the Tennessee *Joint Annual Report of Hospitals*, 2012, 2013, and 2014 editions. Values include data from 123 acute-care, general hospitals, as described in the text. Dollar values are in millions.

Between 2012 and 2014, 65 (52.8%) of the included hospitals reported an increase in total uncompensated care, and the remaining 58 (47.8%) reported a decrease. Similarly, 73 (59.3%) of the hospitals reported a rise, and 50 (40.7%) reported a decline in total uncompensated care between 2013 and 2014.

V. WHAT DO THESE TRENDS SUGGEST?

The findings described above indicate that uncompensated care in Tennessee is large and has risen substantially over the past three years. Between 2012 and 2014, uncompensated care provided by Tennessee hospitals increased by \$354 million—an increase of over 10.0 percent.

This increase in total UCC charges may be considered in the broader context of hospital finances during a critical period in which the Affordable Care Act began to significantly reduce the number of uninsured across the country. Although the absolute amount of bad debt and charity care rose in Tennessee between 2012 and 2014, the overall proportion of hospital charges and net patient care revenue related to uncompensated care remained relatively stable over the three-year period. In addition, many Tennessee hospitals reported a decrease rather than an increase in UCC; between 2012 and 2014, only slightly more than half (65 of 123 hospitals) of the included hospitals reported an increase in UCC charges.

A decline in both the level and proportion of UCC in the state would, however, have been expected as a result of the decrease in the number of uninsured Tennesseans over the three-year time period. According to data reported by the U.S. Census Bureau, the number of nonelderly uninsured in Tennessee fell by 110,000

between 2013 and 2014.¹⁶ The decline in the number of uninsured in Tennessee would have been expected to reduce UCC by \$32.1 million based upon data from the Department of Health and Human Services.¹⁷ Reasons for the seemingly paradoxical rise in UCC are not clear.

National studies have documented that not-for-profit and government hospitals shoulder a greater proportion of UCC than do for-profit hospitals.¹⁸ This relation also held in Tennessee in 2014 (Exhibit II). However, when the proportionate UCC load was expressed in relation to the proportion of net patient care revenue, all three hospital groups appeared to bear roughly equivalent UCC burdens.

Variations in Uncompensated Care Estimates. The data presented above relate only to uncompensated care provided by general medical/surgical hospitals and are measured in terms of hospital charges billed to third-party payers and patients. Three other estimates may also be suggested (Exhibits IV and V).

Analyses by Teresa Coughlin and her associates¹⁹ at the Urban Institute allow us to expand these estimates to include providers other than hospitals, that is, community clinics and physicians. Their studies of national data have indicated that approximately 59.5 percent of all uncompensated care is provided by hospitals, 26.4 percent by

¹⁶ J. C. Smith and C. Madalla, *Health Insurance Coverage in the United States, 2014* (Washington, DC: United States Census Bureau, September 2015).

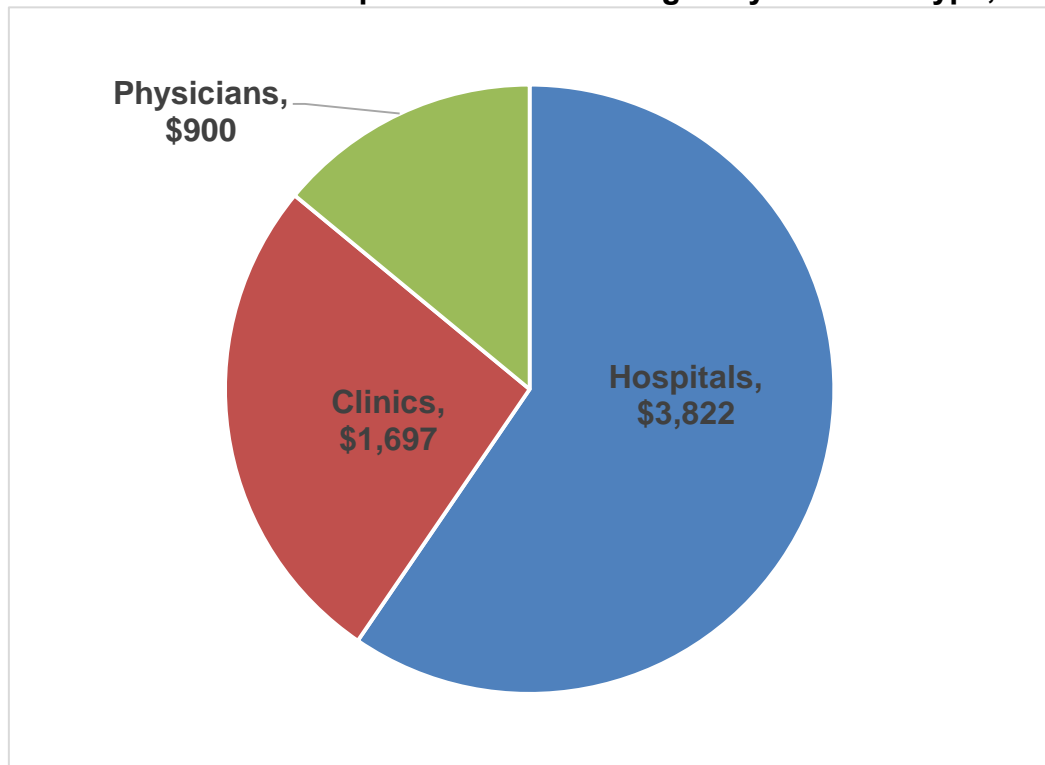
¹⁷ T. DeLeire, K. Joynt, and R. McDonald, *Impact of Insurance Expansion on Hospital Uncompensated Care Costs in 2014* (Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, 2015).

¹⁸ Garthwaite et al., *Hospitals as Insurers of Last Resort*.

¹⁹ Coughlin et al., "An Estimated \$84.9 Billion in Uncompensated Care Was Provided in 2013."

publicly-supported clinics, and 14.0 percent by physicians. Applying these proportions to Tennessee hospital data for 2014 (Exhibit IV) shows that the total amount of uncompensated care provided in the state in 2014 was \$6,419 million in hospital charges billed, with \$3,822 million (59.6% of total) provided by hospitals, \$1,697 million (26.4% of total) by community-based clinics, and \$900 million (14.0% of total) by physicians.

Exhibit IV: Uncompensated Care Charges By Provider Type,



Source: Authors' analysis of the *Tennessee Joint Annual Report of Hospitals*, 2014 edition. Values include data from 123 acute care, general hospitals, as described in the text. Dollar values are in millions.

It is also well known, as discussed in an earlier *Health Care Blog*,²⁰ that hospital charges are poorly and variably related to the actual costs of hospital services.²¹ Hence, as described by the American Hospital Association, the volume of uncompensated care provided by a hospital may be expressed in terms of the actual costs by multiplying the charges for the uncompensated care of each hospital by that hospital's charge-to-cost ratio.^{22,23} Doing so for each of the study hospitals indicated that in 2014 the cost of uncompensated care for Tennessee hospitals was \$973 million—or approximately one-fourth of the estimated UCC hospital charges.

A third variation in the calculation is based upon the proportion of uncompensated hospital care charges that might reasonably be expected to have been collected if the uninsured patients generating these charges had health insurance. This estimate may be important as representing (a) a more realistic loss in revenue to hospitals than total charges, (b) a more realistic estimate of a hospital's community benefit expenditure, and (c) an estimate of the increase in hospital income that may be expected under a full health insurance coverage scenario.

²⁰ D. M. Mirvis and C. F. Chang, *Variations in Healthcare Charges: Does Anyone Know How Much It Will Cost?* (Memphis, Tennessee: The University of Memphis, August 2015) (available at http://www.memphis.edu/mlche/pdfs/blog/blog_variations_costs_aug_20_2015.pdf).

²¹ U. E. Reinhardt, "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy," *Health Affairs* 25(1):57–69, 2006.

²² American Hospital Association, *Uncompensated Hospital Care Cost Fact Sheet*.

²³ The cost-to-charge ratio for each hospital was estimated from the *JAR* as the ratio of total costs to gross patient care charges.

Exhibit V: Estimates of Uncompensated Care Charges and Costs, 2014

UCC CALCULATION	AMOUNT
Hospital UCC Charges	\$3,822 million
Total UCC	\$6,419 million
Hospital UCC Costs	\$973 million
Reimbursable Estimate - All Payers	\$915.9 million
Reimbursable Estimate - Medicaid	\$648.6 million

Source: Authors' analysis of the Tennessee *Joint Annual Report of Hospitals*, 2014 edition. Values include data from 123 acute-care general hospitals, as described in the text.

To provide an estimate of the value of UCC that hospitals can realistically expect to receive from third-party payers, total UCC charges were multiplied by the percentage of all charges and of Medicaid charges that were actually collected by each hospital. As shown in Exhibit V, if all UCC charges (\$3,822 million) were reimbursed at the collection rate for all payers (a mean of 24.6%), hospitals would have received an additional \$915.9 million in 2014. If each hospital's UCC was reimbursed at the lower Medicaid collection rate (a mean of 17.3%), the 123 acute-care hospitals would have received an additional \$648.6 million in 2014.

Impacts of Health Insurance Expansion and the Patient Protection and Affordable Care Act. As noted earlier, most uncompensated care is provided to the uninsured. Hence, expansion of insurance coverage under the Patient Protection and Affordable Care Act (ACA) would be expected to reduce the uncompensated care burden of hospitals and other providers. This expectation served as the basis for reductions, as

part of the ACA, in disproportionate sharing (DSH) funds that are largely intended to compensate for the costs of care for the uninsured.²⁴

Early evidence, although limited, does support the prediction that the ACA-mediated expansion of insurance reduces UCC. For example, the Arizona Hospital and Healthcare Association reported a 31.0 percent drop in UCC between the first quarters of 2013 and 2014.²⁵ The health insurance reforms in Massachusetts that were initiated in 2006 and that served as a conceptual framework for the later ACA were associated with a 40.0 percent reduction in UCC during the first full year of implementation.²⁶

This reduction in UCC has been more pronounced in states that have expanded Medicaid coverage under the ACA. The Department of Health and Human Services projected that UCC would be \$7.4 billion lower (a 21.0% decrease) in 2014 than if health insurance coverage were the same as before the ACA, with a decrease of 26.0 percent in expansion states and a 16.0 percent reduction in the others.²⁷ In a comparison of ten states that did expand Medicaid and six states that did not, the number of uninsured hospital admissions declined by 36.9 percent between 2013 and

²⁴ J. A. Graves, "Medicaid Expansion Opt-outs and Uncompensated Care," *New England Journal of Medicine* 367:2365-2367, 2012.

²⁵ DeLeire et al., *Impact of Insurance Expansion on Hospital Uncompensated Care Costs in 2014*

²⁶ "Access to Health Care in Massachusetts: Results from the 2008 and 2009 Massachusetts Health Insurance Survey," *2009 Annual Report—Health Safety Net* (Boston: Massachusetts Division of Health Care Finance and Policy, 2009).

²⁷ Assistant Secretary for Planning and Evaluation, *Insurance Expansion, Hospital Uncompensated Care, and the Affordable Care Act* (Washington, DC: U.S. Department of Health and Human Services, March 25, 2015).

2014 in the expansion states but by only 2.9 percent in the states that opted out of Medicaid expansion.²⁸

Using data from other states, it may be possible to estimate, if only very roughly, the impact that Medicaid expansion would have on uncompensated care in Tennessee. An analysis of the 2015 Current Population Survey by the Kaiser Family Foundation indicated that 218,000 uninsured Tennesseans would have been eligible for Medicaid if the state had opted in the eligibility expansion under the ACA.²⁹ Based upon the findings of Coughlin and associates³⁰ that the average uninsured person generates \$1,257 in uninsured care per year and an estimate from Urban Institute's Insurance Policy Simulation Model (HIPSM)³¹ that 73.0 percent of persons eligible to enroll in Medicaid would do so, expanding Medicaid coverage in Tennessee would have reduced UCC by \$119 million for hospitals and \$200 million for all three types of providers, respectively.

VI. CONCLUSIONS

The information presented here indicates that hospitals and other healthcare providers in Tennessee deliver a large and increasing amount of uncompensated care. The actual amount of this care reported to the state government varies with whether the

²⁸ R. Rudowitz and R. Garfield, *New Analysis Shows States with Medicaid Expansion Experiences Declines in Uninsured Hospital Visits* (Menlo Park, CA: The Kaiser Family Foundation, September 2015).

²⁹ R. Garfield and A. Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update* (Menlo Park, CA: The Kaiser Family Foundation, January 2016).

³⁰ Coughlin et al., "An Estimated \$84.9 Billion in Uncompensated Care Was Provided in 2013."

³¹ Matthew Buettgens, *HIPSM Methodology* (Washington, DC: The Urban Institute, 2011). <http://www.urban.org/research/publication/health-insurance-policy-simulation-model-hipsm-methodology-documentation>.

providers are for-profit, non-profit, or government-owned institutions or entities, although the relative burdens in relation to patient care revenue actually received are similar.

The amount also varies with the definition used, that is, whether the estimates are based upon charges, costs, or expected reimbursements. Expanding health insurance coverage in the state by, for example, some form of Medicaid expansion will substantially reduce this burden, although a large number of uninsured and a large amount of uncompensated care will remain.

*** End of Blog ***

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