Charity Gap Project

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SUMMARY

Our hospital pricing and billing system, while flawed, aims to promote affordability. The model contemplates that providers will set their own rates, but that high prices will be tempered by the availability of insurance, government benefits, and financial assistance.

The system has broken down for the uninsured. Standard hospital practices bury these patients in tens of billions of dollars of debt each year. Fortunately, the dysfunctional nature of this overlay of debt – inflated, untargeted, unvalued, uncollectible – creates an opportunity for hospitals to eliminate epic amounts of debt at little or no expense.

While others fight the good fight over soaring costs and difficult policy issues, we focus on something that hospitals can control – *i.e.*, the patient's personal financial liability. From that perspective, we identify two distinct causes (and tranches) of debt, and two tailored solutions. Specifically, artificially inflated rates produce high debt for the uninsured, and too many patients incur avoidable debt by failing to complete applications for available financial assistance. The solutions are **uninsured discounts** and **presumptive eligibility**.

Uninsured discounts are a tool for flushing bloated dollars of debt out of the system, specifically the dollars falling in the gap between the full billed charges on an account (*i.e.*, 100 percent of the chargemaster rates) and a more realistic level, for example the average paid by a hospital's primary payers for the same services. Presumptive eligibility tools allow hospitals to extend financial assistance to deserving patients who would otherwise fall through the cracks. Both solutions are proven, inexpensive, and uncontroversial.

With no doubt that these two practices eliminate debt, we set out to determine the level of utilization in the industry. Has most of the upside to the uninsured already been realized or, conversely, does persistent under-utilization mean that there is still an opportunity to deliver substantially more relief? We reviewed applicable IRS reporting (Schedule H), as well as the outward-facing website profiles and financial assistance policies of over 3,000 hospitals. We found that many hospitals employ one or both of these solutions, to varying degrees, but that far more remain stuck in the past.

The takeaway is clear. Tens of billions of dollars of medical debt can be eliminated each year by persuading (or requiring) lagging hospitals to include effective uninsured discount and presumptive eligibility provisions in their financial assistance policies.

I. TRADITIONAL HOSPITAL RATE SETTING PRACTICES HAVE PRODUCED ARTIFICIALLY INFLATED DEBT FOR THE UNINSURED

Certain terms and distinctions are key in considering these issues. A hospital's stated rates, as listed in its itemized "chargemaster," are variously referred to as charges, billed amounts, prices, or rates. The amount received in payment is "reimbursement" (or payment), and "cost" refers to a hospital's own cost of providing its services.

The public is almost numb to astronomical hospital bills. In fact, millions are resigned to thinking they are one hospitalization away from financial disaster. If they thought about it, most patients would assume that bills are high simply as a function of the proportional allocation of a hospital's costs across its services. In reality, certain idiosyncrasies and practices destroy any pretense of a formula directly linking a hospital's costs to its rates.

In particular, one key source of unfairness is the seemingly benign tradition whereby each hospital creates a single set of itemized chargemaster rates that apply on all accounts. This practice made sense in a bygone era when bills were routinely paid in full, and patients expected that everyone was being billed the same amounts for the same services. With Medicare's launch in the 1960's, the government reinforced this tradition by requiring hospitals to use uniform charges for all patients.

The expectation that all payers would pay the full billed charges on accounts changed decades ago as major payers began to balk at skyrocketing health care charges. The biggest payer has been the federal government, as it finances the care provided to Medicare beneficiaries. Because Medicare discharges this obligation on an account-by-account basis, the government is laser-focused on each hospital's cost of providing care. In order to capitalize on its leverage in setting reimbursement levels, thereby reducing Medicare spending, the government requires each hospital to submit its Medicare Cost Report, a complex filing that details every component of the hospital's cost of providing care.

Armed with the Medicare cost report data, big payers like Medicare, state Medicaid programs, and major health insurers have forced hospitals to accept reimbursement driven by cost, rather than charges. Based on its legal authority to set payment rates by fiat, and with access to hospitals' cost data, Medicare opted for the obvious strategy of paying hospitals at very low levels, typically below the level of cost. State Medicaid programs followed suit, developing cost-based payment methodologies which routinely pay hospitals at less than cost. Similarly, as they negotiate for discounts in their contracts with hospitals, large commercial payers rely on cost data to shift reimbursement methodologies away from hospital charges. Increasingly, the charge totals on specific accounts are often irrelevant.

These dynamics leave hospitals with few options. With institutional payers extracting huge discounts, and the uninsured paying very little, a hospital can only survive by extracting disproportionately more from commercial payers. Since some of these commercial payers actually pay the full chargemaster rates, or a percentage of those amounts, one tool for achieving that result is to inflate rates. Hospitals enjoy broad discretion in this area, and they

face little resistance since there is little impact on payments from Medicare, Medicaid, and other major payers. In a system built on a single set of chargemaster rates, uninsured patients necessarily end up incurring debt at the inflated levels.

In short, as the reimbursement environment has evolved the uninsured have become collateral damage in a rate-setting strategy aimed at a totally different segment of commercial payers. The unfairness to the uninsured is undeniable, with the inflated debt contributing to ruined finances, bad credit, bankruptcies, and foregone medical care.

II. UNINSURED DISCOUNTS – BROAD RELIEF AT LITTLE EXPENSE

One would think that hospitals would find it hard to defend demanding 100 percent of inflated charge totals from financially strapped uninsured patients while accepting, say, 30 percent from deep-pocketed payers (Medicare, Medicaid, commercial payers). An uninsured discount is an obvious remedy for a result that is otherwise illogical and unfair.

The government tried to address this problem with mandatory discounts, but the effort has proven ineffective. Pursuant to Affordable Care Act regulations, 26 CFR § 1.501(r)-5), a non-profit hospital must cap the amount due from "any individual who is eligible for assistance under its financial assistance policy" at no more than the "amounts generally billed" (AGB), which is defined as the average percentage of charges paid by the hospital's primary payers (Medicare, Medicaid, commercial payers).[1] As interpreted, this "limitation on charges" only applies to patients who are **determined** eligible for financial assistance.

This AGB regulation has proven weak for multiple reasons. First, requiring a discount for those determined "eligible for financial assistance" is only relevant for the relatively small group of patients who receive partial assistance. The larger group of patients who receive full assistance (*i.e.*, a 100 percent write-off) obviously do not need any other discount. In addition, the AGB regulation offers no relief to patients whose income or resources make them ineligible, or who might have been eligible if they had completed the application process. Finally, although this unfair reimbursement disparity affects the entire industry, the federal AGB limitation only applies to non-profit hospitals.

The regulatory effort may have fallen short, but the value of discounting is clear, and the benefits are easily realized. All hospital financial officers understand how little is collected from the uninsured – pennies on the dollar is often a fair characterization – and they know the folly of billing these patients for the full charge amount. A hospital can easily calculate its average percentage of billed charges actually paid on uninsured accounts. After choosing a discounting approach (*e.g.*, a cap at the AGB average paid by a hospital's institutional payers, or at the Medicare reimbursement level, or at an arbitrary percentage of

[1] In the hospital world, this "amounts generally billed" label is a misnomer since the "billed" amount is always the sum of the itemized charges at the standard rates, regardless of payer or eventual payment amount. Using hospital terminology the AGB regulation describes an average "payment" or "reimbursement" amount, not an average "billed" amount.

charges), a hospital can use a simple uninsured discount provision to slash debt for the uninsured without sacrificing hospital revenues.

With so much patient debt made up of these almost illusory dollars of receivables, we set out to determine the extent to which hospitals are using uninsured discounts to flush debt out of the system. Based on our review of the practices at roughly 3,000 hospitals, we categorized hospitals and their uninsured discount policies, as follows:

Hospitals	Policy
62%	no uninsured discount
19%	discount similar to managed care plan reimbursement, or to AGB
10%	discount to a stated percentage of charges (average 57%)
4%	discount to an unstated amount
5%	ambiguous (*e.g.*, possible discount, or discretionary)

These results are disappointing. With nearly 2/3 of hospitals not extending any automatic discount, most patients who do not secure financial assistance end up owing 100 percent of the billed charges. In stark contrast, across our broad sampling, we found that hospitals accepted an average of 21 percent of charges from Medicare, and an average of 28 percent from all institutional payers (Medicare, Medicaid, commercial payers).

Hospital leaders know that inflated rates hurt the uninsured, but many likely think that their financial assistance programs are enough of a remedy. Without a discount, though, patients who do not qualify for financial assistance, or who do not complete the application, are stuck with debt at 100 percent of the billed charges.

III. HOSPITALS ARE UNDERUTILIZING PRESUMPTIVE ELIGIBILITY TECHNIQUES FOR IDENTIFYING FACTUALLY ELIGIBLE PATIENTS

Why do millions of deserving patients fail to receive available financial assistance? Many application processes are rigid, even intimidating, reflecting a preoccupation with the patient's obligation to fully cooperate, complete the application, disclose every source of income, submit documentation, and prove eligibility almost beyond a reasonable doubt. There are many contributing factors. For example, applicants are poor recordkeepers, they object to the hassle and the perceived invasion of privacy, they fear that information could be used against them in the collection process, or they are simply resigned to incurring the debt.

No one should be surprised that a system that depends on patient engagement, compliance, and a calculated income figure would serve as a barrier to millions of patients. That conclusion is further supported by other data points:

- Per the U.S. Department of Education, 20 percent of consumers are functionally illiterate and cannot complete an application process.
- Per the Federal Reserve, 26 million people live in the "financial shadows," with little means of completing applications and submitting required documentation. The heaviest concentration is in minority, low-income, and young populations.
- Per the Employment Policy Institute, 33 percent of the uninsured are high school dropouts, compared to 7 percent of insured individuals.
- Per the Federal Reserve, 8.7 percent of families do not have bank accounts.
- Per the CFPB, 26 million U.S. adults, about one in ten, are "credit invisible" with no credit record, and another 19 million cannot be scored due to their thin or out-of-date credit histories.

The causes can be debated, but the existence of the problem cannot be disputed. In fact, the government has imposed a reporting requirement aimed at this precise phenomenon. Under federal law, non-profit hospitals receive tax exemption in exchange for providing "community benefits," including charity care, which are reported on IRS Form 990, Schedule H. In addition to data relating to documented financial assistance, the federal government requires each non-profit hospital to estimate the cost of care provided to factually eligible patients who did not receive financial assistance. The applicable instruction provides, as follows (emphasis added):

> Line 3. Provide an estimate of the amount of bad debt reported on line 2 that reasonably is attributable to **patients who likely would qualify for financial assistance** under the hospital's financial assistance policy as reported in Part I, lines 1 through 4, **but for whom insufficient information was obtained to determine their eligibility**. … Organizations can use any reasonable methodology to estimate this amount, such as record reviews, an assessment of financial assistance applications that were denied due to incomplete documentation, analysis of demographics, or other analytical methods.

Without question, Schedule H calls for an estimate of the cost of services for **patients who would have been determined eligible** if the hospital had collected more information.

Based on our review of Schedule H submissions, including the line 3 estimates, we assess that, in a single year, non-profit hospitals imposed over $20 billion in unintended debt on factually eligible patients. Since the same phenomenon also exists in the for-profit hospital sector, that figure undoubtedly understates the size of the problem.

Fortunately, many hospitals have successfully addressed this breakdown using presumptive eligibility. The approaches generally fall into the following categories:

- **Discretionary** – Some policies simply announce the hospital's broad discretion to determine eligibility without a completed application.
- **Attestation** – A financial assistance plan may waive the normal application requirements based on the patient's attestation of low income/resources.
- **Life circumstances** – A hospital may classify accounts as charity care when patients are, for example, homeless, mentally ill, bankrupt, or deceased.
- **Eligibility for other means-tested programs** – Financial assistance is often extended to individuals who have already qualified for some other identified government programs (*e.g.*, WIC, TANF, SNAP, subsidized housing).
- **Income and propensity-to-pay scoring tools** – Multiple tools, often relying on credit reporting data, provide hospitals with a patient's individualized financial score based on a "snapshot" of his or her financial circumstances.
- **Predictive analytics** – Certain vendors offer sophisticated analytics as a means of processing vast amounts of data (publicly regulated data, not social media) in order to determine whether individual patients are likely to qualify for financial assistance under the hospital's eligibility guidelines.

The effectiveness of these techniques varies widely. Limiting relief to homeless patients is highly restrictive. Extending assistance to patients based on enrollment in another means-tested program makes sense, but relief still depends on an application process. Credit scoring and propensity-to-pay tools are inherently limited, and an estimated 40-50 million U.S. adults do not have credit scores. The use of predictive analytics plainly represents the gold standard for presumptive eligibility. In fact, some hospitals have reported that, using analytics, they identify all factually eligible patients, even without completed applications.

As part of our review of the practices of hospitals we categorized and rated the strength of their approaches to presumptive eligibility, as follows:

Hospitals	Characterization of reliance on effective presumptive eligibility
33%	no apparent use of presumptive eligibility
10%	weak use of presumptive eligibility
12%	moderately strong use of presumptive eligibility
45%	strong use of presumptive eligibility

By our assessment, hospitals with a "strong" approach rely on a combination of analytics and/or scoring tools, the patient's enrollment in other means-tested government programs, and life circumstances (*e.g.*, homelessness, mental illness, death without estate).

In summary, some hospitals have solved the "falling through the cracks" problem using analytics, others use more moderate measures and achieve less dramatic results, and many have not even tried.

IV. HOSPITALS CAN EASILY MANAGE THE COST AND MINIMIZE THE RISKS OF MORE GENEROUS FINANCIAL ASSISTANCE REFORMS

Hospitals need not worry that aggressive discounts or presumptive eligibility techniques might backfire, encouraging patients to over-utilize services, or disincentivizing people from buying insurance or applying for Medicaid.

First, it is well understood that lack of insurance is a function of affordability, not choice. People want insurance if they can get it, and they view Medicaid as a desirable fallback. The benefits of full coverage for patients, and of expanded reimbursement for hospitals, will always incentivize patients and hospitals to prefer more durable coverage over episodic financial assistance for individual hospitalizations.

Beyond that reality, hospitals enjoy the flexibility to protect themselves and support positive incentives. Most hospitals would not be overly concerned about the revenue implications of discounting uninsured balances to the average percent of charges paid by their institutional payers (*e.g.*, to the AGB), or even further. Every hospital can directly address that risk as it decides on a discounting policy. With charge levels so high, and the amounts currently paid by the uninsured so low, there is plenty of room to extend steep discounts without hurting revenues or disrupting patient incentives.

The same is true with presumptive eligibility. For many years hospitals around the country have employed a variety of presumptive eligibility techniques. With customary due diligence, hospitals can weigh the expense, feasibility, and effectiveness of their options. Although our review of financial assistance policies revealed little of this concern, hospitals can also control the risk that undeserving patients could abuse the process by framing their uninsured discounts and other assistance as "presumptive," or by reserving discretion to tailor relief to individual circumstances.

The short answer to these concerns is that hundreds of hospitals, all run by rational managers, have already voluntarily implemented uninsured discounts and presumptive eligibility. In fact, the cost-benefit analysis is so compelling that these measures can serve as one litmus test of a hospital's sensitivity to the plight of the uninsured.

CONCLUSION

After completing our review of practices across the nation, we reached out directly to the administrators at nearly 3,000 hospitals, pointing out where each one stood and calling for reform. That exercise produced a single response, a letter from the American Hospital Association's general counsel attributing affordability problems to other factors. Tellingly, AHA never denied that broader use of these two solutions would provide dramatic relief.

The societal cost of the status quo is tens of billions of dollars of toxic debt each year. The hospital industry should embrace uninsured discounts and presumptive eligibility, and the federal government should consider regulatory mandates to make it happen.