trends in insured versus uninsured patient debt

Among the primary objectives of the Affordable Care Act was to ensure that most Americans would be able to obtain health insurance coverage by Jan. 1, 2014. The impact of this mandate—which has made it possible for hospitals to obtain the assurance of payment from a handful of insurers—has been widely viewed as positive, because it has substantially mitigated the need for hospitals to seek payment from each individual patient. However, hospitals have not been absolved of the need for financial interaction with patients, because the collection of copayments and deductibles is still necessary. As a follow-up to this significant change, an examination of how well hospitals and enrollees have responded to this change can provide some valuable insights.

Data from worksheet S-10 of Medicare cost reports for hospital fiscal years ending during each calendar year 2012-14 show shifts in utilization patterns with regard to debts from the insured and uninsured that are approved for charity care, as well as overall bad debt in acute care and critical access hospitals. Because many of the previously uninsured were unable to afford insurance, their ability to handle the copayments and deductibles that go with their new insurance will be an ongoing concern for hospitals to monitor.

When the data are viewed with providers grouped by bed size or critical access designation, it becomes apparent that the initial obligation of uninsured patients decreases between 2012 and

DATA BY FACILITY SIZE

Hospital Category/Beds	Fiscal Year	Charity Care Initial Patient Obligation (Uninsured)	Charity Care Initial Patient Obligation (Insured)	Bad Debt Expense
Critical Access	2012	$953,494,092	$230,871,406	$2,100,030,260
	2013	$994,731,097	$269,133,165	$2,242,447,256
	2014	$853,845,774	$244,646,012	$2,251,009,832
50 or Fewer	2012	$1,022,490,735	$232,608,626	$1,892,667,912
	2013	$1,225,846,357	$239,530,800	$2,110,235,779
	2014	$1,096,696,743	$275,746,852	$2,304,349,742
51-100	2012	$2,358,370,126	$460,430,902	$3,943,714,682
	2013	$2,763,922,609	$581,785,884	$4,436,766,161
	2014	$2,743,908,815	$557,101,288	$5,708,884,705
101-175	2012	$7,702,404,482	$1,179,427,421	$8,845,875,574
	2013	$9,457,965,921	$1,553,709,846	$9,522,902,481
	2014	$6,729,204,505	$1,265,362,424	$8,793,655,636
176-300	2012	$16,455,249,586	$2,091,319,344	$13,159,778,839
	2013	$16,736,327,333	$2,637,600,663	$13,974,867,989
	2014	$14,405,740,497	$2,168,458,109	$12,953,007,449
300+	2012	$40,879,256,415	$7,063,326,768	$28,675,466,055
	2013	$42,312,601,883	$7,737,404,122	$29,358,944,902
	2014	$38,015,761,473	$8,513,034,583	$28,345,511,280

DATA BY TYPE OF CONTROL

Hospital Category	Fiscal Year	Charity Care Initial Patient Obligation (Uninsured)	Charity Care Initial Patient Obligation (Insured)	Bad Debt Expense
For-Profit	2012	$7,591,564,227	$853,896,581	$11,309,426,855
	2013	$9,557,762,732	$1,235,450,067	$13,382,480,898
	2014	$6,500,016,751	$908,766,164	$10,665,096,096
Governmental	2012	$17,910,587,818	$1,672,445,736	$14,749,647,935
	2013	$18,386,209,370	$2,008,446,097	$14,070,858,052
	2014	$17,097,643,823	$2,814,790,799	$16,483,645,225
Not-for-Profit	2012	$43,869,113,391	$8,731,642,150	$32,558,458,532
	2013	$45,547,423,098	$9,775,268,316	$34,192,825,618
	2014	$40,247,497,233	$9,300,792,305	$33,207,677,323

2014 for most categories while the initial obligation of insured patients increases, as would be expected with a mandate to increase the number of insured persons. A notable exception to the decline in uninsured initial patient obligations approved for charity care occurs in facilities with 100 or fewer beds. This debt is in addition to the similar increase in debts larger facilities experience from insured patients going to charity care. Although not part of this analysis, the increase in uninsured obligations seen by the smaller facilities may be the result of a greater portion of them being located in states that opted not to expand Medicaid. The increase in bad debt expense seen by this group over the same period may be an area for further research to determine whether write-off and collection practices in smaller hospitals are less effective.

When the data are anaylzed by hospital ownership, it becomes apparent that most categories have experienced a decline in uninsured write-offs with increases on the insured side. However, government-run hospitals appear to have experienced a 68 percent increase in charity care from insured patients over the period of study, while the amount these hospitals have written off to bad debt also has increased considerably. Although the increase for insured charity care is small in relation to other control types, its change in relation to the government-run category is significant. This increase, along with considerable growth for overall bad debt expense, shows that this area should be closely monitored by government-run facilities.

Analysis of urban versus rural geography detail discloses that both provider types experience similar declines for uninsured charity care with growth on the insured side.

In the coming months, data for 2015 will become available and make it possible to see whether these trends are continuing. In the meantime, providers may find these data useful in determining how they compare nationally and whether write-offs and bad debt should be an area of focus under the new insurance scheme. ■

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DATA BY URBAN OR RURAL DESIGNATION

Hospital Category	Fiscal Year	Charity Care Initial Patient Obligation (Uninsured)	Charity Care Initial Patient Obligation (Insured)	Bad Debt Expense
Rural	2012	$4,758,090,148	$1,009,072,306	$8,665,514,554
	2013	$5,192,193,836	$1,314,192,593	$9,283,767,623
	2014	$4,539,342,462	$1,184,770,809	$10,567,304,448
Urban	2012	$64,613,175,288	$10,248,912,161	$49,952,018,768
	2013	$68,299,201,364	$11,704,971,887	$52,362,396,945
	2014	$59,305,815,345	$11,839,578,459	$49,789,114,196