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Report to the Chairman, Committee on Finance, U. S. Senate

July 1989

HEALTH CARE FINANCING

Unreimbursed Charges of Selected Children's Hospitals

GAO/HRD-89-76

GAO

United States
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Washington, D.C. 20548

Human Resources Division

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July 11, 1989

The Honorable Lloyd Bentsen
Chairman, Committee on Finance
United States Senate

Dear Mr. Chairman:

This letter responds to your September 1988 request for a report on how children's hospitals deal with unreimbursed charges for patient care. To determine this, we visited 13 nonprofit children's hospitals throughout the nation and met with their officials and staffs. Eight hospitals provided audited financial statements. Details of our methodology appear in appendix I.

Results in Brief

Unreimbursed charges at the 13 children's hospitals averaged about 20 percent of their total charges for patient care during fiscal year 1986, the latest year for which they had complete data at the time of our review. Such charges were attributable to charity care, bad debts, and allowances and discounts available under contractual arrangements with certain public and private payers. The contractual arrangements accounted for 59 percent of the unreimbursed charges, followed by charity care and bad debts.

Hospitals we visited attempted to mitigate the impact of unreimbursed charges by (1) considering them in setting patient charges and (2) generating income from other sources. The first approach was often not successful, and the overall result was that 9 of the 13 hospitals did not generate sufficient patient revenues to cover total expenses. However, 6 of the 9 hospitals generated enough income from other operations and fund raising to offset the shortfall in patient revenues, and these hospitals ended the year with a surplus. The other three hospitals ended their fiscal year with a deficit, but in two cases the deficit resulted from extenuating circumstances (see p. 3).

Composition and Extent of Unreimbursed Charges

A hospital has two basic sources of revenue for patient care: self-paying individuals and public and private health insurance plans. The hospital initially bills either the individual (if self-paying) or the individual's health insurance plan for the amount of care provided. For a number of reasons, a hospital may be paid less than the amount billed, and these unpaid amounts constitute unreimbursed charges.

Among the 13 hospitals, unreimbursed charges were attributable to the following:

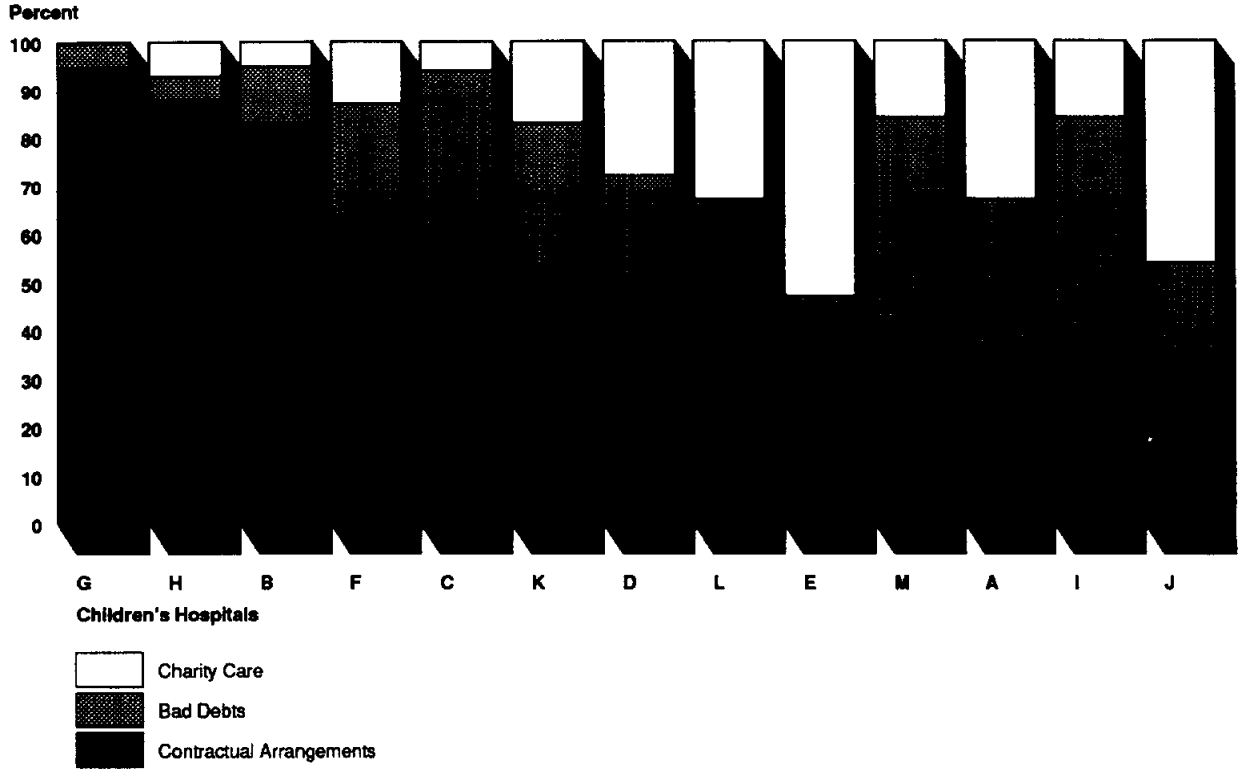
- Contractual arrangements. These consist of various kinds of contractual allowances and discounts. Contractual allowances are the difference between the amounts normally charged for care and the amounts paid the hospital by certain third-party public and private payers, such as Medicaid,[1] Medicare, state children's medical services programs, and private insurance plans. Contractual discounts are the difference between the amounts normally charged for care and the amounts paid by health maintenance organizations and preferred provider organizations for care of their members. Generally, the hospital accepts as payment in full the amount received from these payers, even if it is less than the amount the hospital billed. In addition, a hospital may include discounts for services provided to children of employees among its unreimbursed charges.
- Bad debts. The amount of charges not paid by, and deemed uncollectible from, patients whom the hospital identified upon admission as having the ability to pay. For individual patients, these could be either all the charges for a particular stay or some or all of their insurance deductibles and copayments.
- Charity care. The charges for patients the hospital identified upon admission as not having the ability to pay and therefore eligible for free care.

Unreimbursed charges for the 13 hospitals averaged 20 percent of total charges for patient care in their 1986 fiscal year, ranging from 10 to 30 percent (see app. II). Contractual arrangements represented the greatest portion of unreimbursed charges, averaging 59 percent of total charges, with charity care (23 percent) and bad debts (18 percent) making up the balance. As figure 1 shows, contractual arrangements were the major component of unreimbursed charges in 7 of the 13 hospitals. A combination of bad debts and charity care were the major component in the remaining six.

Hospital officials provided examples of how private and public third-party payer policies and practices contribute to unreimbursed charges. For instance, the California Medicaid per diem rate, which one hospital

[1]Under Medicaid, each state designs its hospital reimbursement method within broad federal guidelines. State methods range from cost reimbursement to various types of prospective payments.

Figure 1: Composition of Hospitals' Unreimbursed Charges for 1986



Note: For hospital G, charity care is included in bad debts.

had negotiated with the state program, paid about 65 percent of the hospital's average inpatient care charges and about 38 percent of its outpatient care charges.

Also, deductibles and copayments under private insurance policies have been rising over the past few years, Minneapolis and Washington, D.C., hospital officials said, and have become too high for some families to afford. Consequently, hospitals are not paid for all amounts for which patients are responsible. And because third-party payers have further restricted their payment policies and practices, according to most hospital officials, unreimbursed charges have increased over the past several years at a rate greater than inflation.

Effects of Unreimbursed Charges

While hospitals received less than they charged patients for services, the effect on the hospitals' overall financial condition was mitigated. This was because the hospitals (1) had considered unreimbursed charges in setting patient charges and (2) were able to generate income from other sources. Three of the 13 hospitals, nevertheless, had deficits for 1986.

Hospitals have several ways of keeping patient revenues in line with expenses. These include setting patient charges higher than expenses, renegotiating contracts with third-party payers, and scaling back certain services. In setting patient charges, the hospitals generally considered the amount of anticipated unreimbursed charges along with estimated operating expenses. In 1986, the patient charges averaged 115 percent of total expenses for the 13 hospitals (see app. III). But because either patient charges were not set high enough or unreimbursed charges were underestimated, only four of the hospitals received patient revenues sufficient to cover total expenses (see app. IV).

Hospitals had sources of income, however, in addition to patient revenues. For six hospitals, such income compensated for the shortfall in patient revenues, and these hospitals had a surplus for 1986 (see app. IV). The most common nonpatient revenues were donations, earnings from investments, and revenue from gift shops and food service operations.

Three of the 13 hospitals we visited showed deficits for fiscal year 1986 (see app. IV), but two of these situations resulted from extenuating circumstances:

- Hospital D had a deficit of $93,266. The hospital, however, is one of four components in a large medical center that in 1986 had $5.7 million in nonoperating revenue, including donations and interest income. These revenues were not allocated among the center's operating components, including the children's hospital. As a result, the hospital showed a deficit even though the medical center had an excess of revenues over expenses of $1.2 million for the year.
- Hospital C, which had a deficit of $1,837,364, incurred an extraordinary expense of $5.7 million in 1986 for employees who chose to take advantage of a one-time, early-retirement option. Without this expense, the hospital would have had a surplus for the year.

Agency Comments

A draft of this report was provided to the National Association of Children's Hospitals and Related Institutions, Inc. (NACHRI), for its review and comment. After we received NACHRI's comments, we talked to its Vice President to clarify some of the points contained in its written comments. The comments below represent those proved by NACHRI both in writing and orally.

Founded in 1968, NACHRI is the only national organization of children's hospitals in the country with membership from nearly all acute care, rehabilitation, and other specialty children's hospitals. It is dedicated to promoting the well-being of children through support of children's hospitals and related institutions committed to excellence in treating, healing, and nurturing children. NACHRI's comments, summarized below, are in appendix V.

NACHRI underscored the need for most of the 13 children's hospitals to generate funds from sources other than patient care revenues in order to cover total expenses. Also, while agreeing that children's hospitals consider unreimbursed charges when setting patient charges, NACHRI said this technique is not always successful because most government payers reimburse on a cost basis and many private payers reimburse on a negotiated percent-of-charges basis or other negotiated basis. Because of this, hospitals may not always be able to generate anticipated additional revenues simply by raising patient charges.

For a variety of reasons, NACHRI said that hospital financial statements do not always show the actual amounts incurred for charity care, bad debts, and contractual allowances—the three components of unreimbursed charges. This was cited as being particularly true under the Medicaid program, where hospitals generally classify all unreimbursed charges as contractual allowances on financial statements. NACHRI stated that sometimes only a portion of the unreimbursed charges are contractual allowances related to the Medicaid program and the remaining are charity care and bad debts related to the patient (e.g., day or visit limits, uncovered services, medically needy spend-down obligations). Hospitals, however, do not always adjust the accounts to show the final charges and payments for each of the categories because their concern is the total amount.

We are sending copies of this report to other interested congressional committees and members and will make copies available to others on request.

The major contributors to this report are listed in appendix VI.

Sincerely yours,

Edward A Densmore

for J. William Gadsby
Director of Intergovernmental
and Management Issues

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Abbreviations

NACHRI National Association of Children's Hospitals and Related Institutions, Inc.

Scope and Methodology

We obtained information from 13 nonprofit children's hospitals on their experiences with unreimbursed charges during fiscal year 1986, the latest year for which they had complete data during our review. The hospitals we visited, which were selected to provide geographic diversity, were as follows:

- Children's Hospital National Medical Center, Washington, D.C.
- Children's Hospital, Boston, MA.
- Valley Children's Hospital, Fresno, CA.
- Children's Hospital of Los Angeles, Los Angeles, CA.
- Phoenix Children's Hospital, Phoenix, AZ.
- Scottish Rite Children's Hospital, Atlanta, GA.
- Henrietta Egleston Hospital for Children, Atlanta, GA.
- All Children's Hospital, St. Petersburg, FL.
- Dallas Children's Medical Center, Dallas TX.
- Santa Rosa Children's Hospital, San Antonio, TX.
- Children's Hospital, Inc., Columbus, OH.
- Children's Hospital Medical Center, Cincinnati, OH.
- Minneapolis Children's Medical Center, Minneapolis, MN.

At these locations, we met with officials and staff of the hospitals' accounting, medical records, patient services, and finance departments and offices. Using a structured interview guide, we obtained information regarding unreimbursed charges and the hospitals' fiscal operations for 1986.

Our review focused on the results of hospital fiscal activities for 1986 only. The information developed represents each hospital's unreimbursed charges and other activities for 1986 and is not an indicator of the results of other years. Eight hospitals gave us copies of audited financial statements.

We did not independently verify the information given us on unreimbursed charges and related matters, such as the impact of such charges on the hospitals' financial condition and ability to provide services. Thus, we are not identifying the individual hospitals by name in figure 1 and the following appendixes.

We performed our review in accordance with generally accepted government auditing standards between February and September 1988.

Composition of Unreimbursed Charges for Hospitals' 1986 Fiscal Year

Dollars in thousands

	Unreimbursed charges Due to								
	Bad debts		Charity care		Contractual arrangements				
Hospital	Amount	%	Amount	%	Amount	%	Total	Total patient charges	Percent unreimbursed
A	$4,154	30	$4,524	33	$5,128	37	$13,806	$89,801	15
B	721	12	303	5	5,047	83	6,071	44,481	14
C	2,892	36	545	7	4,682	58	8,119	82,994	10
D	1,618	21	2,214	28	3,993	51	7,825	27,936	28
E	1,472[a]	4	19,569[a]	53	15,913	43	36,955	126,823	29
F	4,862	23	2,921	13	13,819	64	21,602	142,939	15
G	638	5	[b]	•	11,570	95	12,208	51,496	24
H	1,636	5	2,490	7	31,445	88	35,571	143,453	25
I	5,610	48	1,822	16	4,220	36	11,652	55,036	21
J	1,032	18	2,659	46	2,054	36	5,745	26,836	21
K	1,801	30	1,028	17	3,157	53	5,986	48,473	12
L	2,567	20	4,331	33	6,213	47	13,111	44,350	30
M	5,680	43	2,126	16	5,494	41	13,300	62,792	21
Total	**$34,684**	**18**	**$44,532**	**23**	**$112,735**	**59**	**$191,951**	**$947,410**	**20**

[a]The proration between charity care and bad debts was based upon information from the hospital's 1987 financial statements, which provided a separate accounting classification for charity care and bad debts.

[b]Charity care was not separately classified and was included in bad debts.

Hospital Patient Charges as a Percentage of Total Expenses

Hospital	Patient charges	Total expenses[a]	Total
A	$89,801,000	$75,398,000	119
B	44,481,000	40,851,000	109
C	82,994,171	104,084,475	80
D	27,936,061	20,204,183	138
E	126,823,000	98,951,000	128
F	142,939,000	133,810,000	107
G	51,495,812	39,845,615	129
H	143,453,000	124,218,000	116
I	55,036,030	45,640,093	121
J	26,835,647	25,454,734	105
K	48,473,000	41,066,000	118
L	44,350,174	29,634,203	150
M	62,792,069	46,896,024	134
Totals	**$947,409,964**	**$826,053,327**	**115**

[a]We used total expenses because hospitals' financial statements did not separately identify patient care expenses and expenses for other hospital activities, such as gift shops and cafeterias. Using total expenses instead of patient care expenses results in understating the percentage.

Hospitals' Financial Operations for Fiscal Year 1986

Dollars in thousands

Hospital	Patient charges	Unreimbursed charges	Net patient revenue	Total expenses[a]	Surplus (deficit) from patient care	Other revenue	Net surplus (deficit)
A	$89,801	$13,806	$75,995	$75,398	$597	$1,369	$1,966
B	44,481	6,071	38,410	40,851	(2,441)	3,719	1,278
C	82,994	8,119	74,875	104,084	(29,209)	27,372	(1,837)
D	27,936	7,825	20,111	20,204	(93)	0	(93)
E	126,823	36,955	89,868	98,951	(9,083)	10,863	1,780
F	142,939	21,602	121,337	133,810	(12,473)	13,197	724
G	51,496	12,208	39,288	39,846	(558)	2,381	1,823
H	143,453	35,571	107,882	124,218	(16,336)	27,393	11,057
I	55,036	11,652	43,384	45,640	(2,256)	1,006	(1,250)
J	26,836	5,745	21,091	25,455	(4,364)	4,591	227
K	48,473	5,986	42,487	41,066	1,421	4,037	5,458
L	44,350	13,111	31,239	29,634	1,605	1,762	3,367
M	62,792	13,300	49,492	46,896	2,596	4,202	6,798

[a]See note a, app. III.

Comments From the National Association of Children's Hospitals and Related Institutions, Inc.

ROBERT H. SWEENEY
President

May 8, 1989

Mr. Lawrence H. Thompson
U.S. General Accounting
Room 6864
441 G Street, N.W.
Washington, DC 20548

Dear Mr. Thompson:

I am pleased to have the opportunity to comment on GAO's report, "Unreimbursed Charges of Selected Children's Hospitals".

The Report addresses a number of financial issues confronting children's hospitals. It does this within the constraints of information available from financial statements and provides helpful insight into the financial conditions at 13 children's hospitals and their strategies to offset unreimbursed charges.

The Report identifies that most of the 13 children's hospitals need to generate funds from other sources in addition to patient care revenues in order to cover total expenses. We would underscore the importance of this finding, in particular the critical roles of fund raising and each children's hospital's standing in and support from the community.

The Report also identifies that children's hospitals consider their expected level of unreimbursed charges when they set patient charges, and that this helps to mitigate the effect of unreimbursed charges on their financial condition. This is true but only to a limited extent. Most government payors reimburse on a cost related basis (whether prospective or retrospective), and many if not most private sector payors reimburse on a negotiated percent of charges or other negotiated basis. Thus, a hospital may not be able to generate anticipated additional patient revenues simply by raising patient charges.

The Report provides a breakdown of unreimbursed charges into three categories which are available from hospital financial statements. These categories are contractual arrangements (particularly contractual allowances), charity care and bad debt. For a variety of technical reasons it is difficult to truly distinguish contractual allowances from charity care and bad debt, and further to distinguish charity care from bad debt.

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Surely, this holds true for Medicaid patients in instances where day limits result in uncovered days of care, or "medically needy spend down" obligations under which the obligation to pay is an essential obligation, or situations where seemingly eligible patients fail to complete the enrollment processing.

In addition, Medicaid payment levels for covered services tend to be in the range of 80% of costs (exclusive of those services required but not covered). These payment shortfalls represent a significant amount of uncompensated care in children's hospitals. Unfortunately, these losses are grouped into the broader category of contractual allowances on hospital financial statements, and are not readily discernible.

We cite these issues not to be critical of the Report's analysis of the 13 children's hospitals' financial statements, but rather to point out the limitations of information available from financial statements.

We would further emphasize that uncompensated care, rather than unreimbursed charges, is really the key issue. Unreimbursed charges often must serve as a surrogate measure because it is more easily obtainable, but the distinction is important.

By uncompensated care we are referring to a full definition of charity care and bad debts and a definition of payment levels which fall short of costs, notably with the Medicaid program. Together, this constitutes a financial burden which a hospital must recover either from other paying patients or the community.

To summarize, children's hospitals along with public general hospitals face a difficult circumstance of offering vital services to their communities while at the same time shouldering large amounts of uncompensated care. This derives primarily from their service to patients with little or no health insurance coverage and to patients with coverage from marginal payors (notably Medicaid).

We very much appreciate the opportunity to offer these comments. We also wish to express our appreciation for the effort GAO has made to highlight financial issues facing children's hospitals.

Sincerely,

Robert H. Sweeney
President

RHS/jm

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