
DISTRIBUTION OF UNCOMPENSATED CARE

The first question addressed in this analysis was, To what extent do hospitals in Miami-Dade County share the burden of providing care to the uninsured? A subsidiary question was, What sources of revenue are accessed by Miami-Dade County hospitals? These questions were raised during a discussion of hospital-specific financial information prepared by the Florida Hospital Association (FHA) for 1997. (The data are reproduced in Table A.3 in the Appendix.).¹ This information included ownership, total patient revenue, total operating costs, bad debt, charity care provided, funds received to support the provision of charity care, and the estimated costs associated with uncompensated care delivered by each hospital. The table prepared by the FHA showed that all the hospitals had some level of uncompensated care (charity care plus bad debt), but JMH was the sole hospital to receive surtax revenues that offset some of the cost of the uncompensated care it delivered.

We updated the information using data for calendar year 1999 to obtain a more current picture of the financial status of Miami-Dade County hospitals. (The updated information is presented in Table A.4 in the Appendix). The 1999 data were provided by the Florida Agency for Health Care Administration (AHCA). All hospitals in Florida annually report financial data to the state, and these data are made public in a uniform, computer-readable format, using common definitions.²

¹The table was extracted from Hoo-you and Lucia (1999).

²Financial information is reported according to the *State of Florida Hospital Uniform Reporting System Manual, April 9, 1992, 91-1*.

Our analysis focused on those hospitals that provided general medical services to children and adults, since their data are most relevant to the general health-care concerns of the community and the uninsured. For the Miami-Dade County area, this meant that we excluded two specialty hospitals, Bascom Palmer Eye Institute (an ophthalmic specialty institution) and South Shore Medical Center (a geriatric facility). The 24 Miami-Dade County hospitals in our sample provided more than 95 percent of the hospital care, as measured by patient charges, within the county.³

HOW DO HOSPITALS REPORT CARE PROVIDED TO THE UNINSURED?

The care provided to uninsured patients and to those who are underinsured is reported in two different categories, charity care and bad debt. Charity care is defined as care provided to patients who are identified as not being able to pay for the medical services they receive.⁴ This determination is usually made sometime during the period in which care is provided and, as specified by state statute, requires considerable documentation. The financial reporting of charity care is closely audited to assure accuracy, since this information is used in the state's determination of disproportionate share payments.⁵

³Bascom Palmer Eye Institute and South Shore Medical Center received approximately 2 percent of the total gross hospital revenues in 1999.

⁴More specifically, according to Florida Statute 409.911, charity care or uncompensated charity care is defined as "that portion of hospital charges reported to the Agency for Health Care Administration for which there is no compensation, other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts regardless of the method of payment, for care provided to patients whose family income for the 12 months preceding the determination is less than or equal to 200 percent of the federal poverty level, unless the amount of the hospital charges due from the patients exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for patients whose income exceeds four times the federal poverty level for a family of four be considered charity" (State of Florida Statutes, Title XXX [Social Welfare], Chapter 409 [Social and Economic Assistance], 2001).

⁵The federal regulations for the Medicaid program require states to take into account the special payment needs of hospitals serving low-income populations. In particular, hospitals that treat a high proportion of uninsured or Medicaid-insured patients receive adjusted payment rates through the Disproportionate Share Payment (DSP) program.

Bad debt, in contrast, is usually identified after care has been provided. Bad debt includes amounts not recovered from patients who are identified as “self-pay,” and amounts that are not fully recovered from insured patients. A recent study that matched hospital bills with state tax records in Massachusetts showed that many patients whose hospital expenses were determined to be bad debt could actually have qualified for charity care.⁶ The occurrence of this misclassification in a state that provides fiscal relief to hospitals for charity care is significant.

The conceptual distinction between charity care and bad debt rests on the presumption of payment in situations that result in bad debt, whereas there is no such presumption for charity care. In practice, however, the distinction between the two can often be blurred. For this reason, studies that examine the financial impact on hospitals of providing care to persons without health insurance combine the costs of charity care and bad debt into “uncompensated care.”⁷ Nonetheless, it is important to note that charity care and bad debt are not the same, and caution should be used when combining the two in analyses.

Table 3.1 broadly shows how the burden of charity care and bad debt are distributed among the hospitals in Miami-Dade County for 1999. Of the 24 hospitals included in our analysis, more than half (15) are for-profit institutions owned by investors. Nine hospitals are not-for-profit institutions, and one of these, JMH, is a public hospital.

Total patient charges reported for Miami-Dade hospitals included in the analysis amounted to just under \$7.3 billion for 1999. To convert the charge data to cost data, we used a hospital-specific cost-to-charge ratio,⁸ i.e., the ratio of total operating expenses to gross patient charges. Table 3.1 shows the average cost-to-charge ratios for

⁶Weissman, Dryfoos, and London (1999); and Weissman, Van Deusen Lukas, and Epstein (1992).

⁷For example, see Mann, Melnick, Bamezai, and Zwanziger (1997); and Thorpe, Florence, and Seiber (2000).

⁸We calculated the cost-to-charge ratios using the data reported to the Florida State Agency for Health Care Administration. We compared these to the cost-to-charge ratios calculated from the Medicare Cost Reports for FY 1999. There were few differences, most of which were probably due to timing. The Florida financial data are for the calendar year, and the Medicare data are for the fiscal year.

each category of hospital. The mark-up, which is equal to the reciprocal of the cost-to-charge ratio minus 1, is 1.44, or 144 percent, for the not-for-profits; 223 percent for the investor-owned hospitals; and 101 percent for JMH. Thus, as would be expected, prices charged at for-profit hospitals (i.e., investor-owned hospitals) exceed costs by a greater amount than do prices charged at not-for-profit institutions.

We looked at the percentage of operating costs for charity care and bad debt both separately and together to understand the burden that uncompensated care imposes on hospitals (see Table 3.2). The levels of bad debt acquired and charity care provided vary by hospital type—for-profit, not-for-profit, and county. The overall cost of bad debt, i.e., bad debt multiplied by the cost-to-charge ratio, is 3.2 percent of operating expenses: 4.3 percent for for-profit hospitals, 3.0 percent for not-for-profit hospitals, and 1.9 percent for JMH. Similarly, the burden of charity care varies by hospital type. The costs of charity care represent 6.8 percent of operating expenses overall, 1.1 percent for for-profit hospitals, and 1.4 percent for not-for-profit hospitals.

Table 3.1
Summary of Florida Hospital Financial Data, 1999

Item	Total Miami-Dade Hospitals (n = 24)	Investor-Owned Hospitals (n = 15) ^a	Not-for-Profit Hospitals (n = 8) ^b	Jackson Memorial Hospital ^c
Total patient charges (\$)	7,303,531,061	3,423,216,722	2,447,078,001	1,433,236,338
Total operating expenses (\$)	2,795,759,463	1,069,872,549	1,011,927,609	713,959,305
Average cost/charge	0.38	0.31	0.41	0.50
Gross bad debt (\$)				
Sum	249,615,860	147,236,476	75,324,499	27,054,885
Average	10,400,661	9,815,765	9,415,562	
Gross charity (\$)				
Sum	404,403,801	40,172,155	35,915,033	328,316,613
Average	16,850,158	2,678,144	4,489,379	
Cost of bad debt (\$)				
Sum	90,009,972	46,316,431	30,216,289	13,477,252
Average	3,750,415	3,087,762	3,777,036	

Table 3.1 (continued)

Item	Total Miami-Dade Hospitals (n = 24)	Investor-Owned Hospitals (n = 15) ^a	Not-for-Profit Hospitals (n = 8) ^b	Jackson Memorial ^c
Cost of charity care (\$)				
Sum	190,956,166	12,555,175	14,851,759	163,549,231
Average	7,956,507	837,012	1,856,470	
Surtax revenues				141,989,707 ^d
Cost of charity care as % of operating expenses	6.8	1.1	1.4	23.0 3.0 ^e 13.0 ^f
Cost of bad debt as % of operating expenses	3.2	4.3	3.0	1.9
Total uncompensated care as a proportion of costs	10.0	5.5	4.4	24.8 4.9 ^e 14.9 ^f

Notes: Data for Coral Gables and Parkway Regional Medical Center were incomplete. These incomplete data were adjusted to estimate the 1999 data, using the Miami-Dade County percentage changes calculated from the complete data reported for 1998 to 1999. The estimated cost of uncompensated care = cost/charge ratio (bad debt plus charity care) – (restricted funds for charity + surtax revenue).

^aAventura Hospital and Medical Center, Cedars Medical Center, Coral Gables Hospital, Deering Hospital, Healthsouth Doctor's Hospital, Hialeah Hospital, Kendall Medical Center, Larkin Community Hospital, Miami Heart Institute/Mount Sinai, North Shore Medical Center, Palm Springs General Hospital, Palmetto General Hospital, Parkway Regional Medical Center, Vencor Hospital-Coral Gables, and Westchester General Hospital were identified as investor-owned during 1998 and 1999.

^bBaptist Hospital of Miami, Homestead Hospital, Mercy Hospital, Miami Children's Hospital, Mount Sinai Medical Center, Pan American Hospital, South Miami Hospital, and University of Miami Hospital and Clinics were identified as not-for-profit during 1998 and 1999.

^cJMH is a tertiary, academic teaching hospital whose specialized services result in higher costs than those at community hospitals.

^dJMH is the only hospital that receives restricted and unrestricted funds (surtax revenue).

^eIf all the surtax funds are used to offset charity care.

^fIf one-half of the surtax funds are used to offset charity care.

Table 3.2
Uncompensated-Care (Charity Care plus Bad Debt) Costs
(percentage of operating expenses)

Type of Hospital	Miami-Dade County, 1999	National Benchmarks, 1995 ^a
Not-for-profit	4.6	4.6
For-profit	5.4	4.1
Major public teaching ^b	24.8	17.6

^aData from Prospective Payment Assessment Commission (1996).

^bJackson Memorial Hospital is the major public teaching hospital in Miami-Dade County.

Determining the costs of charity care at JMH is not as straightforward as it is for other hospitals. Jackson receives county revenues as a result of the surtax enacted in 1992. This amounted to approximately \$142 million in 1999.⁹ If none of these revenues offsets the costs of charity care, that care accounts for 23 percent of operating expenses at JMH. However, if all the surtax is used to fund indigent care, charity care represents just 3 percent of operating costs. If the surtax funds are assumed to support a combination of indigent care and other purposes, half of the surtax revenues might be considered to offset charity care, so 13 percent of operating expenses would be attributable to charity care.¹⁰

Adjusted costs for uncompensated care for Miami-Dade not-for-profit hospitals as a group are 4.4 percent of total operating costs; those for investor-owned hospitals are 5.5 percent. The difference between the not-for-profits and the investor-owned hospitals lies primarily in the higher levels of bad debt incurred by the latter. The adjusted costs for uncompensated care at JMH vary from 24.8 percent of operating costs when none of the surtax revenues is consid-

⁹As discussed in Chapter Two, the ballot language that created the surtax stated that the funds were to be used “for the operation, maintenance and administration of Jackson Memorial Hospital to improve health care services.”

¹⁰According to the Public Health Trust budget for 1999, over half the surtax funds—approximately \$70 million—are mandated by the county to support various programs such as primary-care-center support, county Medicaid liability, and nursing homes.

ered to 4.9 or 14.9 percent when all or half of the surtax revenues are assumed to offset uncompensated-care costs.

A comparison of these Miami-Dade County figures with national benchmarks shows that the level of uncompensated care in Miami-Dade hospitals is not much different from that experienced elsewhere. The levels at for-profit hospitals in Miami-Dade, however, appear to be somewhat higher than the national experience. Moreover, there are proportionately more for-profit hospitals in Miami-Dade County than there are nationally.¹¹ Jackson Memorial Hospital appears to face a level of burden slightly higher than that of major public teaching hospitals nationally.

UNCOMPENSATED CARE PROVIDED BY HOSPITALS IN THE COUNTY

Hospitals across the county share the burden of uncompensated care, as shown in Figure 3.1, which shows those hospitals that reported complete financial data.¹² There are three separate bars for Jackson Memorial Hospital. The first, labeled (A), represents the case where none of the surtax revenues are used to offset charity care costs. The second, labeled (B), assumes the use of one-half of the surtax revenues to offset charity-care costs. The third, labeled (C), assumes the use of 100 percent of the surtax revenues to offset charity-care costs.

If none of the surtax revenues offsets charity care at JMH, it and Homestead Hospital provide the highest proportion of charity care, as measured by the proportion of operating expenses. However, if one-half of the surtax revenues is used to offset charity care at JMH, other hospitals, especially Homestead Hospital, have a greater uncompensated-care burden. If all the surtax funds are used to offset charity care, the proportion of operating costs that charity care alone represents falls below that of Homestead Hospital.

¹¹In 1999, 6.6 percent of all hospitals in the United States were for-profit hospitals (data from American Hospital Association, AHA).

¹²In the 1999 hospital financial data provided by the Florida Agency for Health Care Administration, Larkin Hospital reported a positive offset in bad debt; the data from Coral Gables and Parkway were not complete.

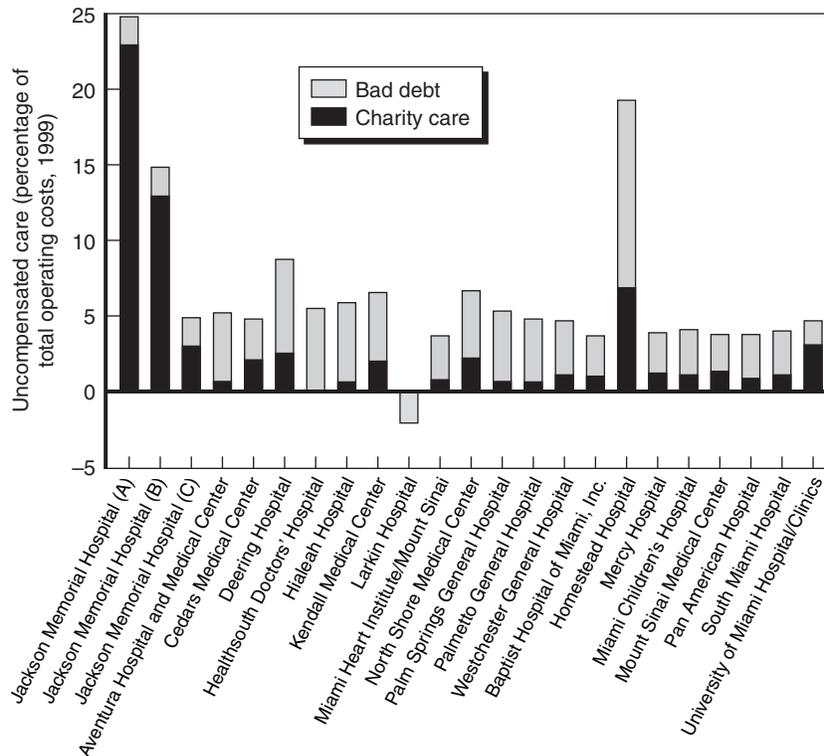


Figure 3.1—Uncompensated Care Is a Substantial Percentage of Operating Expenses at Several Miami-Dade County Hospitals

Figure 3.2 presents the same data in dollar terms. As can be seen, JMHS bears by far the highest cost of uncompensated care among Miami-Dade County hospitals; it is also the sole public hospital and the largest hospital in the county.

The 50 percent offset for JMHS shown in Figure 3.1 derives from an FHA 1997 estimate of the costs of uncompensated care in Miami-Dade County. The formula used by the FHA is given in the note to Table A.3 in the Appendix. According to the FHA, the 50 percent reduction was derived historically from the assumption that half the surtax revenue would be used directly by the hospital, while the rest would be used for programs that benefited the community at large.

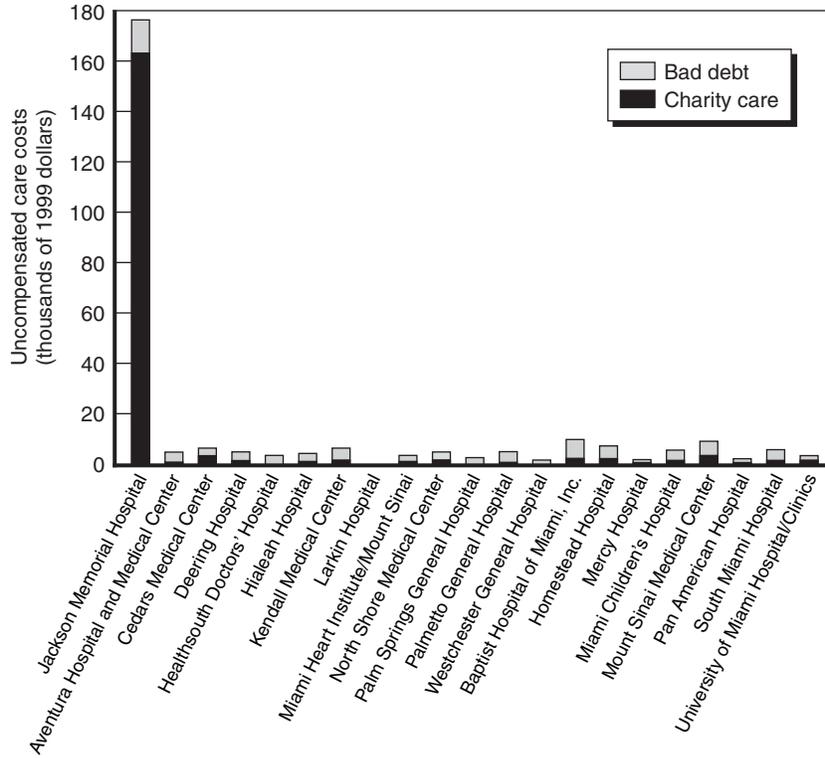


Figure 3.2—JMH Has the Highest Costs of Uncompensated Care, in Absolute Dollar Terms, of All Miami-Dade County Hospitals

However, the FHA elaborated that the assumption had no empirical basis, and in fact, they had decided to stop using it in reporting the costs of uncompensated care. This change in reporting procedure would mean that JMH did not experience a loss due to uncompensated care in 1999, but rather received \$4.8 million above its costs.¹³ Irrespective of the intended purpose of the surtax funds—to support specialized and regionalized services at JMH or to provide funds for

¹³With the change in reporting procedure, the cost of uncompensated care at JMH in 1997 would have been not \$74.8 million, but negative \$4 million; that is, if the entire surtax were applied to JMH's share of the uncompensated care, the hospital would have realized a profit of \$4 million.

indigent care—the surtax represents a major source of revenue for JMH. The \$142 million in surtax funds provided to JMH for 1999 covered nearly 20 percent of the hospital’s operating expenses.

Figure 3.2 clearly shows that bad debt is a major contributor to the cost of overall uncompensated care for all hospitals, with the stark exception of JMH, where less than 2 percent of operating costs were attributable to bad debt. The administrators at JMH assert that they have made better management decisions, including negotiating better contracts (i.e., more favorable discount rates) with third-party payers. This issue is explored below.

EFFECT OF DISCOUNTING ON HOSPITAL REVENUE

According to Table 3.1, the total cost of care provided by Miami-Dade hospitals in 1999 was approximately \$2.8 billion. The difference between total patient charges and operating costs was \$4.5 billion. This would suggest that Miami-Dade County hospitals made profits in 1999. However, this “profit” is illusory. It must be reduced not only by the costs of uncompensated care, but also by the discounts the hospitals provide on most of their charges. This is most easily understood in the context of the full spectrum of hospital revenue sources.

The hospitals in Miami-Dade County provide care to a diverse population that, in turn, generates a variety of revenue sources. Figure 3.3 presents an overview of sources of payment for charges made by all hospitals in Miami-Dade County, based on the hospital financial data from AHCA. Coral Gables Hospital and Parkway Regional Medical Center have been excluded from this analysis because their data were incomplete.¹⁴

Like hospitals nationwide, Miami-Dade hospitals depend heavily on the traditional payers, Medicare and Medicaid. In 1999, 29 percent of Miami-Dade hospital charges were for care provided to conventional-Medicare recipients and 13 percent were for conventional-Medicaid recipients. Medicare and Medicaid managed-care plans

¹⁴The exclusion of these hospitals did not qualitatively affect the distribution of revenues by payer.

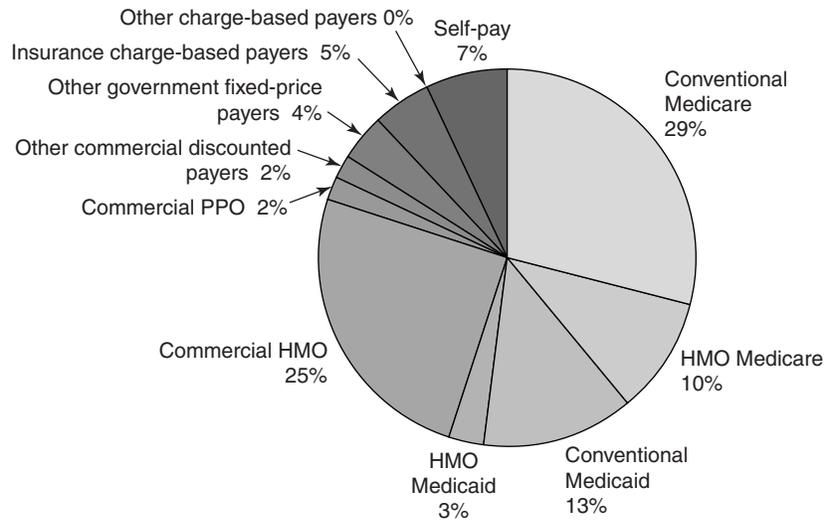


Figure 3.3—Traditional Payers Such as Medicare and Medicaid Are Still Prominent in the Miami-Dade Health-Care Market

(HMOs) paid for 10 percent and 3 percent of hospital charges, respectively. Commercial HMOs and Preferred Provider Organizations (PPOs) paid for 25 percent and 2 percent of hospital charges, respectively. Other discounted and fixed-price payers represented 6 percent in the aggregate. Less than 5 percent of hospital charges were billed to charge-based payers. Self-pay patients accrued 7 percent of hospital charges overall.

Thus, while managed care came relatively late to south Florida, it now is a significant player in the health-care market. Negotiated-price plans, such as HMOs and PPOs, use competition to drive down the amount they pay hospitals. This in turn reduces hospitals' margins and their ability to expand or improve services. Moreover, the reduced realized revenues mean that any level of uncompensated care provided cuts deeply into hospitals' profitability and financial health.

Discounting, that is, the practice of offering third-party payers¹⁵ a rate for goods and services that is lower than the price tag or *charge*, encourages third-party-payer beneficiaries to use the hospital offering the discount. Thus, while discounting reduces per-patient income, it presumably increases the number of patients who use the hospital; total income will be augmented if the percentage increase in patients exceeds the discount percentage.

The financial data reported to the AHCA show that among the 22 hospitals with complete data in Miami-Dade County, conventional-Medicare recipients receive discount rates ranging from 35 percent to 75 percent, and Medicare HMOs receive discount rates ranging from 26 percent to 92 percent. Overall, the average discount rate is 45 percent.¹⁶ Because of the high proportion of patient charges subject to discounting, only a small number of patients have their hospital charges fully reimbursed. The key for most hospitals, then, is to enter into arrangements with health-care plans that will ensure a constant pool of users, while keeping discounted charges higher than operating costs. In a competitive hospital market, there is considerable tension between these two objectives.

TAX-EXEMPT STATUS AND THE PROVISION OF INDIGENT CARE

When asked for their position on the extent to which surtax revenues appeared to offset their costs of uncompensated care, the JMH administrators said that the tax-exempt status granted not-for-profit hospitals implied a *quid pro quo*: Nonprofit hospitals would provide services to the community (for example, uncompensated care) in exchange for a reduction in or avoidance of taxes. Estimating the theoretical cost savings from the tax-exempt status afforded Miami-Dade

¹⁵Third-party payers are payers who are neither the giver nor the recipient of care; these include the government and private-sector insurers—all contributors in Figure 3.1 except for self-pay.

¹⁶The discount rate is calculated as total patient charges minus total deductions from charges, divided by total patient charges.

County not-for-profit hospitals and making comparisons to the amount of uncompensated care provided by these hospitals was beyond the scope of this analysis. And we noted that investor-owned hospitals receive no tax exemption, yet some provide charity care.¹⁷

Tax exemption is conferred on not-for-profit hospitals and other nonprofit organizations because such organizations provide benefits to the community in exchange for not paying taxes.¹⁸ These benefits, which have recently come to be known as *community benefits*, are public goods provided to persons without expectation of payment and may include such services as indigent-care provision or free cancer screenings. Community benefits also benefit the community as a whole: Providing health care, regardless of one's ability to pay, makes for healthier communities.

Florida does not have a community benefits statute. Indeed, few states have explicit regulations that provide guidance to not-for-profit hospitals on the level of community benefits they should provide. New Hampshire defines community benefits to include charity care; financial or in-kind support of public-health programs; allocation or donation of funds, property, and services to contribute to community health needs or promote a healthier community; and support of medical research and education.¹⁹ The Michigan Health and Hospital Association expanded the definition of community benefits to include any uncompensated care (charity care or bad debt) plus the unreimbursed costs of Medicaid and Medicare.²⁰ Thus, while there appears to be support for a quid pro quo with respect to the tax-exempt status of not-for-profit hospitals, there is no consensus as to how this should be defined.

¹⁷All hospitals reported some level of uncompensated care. For two investor-owned hospitals that do not report any charity care, Healthsouth Doctors Hospital and Larkin Hospital, the uncompensated care is composed solely of bad debt.

¹⁸See Reinhardt (2000); and Kane and Wubbenhorst (2000).

¹⁹Statement of Community Benefits Statutes, RSA 7:32-e, New Hampshire, Department of Justice (<http://webster.state.nh.us/nhodoj/CHARITABLE/commbenefits.htm>).

²⁰MHA Community Benefits Measurement Project, Michigan Health and Hospital Association (<http://www.mha.org/commbenreport.asp>).

SUMMARY

- Hospitals in Miami-Dade County provided approximately \$650 million gross charges, or \$281 million in costs of uncompensated care, in 1999. The surtax raised approximately \$140 million. Clearly, surtax dollars are insufficient to finance uncompensated hospital care.
- All hospitals in the county provided some uncompensated care, although the absolute amounts varied, as did the relative amounts (as percentages of total operating costs).
- JMH and Homestead Hospital had the highest uncompensated-care burdens in the county.
- Some consider uncompensated care part of the community benefits that not-for-profit hospitals should provide, but neither Miami-Dade County nor Florida has an explicit policy on how much uncompensated care should be provided.