Senate Bill 1, Article II, Health and Human Services Commission

Rider 61
Texas Hospitals' Uncompensated Care

October 6, 2006

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Background

The Texas Health and Human Services Commission (HHSC) retained Deloitte Consulting LLP (Deloitte Consulting) to complete tasks based on the requirements of Rider 61 of Article II of the 2006-2007 General Appropriations Act.[1] Rider 61, involving Texas Hospitals' Uncompensated Care, requires HHSC to identify areas of Texas Medicaid hospital reporting inconsistency and provide recommendations for increasing uniformity:

> The Health and Human Services Commission shall conduct a study of the **components** and **assumptions** used to calculate Texas hospitals' uncompensated care amounts. The Commission shall provide a report to the 80th Legislature with recommendations for standardizing hospitals' uncompensated care amounts [emphasis added]. [2]

Texas hospitals currently self-report their financial results according to a loose patchwork of rules and inconsistently defined terms. Analysis of terminology and reporting inconsistencies provides a starting point for efforts toward fairer, more descriptive uniformity in unreimbursed care reporting and, potentially, the distribution of limited funds.

Logical policy solutions require more accurate problem measurement. The social and financial problem of insufficient insurance coverage contributes to the financial and policy challenges that governments and providers face in caring for the underinsured when they consume health care services. The United States Census Bureau reports that 15.5% of Americans[3] and 24.2% of Texans[4] are uninsured. There is continued national debate over policy and procedure changes that might increase insurance availability and affordability, enhance coverage, improve financial incentives, and provide optimal clinical outcomes. Without accurate definition and measurement of the problem, however, solutions cannot be targeted toward planning, administering, and improving the financial and clinical results of safety net healthcare.[5] At the federal level, the Centers for Medicare and Medicaid Services (CMS) are working with the Medicare Payment Advisory Commission (MedPAC) and the General Accounting Office (GAO) to make charity care and community benefit data "more reliable and useable."[6] Reliability and usefulness of uncompensated care reporting seems to be a common problem among the states as well, with each state having its own set of reports and policy underpinnings.

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[1] 79th Texas Legislature, Senate Bill 1, Article II, Rider 61.
[2] *Id.*
[3] U.S. Census Bureau, Current Population Reports, P60-229, "Income, Poverty, and Health Insurance Coverage in the United States: 2004."
[4] 2006 U.S. Census Bureau data. Similarly, this uninsured figure has been reported at 24.6% in 2004 (U.S. Census Bureau, "Health Insurance Historical Tables," Table HI-4, "Health Insurance Coverage Status and Type of Coverage by State—All People: 1987 to 2003" (cited by "The Uninsured: A Hidden Burden on Texas Employers and Communities," April, 2005 (at http://www.window.state.tx.us/specialrpt/uninsured05/)).
[5] The Institute of Medicine defines safety net providers as those that "organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable populations." Cited by Larry S. Gage in "Safety Net Hospitals & Health Systems," a presentation given to the Texas Institute for Health Policy Research on December 12, 2002.
[6] Mark B. McClellan, "Tax Exemption for Hospitals and Federal Payment for Uncompensated Care," Centers for Medicare and Medicaid Services, May 26, 2005.

With these issues in mind and with guidance from HHSC, Deloitte Consulting completed the following tasks:

1. **Examined current reporting requirements, instructions thereto, and legislative history related to their development in order to identify inconsistent terminology and calculation methods.**

   Texas hospitals must all complete a Cooperative Annual Survey ("Annual Survey") issued by the Department of State Health Services (DSHS). Certain hospitals must complete some or all of a separate group of reports. Although these reports are used for related purposes, have common terminology, and have similarly calculated factors and results, our examination and comparison of the reports as a group revealed significant measurement and reporting inconsistencies.

2. **Interviewed key personnel at numerous Texas hospitals as well as officials at state agencies responsible for designing reports, accumulating data, and interpreting results.**

   Interviews provided further insight on the pervasiveness and significance of the lack of reporting standardization. The different perspectives of persons closely involved with sequential or tangential steps in the reporting processes highlighted additional areas for improvement in standardization.

3. **Analyzed data from public and private sources, including hospitals' claims for reimbursement from government payers, hospitals' financial statements, and data related to recipients of uncompensated care.**

   Anecdotal reports of discrepancies among reports were borne out by examination of data sets from different sources. Attempts to reconcile reports and explain discrepancies provided additional insight into areas to target first for improving uniformity.

4. **Reviewed legislation, media reports, surveys, and regulatory filings.**

   Such items as legislation, media coverage, surveys, and regulatory filings added both detail and broad perspective on the many issues related to lack of standardization in uncompensated care reporting, and how this lack of uniformity interferes with efforts to reform such governmental funding mechanisms as, for example, Disproportionate Share Hospital payments (and Medicaid more generally).

Upon completing these tasks, Deloitte Consulting summarized its findings in the form of several conclusions and recommendations, included in this Report.

Executive Summary

Texas hospitals reported providing $9.2 billion in uncompensated care—primarily to uninsured and underinsured Texans—in calendar year 2004, up from $7.6 billion in 2003.[7] However, several reimbursement sources and adjustments should be considered when determining the true cost incurred by hospitals in providing care to the underinsured. Applying such adjustments and payments to the reported charges yields a substantially lower residual burden actually borne by hospitals. Using the methodology detailed in this Report, residual unreimbursed care is estimated to be between 5% and 25% of reported values for 2004, and 3% and 22% for 2003. The difference between these ranges of residual burden values and hospitals' self-reported charge figures is of such magnitude that it underscores the importance of addressing the problem.

The process should begin with a cooperative effort by DSHS and other stakeholders to develop a central repository for data collection and a set of coordinating instructions and definitions to make the flow of information among reports more transparent and uniform. The term "uncompensated care" itself requires greater clarity, and its calculation requires a specific, methodical set of adjustments. Accurate measurement and reporting provide a basis from which governments, providers, and other stakeholders can design responses to the underlying social and financial challenges associated with underinsurance in the state and across the nation.

Based on an in-depth analysis of the current reporting requirements, terminology inconsistencies, and funding streams, we recommend the following approach be taken to standardize reporting.

1. DSHS and other interested and involved agencies and parties should be directed to work cooperatively toward developing a more standard and comprehensive center for data reporting and accounting. There is not currently an overall structure among reports, nor is there a central repository of reliable data related to uncompensated care.

2. A standard definition of "uncompensated care" could flow from application of a standard set of adjustments to an initially reported, aggregate level of charges associated with services for which hospitals expect or receive no reimbursement of any sort. An example of how this calculation could flow and be documented is as follows:

1	Aggregate charges: bad debt & charity care (with transparent definition of both components)
2	Adjustment from charges to cost by uniform ratio of cost to charges[8] (selected and uniformly applied after comments considered from relevant stakeholders)
3	Subtraction of federal DSH & UPL payments
4	Subtraction of tax revenues
5	Subtraction of other payments received for otherwise uncompensated care
=	ESTIMATE OF UNCOMPENSATED CARE COST (Residual Uncompensated Care)

3. The definition of "uncompensated care" should include a timing component. Uncompensated care currently describes a value that goes through several adjustments, and the term is used for that value at different stages in the adjustment process.

[7] The 2003 Annual Survey reports $3.6 billion in bad debt and $4 billion in charity care charges. Figures include both inpatient and outpatient hospital uncompensated care charges. The 2004 Survey reports $4.4 in bad debt and $4.8 in charity care charges.

[8] The RCC is a fraction multiplied by a provider's charged amount to adjust that figure to its costs.

4. The procedure for adjusting the aggregate uncompensated care figure should be based on transparent, clearly explained steps based on terminology standard to all reporting and to all government reimbursement sources.

5. Hospital providers should be urged to track more specifically the charges, costs, and adjustments associated with under-insured and uninsured patients.

6. State reporting should be centralized in one, truly comprehensive report.

7. A standard ratio-of-cost-to-charges ("RCC"), selected and defined through cooperative efforts, should be used for state reporting purposes.

8. Additional study is needed to pinpoint specific areas in which current reports' components do not support the legislative and policy intentions driving reporting requirements.

Uncompensated Care: Beyond Bad Debt and Charity Care

Terminology definitions drive the measurement and reporting of uncompensated care. Hospitals report financial results, including the impact of uncompensated care, in different contexts and for different purposes. Although the American Institute of Certified Public Accountants (AICPA), the Financial Accounting Standards Board (FASB), and the Healthcare Financial Management Association (HFMA) agree that uncompensated care is comprised of bad debt and charity care, closer examination of definitional nuances and application reveal inconsistencies. The definitions are consistent in that charity care is service for which no charge is made and no payment is expected. Bad debt results from rendering services for which payment is expected but no payment is received. These straightforward definitions form the basis of a reporting system that is plagued by nuance and inconsistency.

Bad debt and **charity care** definitions are usually mutually exclusive. However, hospitals have great flexibility in designing charity care policies, which in turn means they self-define charity care (and thereby determine the remaining bad-debt portion of uncompensated care). There is thus an unsteady definitional basis upon which charity care and other policies are built and applied, and from which significant revenue adjustments (or reported "uncompensated care") must flow. Charity care reporting appears to be particularly vulnerable to business-judgment decisions rather than reporting in a standardized manner.[9] Terminology inconsistencies are discussed in the next section of this Report. See also Appendices A and B.

In addition to definitional inconsistencies, a major source of difficulty in comparability is the tendency within the healthcare industry for charges to bear little relationship to cost or to expected revenue. Within almost any hospital system, or even within an individual hospital, there is inconsistent charge-setting methodology. Cost structures vary widely within and across hospital systems. Because of this variation, cost data are difficult to match reliably to uncompensated care data.

Charity care is generally reported at fully charged amounts, despite the fact that healthcare receivables bear little relationship to charges.[10] Bad debt can go through a series of adjustments and be reported at a proportion of charges. Appendix G provides examples of variability in bad debt's relation to cost and highlights the sensitivity of bad debt calculations to variations in the ratio of cost to charges (RCC, discussed in Appendices A and B). Charges for which payment is expected are reduced for financial reporting purposes to their realizable values. Much of the adjustment from charges to costs is achieved by means of the RCC. Rather than reliably and consistently adjusting hospital charges to a figure related to the cost of providing services, however, the RCC has several variants that interfere with uniformity and comparability. The different RCCs are discussed in the next section. The combination of inconsistency in the definition of uncompensated care and the variability in charge reporting results in numerous, somewhat irreconcilable data sets ineffective as benchmarks for articulating legislative policy changes.

[9] In fact, CMS notes that a hospital "is permitted to use its own business judgment in determining whether or not a non-Medicare patient is indigent and therefore entitled to a discount pursuant to its own [indigence] policy." "Questions on Charges for the Uninsured," CMS, available at http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/ FAQ_Uninsured.pdf (last accessed 8-25-2006).

[10] For example, a hospital charge of $1000 might have an average commercial insurance receivable of $700.

Reporting Requirements

There are five reports that must be completed annually by some or all Texas hospitals: the Cooperative Annual Survey, the Medicare Cost Report, the Annual Statement of Community Benefits, the Disproportionate Share Hospital Program Conditions of Participation, and IRS Form 990.[11] There is no official structural relationship among these various reports; and the components reported are defined differently for different purposes. For example, the Annual Survey is intended as a comprehensive data source. Despite its inclusion of sub-sections covering such items as DSH payments and community benefits, however, additional reports are required by government payer reimbursement personnel—additional reports requiring data to be given in different formats, and based on different definitions (detailed in Appendix A).

There is little audit oversight or enforceability for uncompensated care reporting purposes, primarily because "uncompensated care" is, by intuitive definition, care for which reimbursement is not to be received. Data tracking is more robust when there are actual data based on charges, adjustments, and payments associated with specific patients. Uncompensated care, however, tends to be aggregated and reported in non-patient-specific format. This tendency, when considered in light of definitional inconsistencies and accounting variability, makes it difficult even to get an accurate estimate at the state level of the value of uncompensated care provided. As noted above, specific-purpose reports (like the Disproportionate Share Hospital (DSH) or Community Benefit supplemental information reports) require additional data detail, suggesting that the comprehensive survey does not provide all needed data. Many of the significant definition variances are discussed in the Community Benefits Report section, below.

1- Cooperative Annual Survey
"Comprehensive" but Lacking in Detail

All Texas hospitals must annually submit the Cooperative Annual Survey ("Annual Survey"). This report summarizes data on uncompensated care, utilization trends, and related information. Designed by the Department of State Health Services, the American Hospital Association (AHA), and the Texas Hospital Association (THA), the Annual Survey collects check-the-box information on such items as type of ownership, organizational structure, charity care policy, and types of services provided, as well as hospital-calculated patient service revenue and expense data. According to its instructions, the Annual Survey represents the state's "only comprehensive source of information on issues such as uncompensated care and hospital utilization trends," and its findings are used in developing health policy and programs.[12] The Texas Health and Safety Code requires the Department of State Health Services (DSHS) to collect this information.[13] However, despite attempts to provide comprehensive information, several other reports request additional data items and use terms defined differently within separate reports, as shown below and in the Appendices.

2- Medicare and Medicaid Cost Reports
Similar Rules; Different Resulting RCCs Due to Service Mix Differences

All Medicare-participating hospitals must complete a Medicare cost report annually. Medicare regulations require hospitals to maintain uniform charges for services in order to prevent cross-subsidization by one payer of another. Further, before large scale change from cost-based

[11] The Annual Statement of Community Benefits and the Disproportionate Share Hospital Program Conditions of Participation are state (DSHS) reports. The Medicare Cost Report and IRS Form 990 are federal reports, over which HHSC has no authority, but which HHSC should consider in attempts to form a more cohesive reporting system.
[12] 2005 Annual Survey of Hospitals form, DSHS/AHA/THA, page 1.
[13] Tex. Health & Safety Code §311.033.

reimbursement to the Prospective Payment System (PPS), providers were concerned about application of the then-relevant "lesser of cost-or-charges" (LCC) principle. Before widespread application of PPS, hospitals worried about inadvertently triggering lower reimbursement for all patients by allowing too many of them to pay discounted fees.[14]

After a period during which providers were criticized for being too aggressive in collection efforts and charging the highest prices to those least able to afford it (i.e., charging uninsured persons the "full charge" due to the requirement to have uniform charges), CMS clarified that it does not prohibit hospitals from providing discounts off stated charges:

> Nothing in the [CMS] regulations, Provider Reimbursement Manual, or Program Instructions prohibit a hospital from waiving collection of charges to any patients, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals, if it is done as part of the hospital's indigency policy….[and the OIG] advises that nothing in that agency's rules or regulations under the Federal anti-kickback statute prohibits hospitals from waiving collection of charges to uninsured patients of limited means, so long as the waiver is not linked in any manner to the generation of business payable by a Federal health care program.[15]

Hospitals must make uniform collection efforts with Medicare and non-Medicare patients, and they must report their full charges when filing their Medicare cost reports. The LCC principle has only limited importance,[16] and it is not implicated significantly in the attempt to standardize reporting of uncompensated care. Recent press attention to hospitals' charging undiscounted amounts to their poorest patients is therefore less often being countered with arguments that the LCC principle requires such billing practices.

An item that is of particular significance in the Medicare Cost Report is the ratio of cost to charges (RCC). The Cost Report includes a data-intensive calculation of the hospital's RCC. Within each hospital, an RCC is calculated for individual departments based on total charges and total expenses; the individual RCCs are applied to Medicare or Medicaid program charges, by department, to arrive at program cost. The aggregate Medicare RCC will generally be different from the aggregate Medicaid RCC due to differences in the service mixes associated with different departments vis-à-vis their related Medicare and Medicaid program costs. The significance of such differences for purposes of uncompensated care reporting is that the appropriateness of different RCCs for different purposes complicates a fundamental adjustment in the uncompensated care reporting process—the adjustment from full charges to service-related costs.

For Community Benefits tracking, discussed in detail below, the ratio is broadened to include a portion of bad debt expense. Including more expenses makes charges smaller in relation to costs, and therefore yields a larger RCC. That is, the numerator of the RCC fraction (costs) grows due to the inclusion of bad debt expense, but the denominator (charges) remains the same. If, for example, an RCC is thereby changed from 1/5 when bad debt expense is excluded to 2/5 when bad debt expense is included, applying that 2/5 RCC to hospital charges yields higher calculated costs. For uncompensated care reporting and reimbursement purposes, therefore, hospitals would prefer to be

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[14] Mark B. McClellan, "Tax Exemption for Hospitals and Federal Payment for Uncompensated Care," Centers for Medicare and Medicaid Services, May 26, 2005.
[15] "Questions on Charges for the Uninsured," CMS, available at http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/FAQ_Uninsured.pdf (last accessed 8-25-2006).
[16] *Id*. "The reality is that this LCC principle has limited applicability today."

allowed to include more expenses in the calculation of this ratio. Appendix G demonstrates more in-depth the sensitivity of bad debt calculations to changes in the RCC.

3- Annual Statement of Community Benefits
Community Benefits, Charity Care, and Indigent Patients

A supplemental report to the Annual Survey, the Annual Statement of Community Benefits, is required of all Texas not-for-profit hospitals (NFPs). DSH hospitals are deemed to qualify for non-profit status under the Texas Charity Law (and must merely report their results for data-collection purposes). NFPs, however, must annually prove they qualify under Texas law by providing a level of community benefits that meets **one** of the following standards:

(A) charity care and government-sponsored indigent care at a level that is reasonable in relation to the community needs, as determined through the community needs assessment, the available resources of the hospital or the hospital system, and the tax-exempt benefits received by the hospital or hospital system;
(B) charity care and government-sponsored indigent health care provided in an amount equal to at least 100 percent of the hospital's or hospital system's tax-exempt benefits, excluding federal income tax; or
(C) charity care and community benefits are provided in an amount equal to at least five percent of the hospital's or hospital system's net patient revenue, provided that charity care and government-sponsored indigent health care are provided in an amount equal to least four percent of net patient revenue.[17]

Rather than encouraging providers to furnish charity care or community benefits more than they might otherwise, this statute allows hospitals to qualify as NFPs under the catch-all "reasonable level" standard in section (A) when that hospital does not qualify under either of the other standards. Charity care law is currently under review by the Texas Attorney General's Office. Texas Attorney General's Office expresses no opinion at this time on the substantive issues raised in this Report, but reserves the right to comment at a later time.

Much of the inconsistency in charity care and community benefit comes from hospitals' ability to design their own policies and to apply charity care policies selectively. Additional variation derives from subtle differences in definition of underlying terminology.

- Annual Survey, Section E (Utilization, etc.) requires reporting of information on charity care defined as that care resulting from "a provider's policy to provide health care services free of charge to individuals who meet certain financial criteria."[18] Charity care is to be measured on the basis of foregone revenue (at full, established rates).
- Annual Survey, Section I (Medicaid DSH) provides an arguably more expansive definition of charity care by including not only the hospital's cost of providing care to financially indigent patients directly but also indirectly through clinics (etc.) financially supported by the hospital.
- Annual Survey, Section L (Charity Care and Community Benefits) defines charity care as that provided to financially or medically indigent patients.[19] Medical indigence is determined according to a hospital's policy.

[17] Tex. Health & Safety Code §§311.043-311.047.
[18] Annual Survey, Section E, Total Facility Beds, Utilization, Finances, and Staffing, Page 15, item 5b, and Page 18.
[19] Medical indigence is fairly consistently defined as indigence resulting from a patient-portion of a bill exceeding a certain percentage of his income, "determined in accordance with hospital's eligibility system" (Annual Survey, Section I).

The primary areas for variability within the above definitions grow primarily from a hospital's flexibility in determining its charity care policy, deciding which community benefits to include in its community benefit reporting, and defining patient's financial and medical indigence status. The Community Benefits Report further explains that medical indigence can be determined by examining a patient's bill after third-party payments have been received. Thus, from the above set of varying definitions, we can see potential for variance in charges associated with charity care,[20] variance in charges associated with externally funded providers (like clinics), and variance in levels of poverty considered in applying medical indigence standards. As with other instances of non-standard definition and reporting, lack of standardization in this area complicates the estimation of accurate uncompensated care values needed for sensible policy-making.

4- Disproportionate Share Hospital Program Conditions of Participation
Different Detail Requested

The Texas DSH supplemental report requires several additional items in detail. Qualitatively, hospitals must provide information about and copies of indigent care policies and satisfy posting requirements. Each hospital must "furnish the state Medicaid director a copy of an assessment of the health care needs of the community…[demonstrating] how the hospital is using its [DSH] funds to address community health needs."[21] Hospitals must also report on efforts to provide non-emergency-room access to primary care and participation in development of regional trauma system. To receive DSH payments, a hospital must provide charity care with charges at least equal to its previous year's DSH payment.

Hospitals must report the total charges and patient-specific payments received related to inpatient and outpatient hospital services, as well as the total number of Medicaid days and total number of uninsured inpatient days during the fiscal year. Instructions indicate that payments made by a state or unit of local government are not considered for this purpose. Similarly, the report excludes charges for services delivered to patients eligible for Medicare or Medicaid.

This report is the only one to require reporting specifically on tax revenues. Hospitals receiving hospital district tax funds must disclose the district from which they receive funds and whether other hospitals receive funds from the same district. Hospitals must report the amount of funds received, and report funds used for inpatient and outpatient services during the fiscal year.

5- IRS Form 990
IRS Steps Up Compliance-Checking Efforts, Attempts to Measure Charity Care

In addition to the increased scrutiny by Texas officials, NFPs are receiving more attention from the IRS regarding whether the NFPs comply with the vaguely defined concept of "community benefit." This is an area for great variation, due in part to the wide latitude hospitals have in determining their charity care policies.[22] Standardizing reporting, as required by Rider 61, should be approached in part by determining sub-categories and other stratifications within the data currently reported as charity care and bad debt. Distinguishing accurately between charity care and bad debt is key to evaluating collection policies and to knowing how resources are being used.

[20] Based on somewhat arbitrarily determined (arbitrarily, at least in relation to community benefit reporting) charges.
[21] Disproportionate Share Hospital Program 2006, Conditions of Participation, Page 4.
[22] Healthcare Finance Management Association, "Statement Number 15: Valuation and Financial Statement Presentation of Charity Service and Bad Debts": Each institutional provider of healthcare services must establish criteria for charity service consistent with the organization's mission and financial ability.

The IRS has sent compliance questionnaires to over 550 tax-exempt hospitals nationally to "determine whether they are flouting standards for tax-exempt status, whether they deny care to people without insurance and whether they provide significant amounts of charity care."[23] One goal of this "wake-up call" questionnaire is to encourage hospitals to ensure prospectively that their "charity care practices are uniform and consistent with their published charity care policies."[24] The results may be used to determine whether NFP hospital standards should be clarified or changed. The 1969-defined standards are based on the vague concept of community benefit. AHA Vice President Melinda Hatton defends the broad standard, arguing that it "recognizes the incredible diversity of tax-exempt hospitals serving communities with different needs." However, hospitals disagree about such fundamental components of community benefit as whether Medicare paying less than cost should be included in the community benefit calculation, and whether and to what extent bad debt should be included.[25] The IRS form required of NFP entities has no healthcare-specific items like those described and analyzed in the other reports filed annually by certain (or all) Texas hospitals.

Whether from a federal or state perspective, community benefit reporting can be viewed as extremely variable. The Catholic Health Association of the United States notes that it difficult to achieve a "uniform methodology for calculating community benefits" because some hospitals use cost accounting methods while others use RCCs for this purpose.[26] More variation can be seen on examination of the widely diverse services and activities "the hospitals themselves define as community benefits."[27] Current tax policy "lacks specific criteria with respect to tax exemptions for charitable entities and detail on how that tax exemption is conferred." The GAO recommends that criteria be "articulated in accordance with desired goals" in order to improve standards and hold hospitals accountable.[28]

[23] Robert Pear, "I.R.S. Checking Compliance by Tax-Exempt Hospitals," *New York Times*, June 19, 2006.
[24] Bruce A. Nelson, "IRS 'Forces" Hospitals to Do a Better Job Tracking Charity Care Practices," *HFMA News*, June 29, 2006.
[25] *Id*.
[26] "Community Benefit Reporting," Catholic Health Association of the United States, 2003.
[27] David M. Walker, "Nonprofit, For-Profit, and Government Hospitals."
[28] *Id*.

Texas Hospitals' Reports of $9.2 Billion in Uncompensated Care in 2004

Analysis of the hospital reports reveals areas in which reporting is so ambiguous and subject to judgment that accurate estimation of the exact value of unreimbursed care actually borne by hospitals is not possible. The estimated range of unreimbursed care costs bears little relationship to the aggregate figure reported in the 2004 Annual Survey, $9.2 billion, comprised of $4.4 billion in bad debt charges and $4.8 in charity care charges. Several adjustments and payments should be applied to this figure. Possible adjustments are detailed in two scenarios presented in Appendix C (one scenario using Texas hospitals' weighted-average Medicaid RCC; another using a national, weighted-average Medicare RCC estimate). Using the methodology detailed in this Report, residual unreimbursed care is estimated to be between 5% and 25% of reported values for 2004, and 3% and 22% for 2003.

Because the Annual Survey instructions do not mention subtracting non-patient-specific revenue from these reported amounts, it is assumed that the hospitals report their fully charged amounts. The initially reported $9.2 billion has presumably (though not certainly) been adjusted appropriately and consistently based on patient-specific revenues received. The scenarios in Appendix C highlight the problems resulting from lack of instructional clarity and lack of consistent reporting methodology related to hospitals' uncompensated care.

Further, from several sources, hospitals receive compensation intended to offset some of the costs associated with the otherwise uncompensated care they provide. Without taking into consideration the likelihood that many underpayments are offset by higher charges billed to and paid by paying patients, there are several government payment sources that are at least partially directed toward compensating hospitals for the care they provide to the underinsured.

- **Upper Payment Limit (UPL):** federal program providing assistance to hospitals with "uncompensated care" costs. At the federal level, the UPL payment is calculated as the difference between the actual Medicaid fee-for-service (FFS) payment and the Medicare payment that would have paid for the same services.[29] The state match is funded via intergovernmental transfers (IGTs).[30]

- **Disproportionate Share Hospital (DSH)**: federal program through which CMS makes "significant payments to hospitals that treat a large number of low-income and uninsured patients."[31]

- **Medicare bad debt reimbursement**: CMS reimburses hospitals for a portion of the bad debt (unpaid deductibles or coinsurance) of Medicare beneficiaries "as long as the hospital sends a bill to a patient and engages in reasonable, consistent collection efforts."[32]

- **Section 1011, Federal Reimbursement of Emergency Health Services Provided to Undocumented Aliens**: part of the Medicare Modernization Act of 2003, Texas was allotted $46 million in fiscal year 2005 and $47 million in 2006.[33]

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[29] "State of Texas Health and Human Services Commission: Rider 60 Activities," Deloitte Consulting LLP, September, 2006.
[30] "Enhance Medicaid Payments to Certain Providers," Carol Keeton Strayhorn, Window on State Government, January, 2003 at http://www.window.state.tx.us/etexas2003/hhs10.html (last accessed 6-29-2006). Intergovernmental transfers are exchanges of fund between different levels of government, and are a "common feature in state finance" ("States' Use of Medicaid Maximization Strategies to Tap Federal Revenues," Urban Institute/Assessing the New Federalism, June, 2002).
[31] "Questions on Charges for the Uninsured," CMS, available at http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/FAQ_Uninsured.pdf (last accessed 8-25-2006).
[32] *Id*.

- **Tax Appropriations to Hospital Districts**: predetermined amounts sets aside by the government from its taxing authority to support the operation of the hospital.[34]

- **State government programs**: programs reimbursing providers for care provided to specified groups, such as Children with Special Health Care Needs and the Kidney Health Program.

- **Local government programs**: county indigent care programs.

- **Tobacco settlement receipts:** The 1998 Agreement Regarding Disposition of Settlement Proceeds provides funding to "all hospital districts, other local political subdivisions owning and maintaining public hospitals, and counties of the State of Texas responsible for providing indigent care to the general public."[35]

[33] Trailblazer Health Enterprises LLC, "Section 1011,"at https://www.trailblazerhealth.com/section1011/Default.aspx? (last accessed 9-5-2006).
[34] Annual Survey, Page 16.
[35] See http://www.dshs.state.tx.us/tobaccosettlement/faq.shtm.

Profile of Texas' Uninsured and Under-insured

Part of the difficulty in measuring uncompensated care is the variety of patients who receive it. Uninsured and underinsured persons consume health care services that are accounted for inconsistently. For some persons, the entire cost of their care falls into the charity care category. For others, there is a mixture of payments, bad debt, and possibly charity care. In order for governments to address the problem by expanding insurance coverage, it is necessary to identify persons whom the additional insurance would cover.

A 2004 GAO report indicates an "uncertain" impact of undocumented aliens on uncompensated care costs.[36] Texas has a larger proportion of immigrants than other, non-border states; and immigrants, like non-immigrants, consume health care services that are not reimbursed. However, over 70% of the uninsured in Texas were born in the United States.[37] The uninsured are more concentrated in Texas' largest Metropolitan Statistical Areas (MSAs) than in border MSAs.[38] A Texas Department of Insurance report issued in 2005 included information on characteristics of uninsured Texans. Significant numbers of uninsured residents are employed and have incomes above the federal poverty level. Additional TDI information is summarized in Appendix E, Table 1.

The Texas Comptroller's office notes that "there is no such thing as a 'typical' uninsured person." Uninsured and underinsured Texans are frequently employed by small employers—employers offering no job-based health insurance or health insurance with too high a portion to be borne by employees.[39] Other Texans with incomes greater than 300% of the Federal Poverty Level (FPL) are considered able to afford insurance, but part of this group forgoes coverage nevertheless.[40] The TDI analyzed the 2003 Medical Expenditure Panel Survey (MEPS); comparisons between large and small employers are summarized in Appendix E, Table 2.

Thus, Texas small businesses are less likely than small businesses nationwide to offer insurance. However, when they do offer insurance, eligible Texas employees tend to enroll in greater proportion than the national population does. Whether companies offer insurance is correlated also with average employee pay rates, as shown in Appendix E, Table 3.

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[36] GAO, "Undocumented Aliens: Questions Persist about Their Impact on Hospitals' Uncompensated Care Costs," May, 2004. The GAO explains that hospitals generally do not collect information about patients' immigration status, and attempting to use lack of social security number as a proxy for undocumented immigrant status does not yield reliable results.

[37] Mary Katherine Stout, "Sorting the Facts about the Uninsured," Texas Public Policy Foundation, May 2006 (referring to 2004 Census data).

[38] Almost 50% of Texas' uninsured live in Houston, Dallas, and Fort Worth-Arlington. Border MSAs (El Paso, McAllen, and Brownsville) were home to approximately 11% of Texas' uninsured residents. "The Uninsured: A Hidden Burden on Texas Employers and Communities," Window on State Government: Texas Comptroller of Public Accounts, April 2005, at www.window.state.tx.us/specialrpt/uninsured05/ (last visited 6-29-2006).

[39] Just over half of Texas employers offer insurance coverage (national average is 63%). The Charity Care and Community Benefit Report for the SETON Healthcare Network—2004, at www.seton.net/about_seton/charity_care/charity_report_2004_final.pdf (last visited 7-10-2006).

[40] Census data indicate that 70% of Texas' uninsured have incomes greater than the FPL; 40% have incomes greater than double the FPL.

Primary Providers of Uncompensated Care

By any definition of uncompensated care, a few key hospitals provide a disproportionate share. The top ten providers, by dollar value of charity and bad debt charges, provided approximately 1/3 of the total reported uncompensated care in 2003.[41]

Hospital	Owner-ship	Total Bad Debt + Charity Care Charges	Bad Debt + Charity as % of Gross Patient Revenue	Total Gross Patient Revenue
Ben Taub General Hospital	Public	$554,459,000	58.3%	$951,653,000
Parkland Memorial Hospital	Public	$430,776,000	35.9%	$1,199,374,832
John Peter Smith Hospital	Public	$334,214,000	53.8%	$621,438,000
UT Medical Branch Hospital	Public	$252,415,937	24.0%	$1,049,981,854
University Hospital	Public	$202,422,349	30.2%	$669,844,669
UT M.D. Anderson Cancer Center	Public	$200,468,769	9.1%	$2,195,213,799
Memorial Hermann Hospital	NFP	$136,827,830	9.1%	$1,506,555,070
Methodist Hospital	NFP	$123,057,773	5.7%	$2,167,009,912
Daughters of Charity (Brackenridge)	NFP	$120,518,876	19.5%	$618,622,514
R.E. Thomason General Hospital	Public	$117,240,224	36.6%	$319,959,025
Total Top 10 Hospitals		$2,472,400,758		$11,299,652,675
Total All Hospitals		$7,608,581,886		$71,956,105,400
Top 10 as Percentage of Total Hospitals		32%		16%

Seven public hospitals and three not-for-profits thus provided 32% of the reported $7.6 billion in charity care. Hospitals may be applying charity care eligibility standards more restrictive than those envisioned by lawmakers. Hospitals may also essentially self-determine their compliance with their own policies, in part by delaying even the consideration of whether a person meets charity-care eligibility standards until after a decision has been made to admit that person to the hospital. Because non-public hospitals have broad discretion in designing their policies and timing their charity care determination, charity care policies are not a particularly robust mechanism for improving health care access for the indigent. Much charity care is, in effect, pushed to public hospitals, where patients cannot be turned away.

[41] These figures reflect reported bad debt and charity charges, and do not take into consideration the payments and donations all ten of these hospitals receive as part of their active philanthropy programs.

Medicaid Reform

Despite nationwide talk of Medicaid reform and some local attempts at universal insurance coverage, states appear not to have approached the problem of managing uncompensated care by addressing lack of standardization in measurement and reporting. Efforts instead seem to focus on preserving federal Medicaid funding and exploring means to expand insurance coverage. Data collection improvements are discussed more frequently in the context of anti-fraud efforts at the state and federal levels.

A few states (namely, California, New York, and Wisconsin) have attempted to improve links between financial data and inpatient clinical data. Results have been mixed. Others have focused on charity care reporting as the entry toward more uniform reporting overall. Pennsylvania and Utah, for example, have required greater financial accounting detail in order for providers to prove they meet the minimum financial threshold to be considered not-for-profit health care entities. Still other states have attempted to attack inconsistencies by requiring NFPs to report generally on their charity care policies and community benefits conferred.[42] All attempts appear to be overwhelmed by the complex interrelationships of political and budgetary concerns endemic to safety net healthcare.

The Department of Health and Human Services (HHS) "notes with interest" the attempts by New York and Florida's state hospital associations to "address the issue of charges to the indigent and medically indigent." According to HHS, hospitals have tried to assist patients in paying for their hospital care by applying written policies consistently, by ensuring charge structures are related to costs and to meeting community health care needs, and by implementing written debt-collection policies.[43]

Studies have shown that the underinsured often delay or neglect seeking treatment.[44] This tendency leads in many instances to their entering the health care system at its most expensive access point—the emergency room.[45] The Kaiser Commission reports that uninsured persons receive less preventive care, are diagnosed at more advanced disease states, receive less therapeutic care after diagnosis, and consume hospital resources in hospital stays associated with avoidable conditions.[46] Most uncompensated care spending is associated with hospital care. When the uninsured access healthcare through the most expensive venues, costs are driven upward more than they would be otherwise. The increased cost is shifted to insured persons through higher premiums and to taxpayers.[47]

A 2005 report by the Task Force on Access to Health Care in Texas indicates that the state ranks eighth in the nation in additional premium cost due to uncompensated care.[48] A recent Families USA study reports that costs associated with uninsured care, nationally, added as much as 8.5% to the cost of premiums. Health insurance premiums were estimated to have been $1,551 higher (per family) due to cost-shifting from the uninsured in Texas in 2005.[49]

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[42] These states include California, Idaho, Illinois, Indiana, Maryland, Massachusetts, New Hampshire, New York and West Virginia.
[43] CMS, "Questions on Charges for the Uninsured," at http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/FAQ_Uninsured.pdf (last accessed 8-25-2006).
[44] Families USA, "Paying a Premium: The Added Cost of Care for the Uninsured," June, 2005: Insured people often do not receive health care when they need it. …Uninsured people delay seeking medical care and end up sicker when they do go for care.
[45] Texas Association of Health Plans, "The Uninsured and Texas: A Relationship Worth Ending," March, 2006.
[46] Kaiser Commission on Medicaid and the Uninsured, "Sicker and Poorer: The Consequences of Being Uninsured," May, 2002, at 93 and 103.
[47] "The Uninsured and Texas: A Relationship Worth Ending."
[48] *Code Red: The Critical Condition of Health in Texas.* April, 2006. Texas ranks eighth, behind New Mexico, Oklahoma, West Virginia, Montana, Alaska, Arkansas, and Idaho.
[49] Families USA, "Paying a Premium."

Conclusions and Recommendations

Primary Areas of Variability and Inconsistency, and Steps toward Increased Uniformity

1. **There is no overall structure among reports, nor is there a central repository of reliable data related to uncompensated care.**

Response. DSHS and other interested and involved agencies and parties should be directed to work cooperatively toward developing a more standard and comprehensive center for data reporting and accounting.

2. **There is no standard definition of "uncompensated care."** Although regulations, programs, and literature seem to agree that uncompensated care is composed of bad debt and charity care, many of the policies around reimbursement and the procedures carried out in determining reimbursement implicate a broader understanding of uncompensated care. The infiltration into the "uncompensated care" lexicon of such items as under-reimbursed care like government-payer shortfalls ultimately clouds all issues around uncompensated care.

Response. A standard definition of "uncompensated care" could flow from application of a standard set of adjustments to an initially reported, aggregate level of charges associated with services for which hospitals expect or receive no reimbursement of any sort. A more uniform and consistent (or at least consistently explained) definition of charity care and community benefit is required to form a consistently interpretable starting point for the recommended set of adjustments in calculating truly residual uncompensated care, borne by hospitals. An example of how this calculation could flow and be documented is as follows:

1	Aggregate charges: bad debt & charity care (with transparent definition of both components)
2	Adjustment from charges to cost by uniform ratio of cost to charges[50] (selected and uniformly applied after comments considered from relevant stakeholders)
3	Subtraction of federal DSH & UPL payments
4	Subtraction of tax revenues
5	Subtraction of other payments received for otherwise uncompensated care
=	ESTIMATE OF UNCOMPENSATED CARE COST (Residual Uncompensated Care)

3. **There is no timing component to "uncompensated care" definition.** Uncompensated care is used to describe calculations performed at various stages of reimbursement process. The $9.2 billion reported by Texas hospitals in 2004, for example, was shown above to be their aggregate charges associated with charity care and bad debt, before reduction from charges to costs, and before consideration of reimbursements.

Response. This issue flows from the first example. Because uncompensated care currently describes a value that goes through several adjustments, and the term is used for that value at different stages in the adjustment process, there is no short-hand way to determine where in the uncompensated care calculation any particular use of the term falls. The term should be defined in state reports to mean the sum of bad debt and charity care, after being reduced to cost, and after all patient-specific and non-patient-specific funding streams have been accounted for and applied.

[50] The RCC is a fraction multiplied by a provider's charged amount to adjust that figure to its costs.

4. **There is no official process for analyzing "uncompensated care" costs to determine unreimbursed cost and primary bearers of the uncompensated care burden.** The term "uncompensated care" can currently be used to describe the initially reported aggregate charges associated with hospitals' charity care and bad debt. That initial value requires several standardized adjustments to determine the finally unreimbursed amount.

Response. The procedure for adjusting the aggregate figure should be based on transparent, clearly explained steps based on terminology standard to all reporting and to all government reimbursement sources. The more specific definition described above will aid in pinpointing primary bearers of the uncompensated care burden. Individual providers' financial results can be examined in light of reimbursement streams and ultimately reported uncompensated care values.

5. **There is insufficient separation between patient-specific and non-patient specific services and reimbursements, and between under-insured and un-insured patient services and reimbursements.** Not only does the lack of patient-specific tracking of such items as charges, specifically associated costs and reimbursements complicate the overall task of examining uncompensated care, it makes fraud more difficult to discover and prosecute.

Response. Within the population of hospital providers, there is insufficient tracking of charges, costs, and adjustments associated with under-insured and uninsured patients. Revenues from two essentially distinct populations are inappropriately aggregated. This aggregation complicates selection and application of an appropriate RCC adjustment. Privacy concerns currently limit the tying of patient-specific claim information to financial reporting. The need to reduce fraud, and the need for more reliable financial reporting justify investment in developing means for patient-specific tracking while protecting privacy. Among the items that should be reported in greater detail are improved tracking between bad debts associated with co-pays and deductibles on patients with some kind of insurance, versus bad debt associated with self-pay patients that pay portions of their bills, versus bad debt associated with self-pay patients paying none of their charges. Such detail tracking would also improve design and implementation of charity care policies that meet public policy goals.

6. **The set of reports and definitions is too complex; complexity inhibits usefulness**. An overly complex set of required reports, inconsistently defined terms, and skewed incentives leads to unnecessarily burdensome reporting—reporting that does not provide the information needed to determine fair reimbursement or coordinated public policy formulation. Inconsistency and lack of uniformity make comparability between hospitals and over time unreliable.

Response. Data collection and reporting could be simultaneously simplified and made more informative. Increasing the detail required on reports does not require increasing the reporting burden on hospitals. Expanding the required reporting detail in certain data categories corresponds with the type of tracking associated with better management accounting and financial management. Thus, external reporting requirement changes could stimulate business efficiencies. Examining current reporting processes and requirements and their relationship to policy goals would help ensure that all processes and requirements are up-to-date. Requirements identified as unduly burdensome (given their purpose or results) could be modified or eliminated.

7. **Complexity is driven in part by numerous RCCs; there is lack of transparency in the elements used to derive and apply RCCs.** Although there are policy justifications for each RCC in its context, uniformity and reliability would be improved by selection and clear definition of a standard RCC.

Response. A standard ratio of cost to charges, selected and defined through cooperative efforts, should be used for state reporting purposes. Identifying specific, current needs of hospitals, hospital associations, government payers, policy makers, and other stakeholders should precede specific design of the uniform RCC for uncompensated care reporting purposes.

8. **A disorganized patchwork of rules leads ultimately to burdensome data collection with results of limited usefulness**. Shifting focus to accuracy of reporting based on standard details and elements would provide for greater uniformity. Less burdensome reporting, properly designed, could result in more useful reports.

Response. Additional study is needed to pinpoint specific areas in which current reports' components do not support the legislative and policy intentions driving reporting requirements. Cooperative efforts could determine more useful and standard components for use in an organized, comprehensive, single report, from which all interested parties could glean the information required for fair evaluation, reimbursement, compliance verification, and public policy development.

Appendix A: Definitional Variations

Term	Source	Definition
Uncompensated care	GAO	Charity care + bad debt
	Annual Survey, Section E, Utilization	Care for which no payment is expected or no charge is made. It is the sum of bad debt and charity care absorbed by a hospital or other health care organization in providing medical care for patients who are uninsured or are unable to pay.
Charity care	GAO	Care for which hospital never expected to receive payment (due to patient's inability to pay)
	Annual Survey, Section E, Utilization	Health services that were never expected to result in cash inflows. Charity care results from a provider's **policy to provide health care services free of charge** to individuals who meet certain financial criteria. For purposes of this survey, charity care is measured on the basis of revenue forgone, at full established rates.[51]
	Annual Survey, Section I, Medicaid DSH Program	Unreimbursed cost to a hospital of providing, funding or otherwise financially supporting healthcare services on an inpatient or outpatient basis to a person classified by the hospital as financially or medically indigent or providing, funding, or otherwise financially supporting healthcare serviced provided to **financially indigent** patients through other nonprofit or public outpatient clinics, hospitals, or health care organizations.[52]
	Annual Survey, Section L, Charity Care and Community Benefits	Health care services provided, funded, or otherwise financially supported on an inpatient or outpatient basis to a person classified by the hospital as "**financially indigent" or "medically indigent**."
	Uncompensated Trauma Care Application	Unreimbursed cost to a hospital of providing health care services on an inpatient or emergency department basis to a person classified by the hospital as "**financially indigent" or "medically indigent**."
	Annual Statement of Community Benefits	Unreimbursed cost to a hospital of providing, funding or otherwise financially supporting health care services on an inpatient or outpatient basis to a person classified by the hospital as "**financially indigent" or "medically indigent"** or providing, funding, or otherwise financially supporting healthcare serviced provided to financially indigent patients through other nonprofit or public outpatient clinics, hospitals, or health care organizations.
	Texas Administrative Code	Same as above (Annual Statement of Community Benefits)

[51] Charity care determinations thus are intended to be made on a patient-specific basis (i.e., made to individuals based on their ability to pay). Non-patient-specific revenue (like DSH payments) are not to be considered during the charity-care determination process.

[52] This DSH section of the Annual Survey thus specifically provides for consideration o the financial support a hospital may make to another entity for that entity's provision of services to indigent patients. This factor conceptually connects the DSH program with the Community Benefits reporting. Further, the Annual Statement of Community Benefits also includes such financial expenditures for indirect patient care costs.

Charity charges	Annual Statement of Community Benefits	Total amount of hospital charges for inpatient and outpatient services attributable to charity care in a cost reporting period. These charges do not include bad debt charges.
	Annual Survey, Section I, Medicaid DSH Program	Total amount of hospital charges for inpatient and outpatient services attributable to charity care in a cost reporting period. These charges do not include bad debt charges, contractual allowances or discounts (other than for indigent patients not eligible for medical assistance under the approved Medicaid state plan).
	Texas Administrative Code	Same as above (Annual Survey, Section I, Medicaid DSH Program)
Bad debt (or bad debt expense, or bad debt charges)	GAO	Care for which hospital expected but did not receive payment (patient unable or unwilling to pay)
	Annual Survey, Section E, Utilization	Provision for actual or expected uncollectibles resulting from the extension of credit. Because bad debts are reported as an expense and not a deduction from revenue, the gross charges that result in bad debts will remain in net patient revenue.
	Annual Survey, Section I, Medicaid DSH Program	Uncollectible inpatient and outpatient charges that result from the extension of credit.
	Uncompensated Trauma Care Application	Unreimbursed cost to a hospital of providing health care services on an inpatient or emergency department basis to a person who is financially unable to pay, in whole or in part, for the services rendered and whose account has been classified as bad debt based upon the hospital's bad debt policy. A hospital's bad debt policy should be in accordance with generally accepted accounting principles.
	Texas Administrative Code	Uncollectible inpatient and outpatient charges that result from the extension of credit. § 355.8065
Net patient revenue	Annual Survey, Section E, Utilization	Estimated net realizable amounts from patients, Medicaid DSH, third-party payors, and others for services rendered (including retroactive adjustments under reimbursement agreements with third-party payors).
	Annual Statement of Community Benefits	Estimated net realizable amounts from patients, Medicaid DSH, third-party payors, and others for services rendered (including retroactive adjustments under reimbursement agreements with third-party payors). Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined; bad debts remain in net patient revenue.
Tax appropriations	Annual Survey, Section E, Utilization	Predetermined amount set aside by government from its taxing authority to support the operation of the hospital.
Total gross inpatient revenue	Annual Survey, Section E, Utilization	Hospital's full-established rates (charges) for all services rendered to inpatients.
Total gross outpatient revenue	Annual Survey, Section E, Utilization	Hospital's full-established rates (charges) for all services rendered to outpatients.

<table>
<tr><td rowspan="6">RCC</td><td>Annual Survey, Section L, Charity Care</td><td>FY2005 RCC</td><td colspan="2"><u>Audited FY 2004 total patient care operating expenses</u>
Audited FY2004 gross patient service revenue</td></tr>
<tr><td>Uncompensated Trauma Care Application</td><td colspan="3">A hospital’s overall RCC determined by the Texas HHSC from the hospital’s Medicaid cost report. Latest available RCC shall be used to calculate its uncompensated trauma care costs. If the facility does not have a HHSC-determined RCC, the facility’s RCC will be derived from an average of the RCCs provided by qualified hospitals that year.</td></tr>
<tr><td rowspan="4">Annual Statement of Community Benefits</td><td colspan="3">“Derived in accordance with generally accepted accounting principles for hospitals.”</td></tr>
<tr><td rowspan="3">FY2005 RCC</td><td>Step 1</td><td><u>Prior year Medicare Cost Report Operating Expenses (excluding contractual adj.)</u>
Prior year Medicare Cost Report Total Patient Revenues (excluding Medicaid DSH)</td></tr>
<tr><td>Step 2</td><td>(Current year’s audited bad debt expense * Step 1 RCC) + Total Operating Expense</td></tr>
<tr><td>Step 3</td><td><u>Step 2 result</u>
Step 1 result</td></tr>
<tr><td>Texas Administrative Code, Additional Reimbursement to Disproportionate Share Hospitals</td><td colspan="3">Hospital’s overall RCC, as determined from Medicaid cost report submitted previous year.</td></tr>
<tr><td rowspan="3">Financially indigent</td><td>Annual Survey, Section I, Medicaid DSH Program</td><td colspan="3">An uninsured or underinsured person who is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the hospital’s eligibility system.</td></tr>
<tr><td>Annual Survey, Section L, Charity Care and Community Benefits</td><td colspan="3">Same as above</td></tr>
<tr><td>Uncompensated Trauma Care Application</td><td colspan="3">Same as above</td></tr>
<tr><td rowspan="3">Medically indigent</td><td>Annual Survey, Section I, Medicaid DSH Program</td><td colspan="3">A person w<u>hose medical or hospital bills after payment by third-party payers</u> exceed a specified percentage of the patient’s annual gross income, determined in accordance with the hospital’s eligibility system, and the person is financially unable to pay the remaining bill.[53]</td></tr>
<tr><td>Annual Survey, Section L, Charity Care and Community Benefits</td><td colspan="3">Same as above</td></tr>
<tr><td>Uncompensated Trauma Care Application</td><td colspan="3">Same as above</td></tr>
<tr><td>Third Party Payor</td><td>Annual Survey, Section J, Medicaid DSH Program</td><td colspan="3">Health services which were the responsibility of Blue Cross/Blue Shield and other commercial and/or private insurers.</td></tr>
</table>

[53] The mention of “third-party payers” in the DSH portion of the Annual Survey seems broadly interpreted to mean that third-party payments traceable to a specific patient should first be excluded before comparing the patient portion to his annual gross incoming. However, without clearer definition, it could be argued that a patient-specific proportion of DSH (and other non-patient-specific funding streams) could be calculated, applied to the patient’s balance before making a medical indigence determination.

Hospital eligibility system	Annual Survey, Section L, Charity Care and Community Benefits	Financial criteria and procedure used by a hospital to determine if a patient is eligible for charity care. The system shall include income levels and means testing indexed to the federal poverty guidelines, provided, however, that the hospital does not establish an eligibility system which sets the income level for charity care lower than that required by counties under Section 61.023, or higher, in the case of the financially indigent, than 200 percent of the federal poverty guidelines. A hospital may determine that a person is financially or medically indigent pursuant to the hospital's eligibility system after health services are provided.
Upper Payment Limit	42 CFR 447.321	A reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles.
Low-income days	Texas Administrative Code, Additional Reimbursement to Disproportionate Share Hospitals	Number of days derived by multiplying a hospital's total inpatient census days by its low-income utilization rate.
Low-income utilization rate	Texas Administrative Code, Additional Reimbursement to Disproportionate Share Hospitals	$\frac{\text{(Title XIX inpatient hospital payments + inpatient payments from state \& local governments)}}{\text{(Gross inpatient revenue * RCC)}} + \frac{\text{(Total IP charity charges – IP payments from state \& local governments)}}{\text{Gross inpatient revenue}}$

Appendix B: Accounting Terminology

The essential components of hospitals' financial reporting are based on the following set of terms.

- **Charges.** Health care entities have industry-specific anomalies between their charges and revenues. There is such a significant lack of clear relationship between the two key financial elements that Generally Accepted Accounting Principles (GAAP) has specific rules for adjustment of health care entities' charges so that they more closely resemble collectible revenues. Charges bear little relationship to costs. Growth in charges tends to outpace growth in costs, making inter-year comparability less appropriate.

- **Revenue.** Most service providers in industries other than health care have a clearer relationship between charges and the revenue shown "on the face" of their financial statements (that is, as a line item in the income statement—"net sales"—which essentially reflects gross charges). Health care charges bear little relation to net realizable revenue. There are several items that must be deducted from the amount shown on the top line of the face of the operating or income statement. Gross revenue (charges) may be disclosed in the footnotes to the financial statements, but the line items on the face of the statements reflect an amount closer to net realizable revenue.

- **Ratio of costs to charges (RCC).** Generally, a fraction multiplied by a provider's charged amount to adjust that figure to its costs. Composition of numerator and denominator vary for different reports. The numerator includes items both directly and indirectly related to direct patient service provision, and there is wide variation in includible and non-includible expenses among possible RCCs. The denominator is composed of charges. However, such charges have excluded (in general) any contractual adjustments. Managed care has its negotiated rates generally represented as charges, although these charges differ from a hospital's charge description master (CDM). The outpacing of costs by charges also results in a time lag between the data upon which an RCC is calculated and the data to which that RCC is applied. This time lag provides opportunities for providers to game the system.

- **Charity care**. Charity care services are recorded internally and for certain specific reports at full charges, but these charges do not appear in gross or net revenue on the face of the financial statements. A provider's charity care policy, along with details regarding charges, can be disclosed in the financial statement footnotes. Charity care is not billed to any payer and is not expected to result in revenue.

- **Bad debt**. Bad debt offsets revenue—estimated bad debt reduces the amount of revenue appearing on the face of the financial statements. As patient services are rendered, "reserves for uncollectible accounts" are accrued, and these reserves are not included in gross revenue. Bad debt is treated as an operating expense on the financial statements.

- **Contractual adjustments/discounts**. Contractual adjustments are not included in gross revenue. They are recorded as an offset to revenue, usually at the time a specific patient's bill is entered into the accounting system. Uncompensated care is recorded at full charges, which makes it difficult to compare it validly to revenue (revenue which is generally recorded at net realizable value).

- **Self-pay charges**. Charges for self-pay patients are included in gross revenue at charged amounts. Receivable records for self-pay patients will show the gross charge as receivable until that amount is collected or until the hospital writes off all or a portion of the amount due. A reserve is collected for general ledger (internal accounting) purposes, and the associated allowance account is tracked in the aggregate and not applied to specific patient accounts. The allowance reduces the gross revenue to the net revenue shown on the face of the financial statements.

- **Other adjustments**. In some instances, hospitals settle with third-party payers for less than the charged or predicted payable amount. Specific patient receivables and gross patient revenue are reduced in such situations.

Interviews of Texas hospital accounting and finance professionals revealed that the general approach for public, private, for-profit and not-for-profit hospitals is to account for patient service revenue in this manner. Many significant calculations and results are almost entirely self-defined by individual hospitals. Consequently, reported amounts are inherently subjective. Without coordination among reports, consistently defined terminology, and greater detail submitted and subject to third-party audit, decision makers cannot access the critical information they need to make optimal financial or strategic decisions.

Appendix C-1: Adjusting the $7.6 Billion Figure Reported in 2003

Hospital charges bear little relationship to hospital costs. The Annual Hospital Survey instructs that bad debt and charity care be reported at charged amounts, and the Survey makes no mention adjustment from charges to costs or whether to consider sources of non-patient-specific revenues.

Hospital financial personnel and governmental agency employee interviews revealed further uncertainty related to the accuracy of reported uncompensated care totals. Hospitals report uncompensated care at charges without adjusting for non-patient-specific revenue receipts. Interviewees agreed that reporting such receipts against uncompensated care figures would be appropriate, but it remains uncertain whether and to what extent hospitals consider and report such payments for uncompensated care reporting purposes. The Survey provides no instructions on this matter. As demonstrated in the scenarios below, uncompensated care values are very sensitive to changes in the RCC. Without certainty as to the methods used or consistency in application of chosen methods, it is nearly impossible to arrive at a financially meaningful conclusion about the aggregate value of uncompensated care provided by Texas hospitals. The following table illustrates the potentially broad range and wide variation in truly uncompensated patient care.

Several possible sources of payments are excluded from the charts that follow. One such source is section 1011 of EMTALA, which allots Texas approximately $47.5 million per year to offset costs associated with emergency health services provided to undocumented immigrants.[54] Medicare bad debt reimbursement ($78,000,000 in 2003[55]) is also excluded from the calculation above. Beginning in 2003, certain Texas hospitals could apply for reimbursement from a Trauma Fund, which appropriated $108 million for 2004 and $163 million for 2005.[56] Tobacco settlement revenue could also be applied toward reported uncompensated care charges. Reported distributions were $22 million in 2003 and $28.5 million in 2004.[57]

Even without including these other payment sources, it is possible calculate a broad range of justifiable values for "uncompensated care," an entire range drastically different from the aggregate initial value reported by hospitals, and with great sensitivity to the choice of RCC. The system acutely needs standardization and uniformity in the precise recording and reporting of financial results.

[54] Texas Medical Association, http://www.texmed.org/Template.aspx?id=3730 (last visited 8-23-2006).
[55] The United States Government Accountability Office (GAO) analyzed state and CMS data to determine that Texas hospitals were reimbursed $78 million in 2003 for Medicare bad debt (Statement of David M. Walker, Comptroller General of the United States, "Nonprofit, For-Profit, and Government Hospitals: Uncompensated Care and Other Community Benefits," May 26,2005.
[56] Texas Department of State Health Services, "Designated Trauma Facility and Emergency Medical Services Account: Implementation of HB-3588," September 21, 2004.
[57] Reported by DSHS. See: http://www.dshs.state.tx.us/tobaccosettlement/pay2003.shtm (last visited 9-26-2006).

Appendix C-1: Adjusting the $7.6 Billion Figure Reported in 2003 (continued)

Item or Adjustment	Scenario 1 Medicaid RCC	Scenario 2 Medicare RCC
2003 Bad Debt and Charity Care Charges[58]	$7,600,000,000	$7,600,000,000
Adjustment from Costs to Charges (using RCC)[59]	* 35%	* 54%[60]
2003 Bad Debt and Charity Care, at Estimated Cost	$2,660,000,000	$3,800,000,000
Less Federal Portion of DSH ($329,000,000)[61]	(329,000,000)	(329,000,000)
Less Federal Portion of UPL ($396,000,000)[62]	(396,000,000)	(396,000,000)
Less Tax Revenue ($1,600,000,000)[63]	(1,600,000,000)	(1,600,000,000)
Less Charitable Contributions Received ($104,000,000)[64]	(104,000,000)	(104,000,000)
Estimate of Aggregate (Residual Uncompensated Care)	**$231,000,000**	**$1,675,000,000**
Residual Uncompensated Care as Percentage of Initial Value	**3%**	**22%**

[58] The Annual Hospital Survey reports uncompensated care as the sum of bad debt and charity care (Page 16).

[59] The 35% is calculated based on the Texas Provider Identifiers (TPIs) included in Deloitte Consulting's 2006 SDA recalculation analysis, based on 2003 data. Total Medicaid costs were $1,503,311,171; total charges were $4,250,951,966. The associated ratio is 35.0%. The AHA notes that uncompensated care data are expressed in terms of charges, but that such data can be particularly misleading when "comparisons are being made among types of hospitals, or hospitals with very different payer mixes," and that the AHA (other than in the Annual Survey) purports to express uncompensated care in terms of costs (American Hospital Association Uncompensated Care Cost Fact Sheet, November, 2005).

[60] This national, weighted-average Medicare RCC estimate is calculated using the same method as the Medicaid RCC, but using Medicare costs (Medicare costs are divided by hospital charges). This value is intended as a proxy to demonstrate the significant differences likely between charges and costs.

[61] Annual Survey instructions indicate that "routine patient revenue" must include Medicaid DSH payments (Page 18). Thus, although DSH reimbursement is non-patient-specific revenue, it should be considered as partially compensating for otherwise unreimbursed care. The total federal portion of DSH payments not made to compensate for the Medicaid shortfall in 2003 was $329,000,000. "Medicaid shortfall" refers to the difference between the cost of services rendered to Medicaid patients less the Diagnostic Related Group (DRG) payments made by Medicaid for those services and the payments that would have been made by Medicare for the same DRGs.

The federal portion of DSH applied toward uncompensated care was calculated as follows: total DSH funds were reduced by total Medicaid shortfall reimbursement. This subtotal is reduced by the general revenue (IGT, or state component) portion of DSH paid by the nine Texas public hospitals in order to draw down the federal matching funds (this reduction in order to insure that our estimate is conservative and does not double-count certain revenues). The remaining DSH funds, $329,000,000 in 2003, are applied toward the running uncompensated care balance in the chart above. Perhaps what is most noteworthy about this calculation is its complexity, and the unlikelihood that more than 460 hospitals state-wide can consistently and accurately perform similarly complex computations in their uncompensated care reporting.

[62] HHSC reports the 2003 federal share of UPL was $396,000,000.

[63] The 2003 reported tax revenues (predetermined amounts set aside by the government from its taxing authority to support the operation of a hospital) were $1,600,000,000 (Annual Survey Page 16). There is no deduction in the chart above for local government revenue, although some or all of this revenue could be argued to offset charges associated with uncompensated care. The Annual Survey form defines local government revenue as "inpatient and outpatient hospital services that were provided under the county Indigent Health Care Program or that were the responsibility of any city or county governmental program" and should not include care "provided under [the] facility's charity care policy" (Page 24, Section J). Local revenue in 2003 was $627,000,000. The Annual Survey defines state government revenue as "inpatient and outpatient hospital services which were the responsibility of a unit of state government such as the Children with Special Health Care Needs, and the Kidney Health Program, etc." (Page 24, Section J).

[64] Annual Survey, Section J1d. Reported charitable donation receipts in 2003 were $104,000,000.

Appendix C-2: Adjusting the $9.2 Billion Figure Reported in 2004

Item or Adjustment	Scenario 1 Medicaid RCC	Scenario 2 Medicare RCC
2004 Bad Debt and Charity Care Charges[65]	$9,200,000,000	$9,200,000,000
Adjustment from Costs to Charges (using RCC)[66]	* 34%	* 54%[67]
2004 Bad Debt and Charity Care, at Estimated Cost	$3,128,000,000	$4,968,000,000
Less 2004 Federal Portion of DSH ($345,000,000)[68]	(345,000,000)	(345,000,000)
Less Federal Portion of UPL ($458,000,000)[69]	(458,000,000)	(458,000,000)
Less Tax Revenue ($1,800,000,000)[70]	(1,800,000,000)	(1,800,000,000)
Less Charitable Contributions Received ($82,000,000)[71]	(82,000,000)	(82,000,000)
Estimate of Aggregate (Residual Uncompensated Care)	**$443,000,000**	**$2,283,000,000**
Residual Uncompensated Care as Percentage of Initial Value	**5%**	**25%**

Texas hospitals received compensation from the combined Emergency Medical Services and Trauma Care System Account ("911 Monies") AND the Emergency Medical Services, Trauma Facilities, and Trauma Care System Fund ("1131 Monies") in return for their unreimbursed trauma care (delivered in 2003 and 2004). $623,788 was distributed in 2004, and $1,766,715 in 2005.[72] The total distributed to eligible hospitals was $2,390,493.[73]

Neither Appendix C-1 nor C-2 includes an estimate of the value of NFPs' preferential tax treatment. Such an estimate would include income tax savings, state and local tax savings, property tax savings, savings on tax-exempt debt access, and possibly the tax saved by charitable donors to the NFPs.[74]

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[65] The 2004 Annual Hospital Survey reports uncompensated care as the sum of bad debt ($4.4 billion) and charity care ($4.8 billion) in charges.

[66] The 34% is calculated based on the Texas Provider Identifiers (TPIs) included in Deloitte Consulting's 2006 SDA recalculation analysis, based on 2004 data.

[67] This national, weighted-average Medicare RCC is calculated using the same method as the Medicaid RCC, but using Medicare costs (Medicare costs are divided by hospital charges).

[68] The net federal share of the non-Medicaid-shortfall DSH payments to Texas hospitals in 2004 was $356,131,079.

[69] HHSC reports the 2004 net federal share of UPL was $458,000,000.

[70] The 2004 reported tax revenues were $1,800,000,000.

[71] Annual Survey, Item J1d, reports 2004 charitable donations total as $82,000,000.

[72] It is unclear exactly how the distributions' timing relates to the period during which services were delivered. Distributions are reported at http://www.tdh.state.tx.us/hcqs/ems/2005DSHSUncompensatedTraumaCareDistrtoHosp.htm (last visited 9-26-2006).

[73] *Id*.

[74] One hospital accountability analyst, Jack Hanson, provides useful guidance in estimating the value of tax preferences. He describes five categories of value to include in such an analysis:

- Income tax savings: apply federal tax rates paid by for-profit hospitals to NFPs' income reported on audited financial statements;
- State and local sales tax savings: multiply each hospital's annual "expenses on supplies" (from IRS form 990) by the local sales tax rate;
- Local property tax savings: if assessment records are not available for exempt property, one might hire a private assessor or examine comparable for-profit hospitals (identifying a "comparable" hospital has its own challenges);
- Savings from access to tax-exempt debt: multiply total amount of outstanding bond debt by the difference between the hospital's interest rates and the rates applicable during the relevant time period (available from bond rating agencies);

Appendix D: Selected Report Details

Cooperative Annual Survey

Section E
(Total Facility Beds, Utilization, Financing, and Staffing)

- Net patient revenue: net realizable value for services; including DSH payments.
- Gross patient revenue: at charged amount, inpatient and outpatient.
- Tax appropriations: predetermined, set-aside amount by government to support hospital's operation.
- Other revenue: operating and non-operating.
- Revenue by payor: at gross and net realizable amounts; broken down into Medicare, Medicaid, other government, self-pay, third-party payors, and other non-government.
- Fixed Assets and Depreciation, Capital Expenses, Information Technology Expenses.

Section I [75]
(Medicaid Disproportionate Share Hospital (DSH) Program)

- Bad debt charges (inpatient and outpatient): uncollectible inpatient and outpatient charges that result from the extension of credit.
- Charity charges (inpatient and outpatient): hospital charges for services attributable to charity care, not including bad debt, contractual allowances or discounts (other than for indigent patients not eligible for medical assistance under the approved Medicaid state plan).
- Financially indigent: an uninsured or underinsured person who is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the hospital's eligibility system.
- Medically indigent: a person whose medical or hospital bills after payment by third-party payers exceed a specified percentage of the patient's annual gross income determined in accordance with the hospital's eligibility system, and the person is financially unable to pay the remaining bill.
- Local government payments for inpatients: payments that were provided under the county Indigent Health Care Program or that were the responsibility of any city or county governmental programs; not including tax revenue or care provided under facility's charity care policy (e.g., hospital district patients).
- State government payments for inpatients: payments received for services which were the responsibility of a unit of state government such as the Kidney Health Program, state trauma fund, etc.

- Charitable contributions that are tax-deductible for donors, as reported in IRS form 990. ("Are We Getting Our Money's Worth? Charity Care, Community Benefits, and Tax Exemption at Nonprofit Hospitals," 17 *Loy. Consumer L. Rev.* 395, 2005).

[75] The instructions for this section explain that the "definitions for bad debt charges and charity charges…are specific to the DSH program and are different from the AHA definitions" (Annual Survey, Page 23).

Section J
(Other Financial and Utilization Data)

- Gross Patient Service Revenue from Medicaid
- Gross Patient Service Revenue from Local Government (County, City): payments for services provided under the county Indigent Health Care Program or that were the responsibility of any city or county governmental program, not including care provided under charity care policy
- Gross Patient Service Revenue from State Government (CSHCN, Kidney Health Care CHIP, etc.)
- Gross Patient Service Revenue from Other Government Sources (CHAMPUS, etc.)
- MEDICAID DSH PAYMENTS: payments received during the reporting period, matching the payments included in Net Patient Revenue in Section E

Section K
(Charity Care and Community Benefits Information)

- Charity Admissions: number of charity admissions.
- Charity Care Policy: if the hospital has a policy, a copy of it should be included with Annual Survey. Indicate whether policy addresses care for "financially indigent" and "medically indigent."
- Charity Provided through Other Organizations: unreimbursed cost of providing, funding, or supporting services provided to financially indigent persons through other nonprofit or public outpatient clinics hospitals, or health care organizations.
- Unreimbursed Costs of Charity Care: total billed charges for charity care multiplied by RCC, less total payments received for charity care provided (report zero if amount is negative). Based on audited Fiscal year financial statements.
- Community Benefits Information: estimated unreimbursed cost for subsidized health services in emergency, trauma, and neonatal care, community clinics, preventive medicine efforts, donations made, research receipts and expenses, and education expenses.

Section N
(Emergency Room Visits for Insured/Uninsured Patients)

- Total Number of Visits by Patients WHO WERE treated in the ER, broken down by:
  - Insured—admitted;
  - Insured—not admitted;
  - Uninsured—admitted;
  - Uninsured—not admitted.
- Percentage of ER visits for conditions or services outside hospital's area of specialty.
- Percentage of ER visits transferred to other facilities.

Annual Statement of Community Benefits

Key Financial *Estimates* Reported in Annual Statement of Community Benefits
(Charity Care, Government-Sponsored Indigent Health Care, and Other Community Benefits Information)

- Charity care provided by hospital and through others (clinics, etc.)
  - Billed charges (excluding bad debt)
  - Multiplied by Community Benefits RCC (based on Medicare Cost Report figures with a GAAP-appropriate adjustment)
  - Less payments received (third-party, patient, and other payments, including tax appropriations relative to charity care received by public hospitals)

- Government-sponsored indigent health care (not including Medicare or non-government charges)
    - Billed Medicaid charges (not including Medicaid DSH payments)
    - Billed state and local government charges
    - Charity Care RCC applied
    - Less payments received: Medicaid (Managed Care and DSH, separately reported), State Government, Local Government, and other Government
- Other community benefits
    - Unreimbursed costs of subsidized health services: emergency, trauma, neonatal intensive care, clinics, collaborative efforts with local governments, etc.
    - Donation made by hospital
    - Unreimbursed research-related costs
    - Unreimbursed education-related costs
- Medicare, CHAMPUS, and other government-sponsored programs
    - Billed charges (inpatient and outpatient reported separately)
    - Charity Care RCC applied
    - Payments received: Government (but not Medicaid), patients, other
- Value of tax exempt benefits[76]
    - Franchise tax not paid
    - Ad Valorem taxes not paid (county property tax—appraised value of real and personal property)
    - Sales tax not paid
    - Charitable donations received and not taxed
    - Foregone interest charges on tax-exempt bond financing

IRS Form 990:
Key Financial Items Reported in IRS Form 990 (for organizations exempt under Section 501(c)(3))

- Compensation of highest paid employees (other than officers, directors, and trustees), independent contractors for professional services, and independent contractors for other services
- Cash received from contributions, membership fees, and other income sources
- Other information for specific types of entities

[76] Consensus among interviewed hospital and government personnel is that such foregone taxes are difficult to place a value on. Determining what is taxable and the value of that taxable portion are not a precise science. Further, federal income taxation exemption depends heavily on the business cycle, and therefore adds variability to the process of measuring and reporting.

Appendix E: Texas Demographics

TABLE 1[77]
Texas Department of Insurance Data

		Number Of Uninsured	Percent of Total Uninsured	Percent Uninsured within Income Category
Income/Poverty Level	Under 50%	619,243	11.6%	44.3%
	51%-99%	831,628	15.5%	36.0%
	100%-149%	971,920	18.1%	38.1%
	150%-199%	844,229	15.8%	35.5%
	200%-249%	585,382	10.9%	29.9%
	250% or higher	1,505,906	28.1%	13.4%
Age Range	Ages 6 & younger	438,532	8.2%	16.9%
	Ages 7-17	825,914	15.4%	22.1%
	Ages 18-24	876,978	16.3%	40.4%
	Ages 25-34	1,319,890	24.6%	39.2%
	Ages 35-44	893645	16.6%	28.3%
	Ages 45-64	977,591	18.2%	20.5%
	Ages 65+	41,134	0.8%	2.0%
Employment Status	Employed	2,672,274	66.8%	26.6%
	Unemployed	296,977	7.4%	47.6%
	Not in labor force	1,031,443	25.8%	35.6%
Race/Ethnicity	Anglo	1,456,602	27.1%	14.3%
	Black	548236	10.2%	22.7%
	Hispanic	3,171,660	59.0%	38.6%
	All Other	197,187	3.7%	19.3%
Immigration Status	US Citizen (native)	3,657,478	68.1%	19.7%
	US Citizen (naturalized)	243,676	4.5%	27.5%
	Non-Citizen	1,473,530	27.4%	60.3%

[77] "Working Together for a Healthy Texas," Texas Department of Insurance, September, 2005 (based on data from the Census Bureau (2004) and HHSC (2003)).

Table 2[78]
Medical Expenditures Panel Survey ("MEPS")

	Texas			United States		
	All Businesses	Small Businesses	Large Businesses	All Businesses	Small Businesses	Large Businesses
Total Number of Firms	100.00%	73.25%	26.75%	100.00%	75.20%	24.80%
Firms Offering Insurance	48.70%	31.40%	96.10%	56.20%	43.20%	95.40%
Employees Eligible for Insurance in Firms Offering Insurance	77.20%	83.40%	76.20%	78.50%	78.50%	78.50%
Employees Eligible and Enrolled in Firms Offering Insurance	82.40%	80.20%	82.60%	80.30%	77.30%	81.00%
Percent of Total Employees in All Firms Eligible for Insurance	65.93%	39.95%	74.52%	68.14%	48.36%	75.99%
Percent of Total Employees in All Firms Enrolled in Insurance	54.33%	32.04%	61.56%	54.71%	37.38%	61.55%

Table 3[79]
Pay Rates and Insurance Coverage

		Percent not offering insurance within salary category	**Percent of total not offering insurance**
Average Employee Salary	less than $10,000	87.5%	5.7%
	$10,001-$15,000	87.9%	14.2%
	$15,001-$20,000	69.6%	21.3%
	$20,001-$25,000	54.0%	22.3%
	$25,001-$50,000	37.7%	30.7%
	$50,001-$75,000	26.2%	2.5%
	More than $75,000	34.8%	1.0%
	No Response	34.5%	2.2%
Predominant Employee Wage Type	Minimum Wage	91.3%	2.8%
	Minimum Wage - $10/hour	73.0%	35.5%
	$10-$15/hour	51.2%	27.8%
	$15-20/hour	37.9%	7.5%
	More than $20/hour	42.9%	2.4%
	Salaried	35.1%	18.0%
	Independent Contractors	69.6%	3.6%
	Hourly plus tips	93.1%	1.2%
	No Response	47.3%	1.2%

[78] "Working Together for a Healthy Texas," Texas Department of Insurance, September, 2005.
[79] *Id*. (based on TDI 2004 Texas Small Employer Survey).

Appendix F: Accounting Treatment of Contractual Adjustments

Scenario 1: Patient has commercial insurance, Medicare, Medicaid, or some other 3rd party payer.

- Hospital charges = $1000
- Insurance allowable = $800
- Contractual adjustment = $200
- Patient's specific account balance is adjusted to the $800 allowable amount

Accounting treatment:

- $200 contractual adjustment is not bad debt or charity care. It is not included in net revenue.[80]
- $200 adjustment is tracked internally in an account called "revenue allowances."

Scenario 2: Patient has no insurance ("self-pay" patient).

- Hospital charges = $1000
- Patient account reflects full $1000 charge

Accounting treatment:

- In its general ledger, the hospital generally establishes a reserve for collectability of receivables as a whole (i.e., amounts expected to be uncollected in these instances are not tracked by patient for this purpose).
- This reserve is applied partially against the "revenue allowances" account to reduce the gross receivable balance. The reduced gross receivable balance (i.e., net receivable balance), is shown on financial statements.
- Any uncollected portion of the $1000 charge may be accounted for as charity care or bad debt, depending on the hospital's specific charity care policy.

[80] Contractual adjustments are tracked by means of contra revenue accounts generally entitled "revenue allowances." However, for reporting purposes, such contractual adjustments are not included in revenue, bad debt, or charity care.

Appendix G: Bad Debt Sensitivity to the RCC

The following table illustrates both the sensitivity of bad debt to the selection or calculation of RCC, as well as the problems associated with aggregating different types[81] of bad debt together and applying some hospital-wide RCC.

	Charge	Type of Insurance	Allowable	Contractual Adjustment or Self-Pay Discount	Due from Patient	Payment from Patient	Bad Debt	Cost of Service (RCC 35%)	Bad Debt as % of Cost of Service
Patient 1	$1,000	Medicare	$800	($200)	$160	$0	$160	$350	0.46
Patient 2	$1,000	Medicare	$800	($200)	$160	$80	$80	$350	0.23
Patient 3	$1,000	Medicaid	$450	($550)	$0	$0	$0	$350	0.00
Patient 4	$1,000	Commercial	$850	($150)	$85	$0	$85	$350	0.24
Patient 5	$1,000	Commercial	$850	($150)	$85	$45	$40	$350	0.11
Patient 6	$1,000	Self-pay	$1,000	$0	$1,000	$200	$800	$350	2.29
Patient 7	$1,000	Self-pay	$1,000	($300)	$700	$350	$350	$350	1.00
							$1,515	$2450	.62

For a hospital with the population of patients shown in this table, total bad debt would be recorded internally as $1515. This amount represents 62% of the cost of services, but it would be over-adjusted if the entity's 35% RCC were applied. This entity's bad debt (adjusted to cost) would approximate $939, but it would be recorded for uncompensated care purposes at only $530.25. This short example demonstrates how variable the relationship between costs and charges is, particularly with respect to bad debt associated with patient-owed portions. Thus, great variability can be expected in hospitals' reporting, underscoring the need for standardization.

A weighted mean RCC calculable based on gross total patient revenue (matching as closely as possible each hospital with its 2003 Medicare cost report RCC) can be estimated at .325. If this RCC were applied for illustrative purposes to the summary version of the data in the above chart, a 4% difference is shown in bad debt/cost of service from just a 2.5% reduction in RCC. As a significant adjustment in hospital financial data, the RCC affects all downstream calculations.

Patients	Average Charge	Type of Insurance	Average Allowable	Average Contractual Adjustment or Self-Pay Discount	Average Due from Patient	Average Payment from Patient	Average Bad Debt per Patient	Cost of Service (RCC 32.5%)	Bad Debt as % of Cost of Service
All	$7000	Mixed	$821	($221)	$313	$96	$216	$325	0.66

[81] That is, bad debts that represent different proportions of total charges, total allowable amounts, etc. are aggregated into one amount, although the accurate costs associated with such bad debts would be more variably related to any hospital-wide RCC.