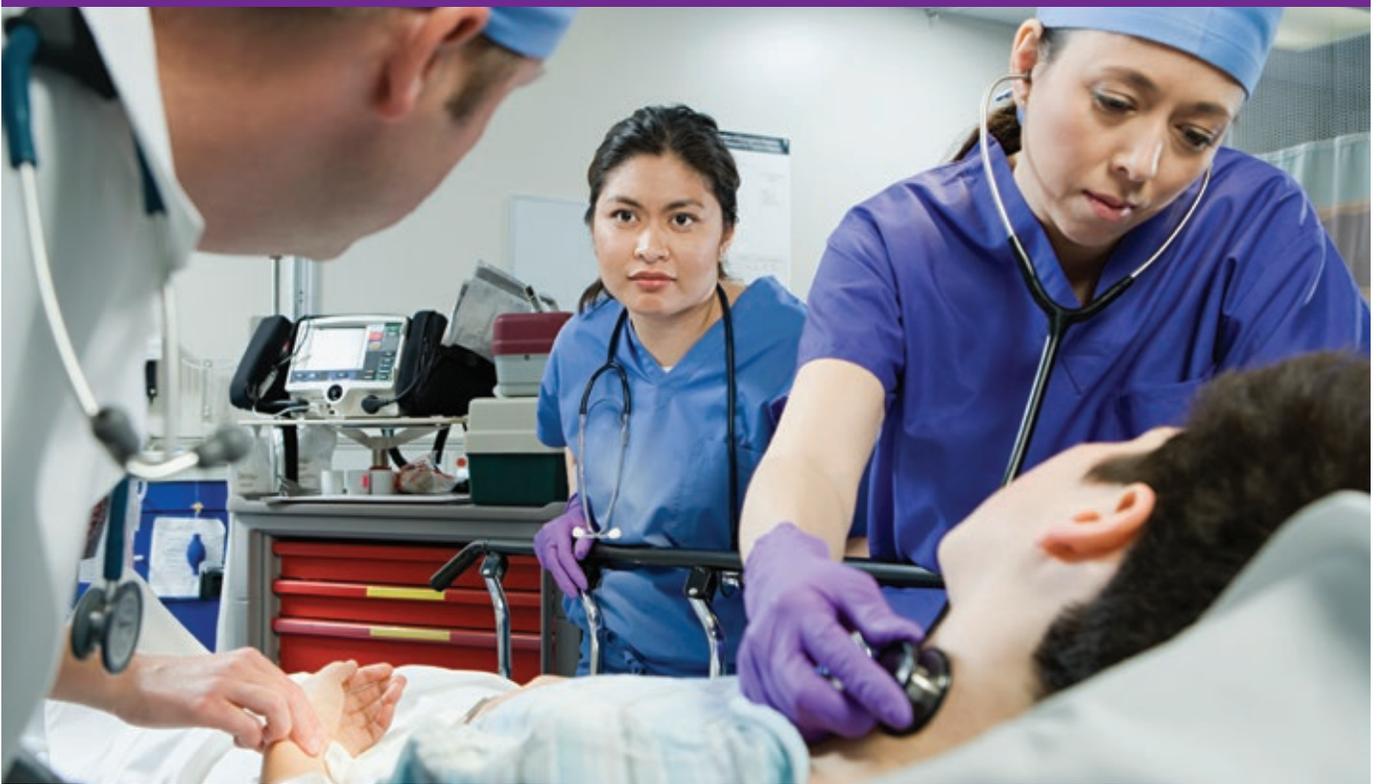


POLICY BRIEF 2015-07

A Floor-and-Trade Proposal to Improve the Delivery of Charity-Care Services by U.S. Nonprofit Hospitals

OCTOBER 2015



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A Floor-and-Trade Proposal to Improve the Delivery of Charity-Care Services by U.S. Nonprofit Hospitals

In the United States, when patients are unable to pay all or part of their bill, nonprofit hospitals either provide charity care, with no expectation of payment, or they bill patients and categorize the unpaid portion of the bills as bad debt. In 2011 nonprofit hospitals provided \$57 billion in uncompensated care (i.e., both charity care and bad debt). In a new Hamilton Project discussion paper, David Dranove, Craig Garthwaite, and Christopher Ody highlight that the supply of charity care and demand for charity care are not geographically well aligned. Nonprofit hospitals in high-income areas have more financial resources available to provide charity care, but hospitals in the poorest communities face the largest demand for uncompensated care. Because of this geographic mismatch between resources and demand, there are holes in the health-care safety net that expose many low-income individuals to potentially crushing medical debt.

To address this problem, Dranove, Garthwaite, and Ody propose a floor-and-trade system to strengthen the health-care safety net and to direct charity care toward the neediest patients in low-income areas. In their proposal, states would set a minimum level of charity care (a “floor”) that would dictate the minimum share of a nonprofit hospital’s operating costs that must be dedicated to charity care. States would then set a family “income threshold”: hospitals may count as charity care toward their mandated floor only that care provided to families with incomes below the threshold. To meet these requirements, nonprofit hospitals would have the option to trade charity-care credits to adjust for variations in each area’s level of need. That is, hospitals falling short of the floor would be allowed to purchase credits from hospitals providing charity care in excess of the minimum. By allowing hospitals to trade credits, the authors emphasize that this proposal directly addresses the geographic mismatch in charity-care need more efficiently than previous floor-only proposals.

The Challenge

A variety of U.S. public sector programs provide health insurance to individuals with limited resources. Even with these public programs in 2011 hospitals provided \$57 billion in uncompensated care, which is a combination of charity care, for which the hospital does not seek repayment, and services for which the hospital unsuccessfully attempted to collect payment, known as bad debt. The authors estimate that 59 percent of this amount was bad debt, suggesting that many of the uninsured and underinsured patients who receive hospital care are left owing medical debts. In the event of a medical crisis even those with health insurance may face high deductibles that they are unable to pay.

The authors argue that geographic disparities lead to higher demand for charity care in low-income areas where hospitals have the fewest resources to meet such demand. Nonprofit hospitals in high-income areas provide charity care, but they are not able to treat uncompensated patients outside of their catchment area. As a result, patients receiving charity care at these hospitals tend to have higher incomes than do patients receiving such care in lower-income areas. Moreover, according to the authors, the Patient Protection and Affordable Care Act (ACA) might have exacerbated this mismatch, particularly in states that have not implemented the ACA’s Medicaid expansion, because the poorest segment of the population is exempt from the insurance mandate.

BOX 1.

The Geographic Mismatch

Geographic location may determine whether a patient faces crushing medical debt. The authors find that a patient living in a higher-income area is more likely to receive charity care than is another patient who has the same income but lives in a lower-income area. As an example, their analysis shows that if a hospital in a community with an average income of \$23,850 (100 percent of the federal poverty level, or FPL) sets an eligibility threshold for a family of four at \$23,850, then a similar hospital in a community with an average income of \$95,400 (400 percent of the FPL) would set its threshold at \$32,436. Patients with incomes between \$23,850 and \$32,436 would receive charity care at the second hospital but not at the first; they would thus face far different financial consequences, depending on which hospital treats them.

Even with income thresholds for eligibility for charity care, not all individuals below the threshold will receive charity care. Bad debt—when hospitals unsuccessfully attempt to collect payment—is most common in the lowest-income hospital markets. Hospitals in low-income areas devote comparatively more of their operating budgets to charity care, and at the same time face the highest uncompensated care expenses.

A New Approach

The authors' proposal features three components:

1. Each state sets its own “floor” for charity care, which allows for state-level differences in preferences and need.
2. Each state sets the “income threshold” above which uncompensated care would not be considered charity care for the purposes of meeting the floor.
3. Each state establishes a system of tradeable credits, through which nonprofit hospitals in areas with different demand for charity care can trade charity-care credits to meet their state's floor. This would also allow nonprofit hospitals to focus on patients below the income threshold, regardless of how many of these patients are in their service area.

State-Level Charity Care Floor and Income Thresholds

The authors propose, first, that each state set a floor for the percentage of a hospital's operating costs that must be dedicated to charity care per year. The average nonsystem nonprofit hospital (i.e., one that is not part of a hospital system and does not distribute profits) currently dedicates 2.3 percent of operating expenses to charity care annually; this percentage varies substantially across states, however. As estimated by the authors, charity care, on average, ranges from as low as 0.32 percent of operating expenses in Hawaii, where the share of uninsured residents is quite low, to 5.06 percent in Wyoming. The authors call for state lawmakers to set a state-level income threshold above which uncompensated care may not count toward a hospital's obligation to meet the charity-care floor. This income threshold would work with the charity-care floor to ensure that hospitals in relatively high-income areas are providing care to the neediest patients, either by meeting the floor or by purchasing credits if they fell short of the floor.

The authors propose establishing the floor-and-trade system at the state level for three reasons. First, the current health insurance safety net is determined at the state level through Medicaid. In fact, some states already regulate the community benefit activities of nonprofit hospitals. For example, 31 states require hospitals to provide some reporting of the community

benefits that they provide and 25 states have specific community benefit standards. Five of these states specific thresholds for the level of community benefit that nonprofit hospitals must provide, such as share of operating costs that a nonprofit hospital must spend on community benefits.

Second, the authors argue that giving states the power to set both the floor and the income threshold allows them to tailor the specifics of implementation to improve efficiency and respond to differing community needs. They maintain that a floor and an income threshold set nationally would likely be too blunt to be able to target charity care to the neediest households. Third, the authors argue that states are the logical actors to determine how these tax benefits are earned because state and local property tax exemptions provide the bulk of the tax savings for nonprofit hospitals.

Definition of Charity Care

In order for a state to set a charity-care floor and an income threshold for patients whose uncompensated care may be counted as charity care, the state must first define what type of hospital expenses qualify as charity care. The authors provide several examples of types of uncompensated care that states should consider in defining charity care. For example, states may want to consider including care for Medicaid patients, who have insurance through a public program designed for those with limited means and whose treatments are not always fully reimbursed, as the rate of insured individuals increases through the ACA. While current IRS regulations count underpayments from Medicaid as a community benefit, the authors' baseline proposal excludes this care. The authors also suggest that each state consider including subsidized preventive care if it reduces the need for free hospital care and if the state would like to expand the safety net to this care (although they note that monitoring preventive care would likely be complex and cumbersome).

While the authors suggest that states make their own determinations about which types of payments to include, they do not believe that states should include bad debt either from uninsured patients or from Medicare shortfalls. The authors maintain that once a hospital seeks payment from a patient, medical bills for that patient should be permanently excluded from the pool of available charity-care credits. The authors also argue that shortfalls from Medicare, the health insurance program for the elderly, should not be counted as charity care because they are generally profitable, as evidenced by how actively for-profit hospitals choose to serve Medicare inpatients, the profitability of outpatient services that are sold in conjunction with inpatient services, and the Medicare reimbursement structure that is designed to produce shortfalls only for inefficient provision.

Setting the Floor and the Income Threshold

While states may choose to set a floor that raises the level of charity care, it is important to note that states may alternatively choose to set the floor as neutral with respect to the existing charity-care costs of their hospital sector. Even if the total amount of charity care remains constant, the authors argue that there would be welfare-improving transfers across hospitals that would result in serving the neediest patients under the income threshold.

The authors suggest several considerations for state lawmakers setting their state's charity-care floor and their income threshold. First, they call for lawmakers to consider the benefits that nonprofit hospitals receive in their state through local and state property tax rates. Lawmakers would also consider the state's unmet demand for charity care, which may include the state's other indigent care programs and whether the state implemented the ACA's recent Medicaid expansion. In setting the charity-care floor lawmakers would determine their state's relative preferences for charity care as compared to other community benefit activities such as research and teaching. In setting the income threshold, the authors propose that lawmakers consider the average income among those who are currently insured in the state.

Tradeable Credit System

Once state lawmakers have set a charity-care floor and an income threshold, the authors propose that states create a system of tradeable credits. By enabling hospitals to trade charity-care credits, the proposal would incentivize hospitals in low-income areas to provide more charity care, and would allow hospitals in relatively high-income areas to be able to provide care for poorer patients, either directly or indirectly by purchasing credits. The authors present several key considerations for structuring the tradeable credit system.

Definition of the Charity Care Credit

The two primary options for measuring charity care are based on the cost to the facility of providing the care and on the type or amount of care that is provided. The authors suggest that charity-care credits may follow current practice to compute the value of charity care, using information about charges and cost-to-charge ratios (based on the Medicare Cost Reports). The primary advantages of this approach are familiarity and standardization, as this is the current accounting-based measure used by Medicare and is widely available. However, the authors acknowledge potential concerns with this measure, such as the fact that measuring credits based on cost to the facility can reward inefficient hospitals that incur higher costs.

Roadmap

- Individual states will enact a floor-and-trade system in which all hospitals are required to provide a minimum amount of charity care to low-income patients, either directly or through purchasing charity-care credits.
 - Each state will define which types of uncompensated care will be counted as charity care.
 - Each state will set a charity-care “floor” as a percentage of a hospital’s operating costs.
 - Each state will set the “income threshold” as the family income limit above which uncompensated care cannot be counted toward a hospital’s charity-care provision.
- Hospitals operating below the charity-care floor will transfer resources to hospitals operating above the floor in exchange for tradeable “charity-care credits.”
 - Each state will designate a regulatory body, such as an existing hospital licensing board or state department, to oversee the exchange.

The authors also discuss an alternative fixed-price schedule to establish the value of various units of care. A state could use Medicare’s diagnosis-related group (DRG) system to specify the value of charity-care services. The advantages of this approach include hospital familiarity with DRGs, ease of both standardization and customization through local wage adjustments, and incentives for hospitals to treat each diagnosis efficiently. However, one key drawback is that lower-cost hospitals may sacrifice quality when treating diagnoses for which they will receive only fixed credit.

Structure of Credit Trading System

Once the state has defined a charity-care credit, it must determine how the trade system will operate. There are two primary means by which hospitals can transfer money to satisfy their charity-care obligations under a floor-and-trade system. The first option is to allow hospitals to simply transfer money directly among themselves. Alternatively, the

Learn More about This Proposal

This policy brief is based on The Hamilton Project discussion paper, “A Floor-and-Trade Proposal to Improve the Delivery of Charity-Care Services by U.S. Nonprofit Hospitals,” which was authored by

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state could establish a regulated pool of charity-care funds. Under this system, hospitals that find themselves above their floor can post credits for their excess charity care to the state exchange and those below their floor could purchase credits from the exchange.

A formal exchange would allow the state to implement more-sophisticated market designs and allow the exchange to adapt to different economic shocks. For example, hospitals might be allowed to bank credits if different hospital fiscal years introduce demand for credits without sufficient supply. This would cushion the exchange for situations like a recession, in which aggregate demand for charity care may rise and hospitals would be able to increase provision of care, and store credits for later.

Conclusion

Millions of Americans face hospital bills they cannot afford, relying on charity care to avoid financial crises. The authors explain that the hospitals that receive the largest tax benefits tend to be located in wealthier communities, whereas the demand for uncompensated care is highest in poorer communities. This leads to a geographic mismatch, in which hospitals in low-income areas are not able to provide enough charity care to help the poorest patients.

In order to address this geographic mismatch and strengthen the health-care safety net, the authors propose a floor-and-trade system for charity-care credits. States would set a floor for the percentage of a nonprofit hospital’s operating costs that must be dedicated to charity care. Then, states would set a family income threshold above which uncompensated care cannot count toward a hospital’s charity-care floor. Nonprofit hospitals would have the option to trade charity-care credits

BOX 2.

How This Proposal Redirects Charity Care and Increases Social Welfare

Suppose Montgomery Burns Memorial Hospital (Burns Memorial) is located in a high-income suburban area and faces a charity-care floor of \$2.5 million. Burns Memorial provides \$1 million in charity care to patients whose incomes are below the income threshold, and \$0.5 million in charity care to patients whose incomes are above it. Burns Memorial also has \$2 million in bad debt, but it is all for patients whose incomes are above the threshold.

Hospital for the Poor (HFP) is located in a low-income area and faces a charity-care floor of \$1.5 million. HFP provides \$2.5 million in charity care, all of it going to patients whose incomes are below the threshold. HFP also spends \$0.5 million on care to patients who are above its hospital-specific charity-care threshold, but below the state’s income threshold.

Before the floor-and-trade system, HFP would bill for the \$0.5 million in care for patients whose incomes are above its charity-care threshold and earn \$0.1 million by selling these debts to a third-party debt collector. However, after implementation of this proposal, Burns Memorial would need to purchase \$1.5 million in charity-care credits below the income threshold; HFP could thus sell the \$1 million in excess charity care it is providing, along with the \$0.5 million in care it previously billed. In this scenario, HFP has an incentive to agree not to bill low-income patients because it would have received only \$0.1 million for the bad debt. As a result of the new system, HFP would be better off financially and the balance of charity care would shift to lower-income patients, leaving them less likely to face high levels of medical debt.

to adjust for variations in each area’s level of need; as a result, hospitals in low-income areas could afford their charity care and those in higher income areas could help the poorest patients.

The authors propose the floor-and-trade system to shift provision of charity care toward the lowest-income segment of the population. States will also have the option to increase overall provision of charity care, based on their population’s needs. Unlike previous attempts at setting a universal charity-care floor, the authors advocate for state customization and a trade system that allows each hospital to serve the poorest patients in its state.

Questions and Concerns

1. Can for-profit and public hospitals also sell charity care on the exchanges?

Nonprofit hospitals comprise approximately 60 percent of U.S. hospitals, and for-profit and public hospitals each account for another approximately 20 percent each. While they do not face community benefit requirements, for-profit hospitals are still bound by the Emergency Medical Treatment and Active Labor Act (EMTALA) to treat emergency patients and provide uncompensated care. Allowing for-profit hospitals to sell credits in the exchange would provide an incentive for them to not seek payment from their lowest-income patients. It is possible that for-profit hospitals are more likely to profitably exploit any limitations in the charity-care exchange market design, however. If states choose to allow for-profit hospitals to participate in the trade system, they would face higher need for regulatory oversight.

However, these drawbacks are not present in allowing public hospitals to sell credits on the charity-care exchange because evidence suggests that government hospitals are less likely to exploit loopholes in reimbursement schemes. Public hospitals provide large amounts of charity care to indigent patients; the authors propose that states allow these hospitals to sell care on the exchanges.

2. Should patients who choose not to purchase insurance on the ACA exchange qualify for charity care?

The implementation of the ACA has caused a large decline in the number of uninsured Americans, but a large fraction of the population remains uninsured. Some people are explicitly left out of the market, including, for example, undocumented immigrants and individuals with incomes below 100 percent of the Federal Poverty Level who reside in states that did not implement the Medicaid expansion. Another portion of the remaining uninsured population qualifies for Medicaid, but has not taken up coverage. Given that Medicaid patients can sign up anytime, these individuals are effectively insured from the point of view of the hospital. If they require expensive medical treatments, the authors point out, they can sign up for Medicaid.

However, some of these uninsured are individuals who have chosen not to purchase insurance on the exchanges and instead pay the annual fine and remain uninsured. If these people require medical services they will be unable to sign up for insurance until the next ACA open enrollment period. The authors point out that allowing care for these individuals to be counted as charity care may incentivize individuals to not purchase insurance on exchanges. Hospitals are cognizant of this potential moral hazard, and anecdotal evidence suggests that since the passage of the ACA they have pared back charity care to individuals who are likely eligible for subsidized health insurance. Despite this issue, care for these individuals is still costly for hospitals that are required to provide them with medical services regardless of their ability to pay. In considering whether to classify patients who paid the fine to remain uninsured as charity care, states must balance the desire for these individuals to receive treatment with the potential inefficiencies from the disincentive to purchase health insurance.

Highlights

David Dranove, Craig Garthwaite, and Christopher Ody propose a floor-and-trade system to strengthen the health-care safety net for hospitals providing charity care. Such a system would aim to replace the current geographic mismatch in which nonprofit hospitals in higher-income areas enjoy large tax benefits, while hospitals in poorer communities face the largest demand for charity care.

The Proposal

States to Establish State-Level Charity-Care Floors and Income Thresholds. Each state would set its own charity-care floor as a percentage of operating costs. Each state would also set an income threshold above which uncompensated care would not be considered as charity care for the purposes of meeting the floor. State customization would allow adjustment for regional variation in preferences and need.

States to Oversee State-Level Charity-Care Credit Exchanges. Once state lawmakers have set a charity-care floor and an income threshold, states would create a tradeable credit system. By enabling hospitals to trade charity-care credits, the proposal would incentivize hospitals in low-income areas to provide more charity care, and would allow hospitals in relatively high-income areas to be able to provide care for poorer patients, either directly or indirectly by purchasing credits.

Benefits

This proposal would shift provision of charity care toward the lowest-income segment of the population. States will also have the option to increase overall charity-care provision, if they determine that it is of particular value to their population. Unlike previous attempts at setting a universal charity-care floor, this proposal would allow for state customization and a trade system that allows each hospital to serve the poorest patients in its state.



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