American Hospital Association

Hospital Bad Debt

Criticism: Hospitals do not always make a reasonable effort to collect bad debts.

AHA Response: Hospitals do make a "reasonable" effort to collect unpaid deductibles and coinsurance. Doing so is required by law in order for Medicare to reimburse hospitals for a portion of this bad debt. However, the simple fact is that most Medicare beneficiaries have very modest incomes: In 2006, almost two-thirds of Medicare beneficiaries had incomes of less than $30,000. Hospitals are simply not willing to go beyond making a "reasonable" effort to collect payments from these low-income beneficiaries. They are unwilling to aggressively pursue payment of these debts simply because the Medicare program is unwilling to reimburse for its unpaid deductibles and coinsurance. Rather, in the face of overall Medicare margins that were already *negative* 5.2 percent in 2009, hospitals may be forced to cut certain programs and services that are essential to Medicare beneficiaries.

Criticism: Medicare makes billions of dollars in additional payments annually to rural hospitals and hospitals with a high number of low-income patients. These payments would be unaffected by H.R. 3630.

AHA Response: Medicare payments to rural hospitals and hospitals with a high number of low-income patients are not designed to compensate hospitals for unpaid beneficiary copayments and deductibles. Rather, Medicare payments to rural hospitals are intended to help them remain viable given their smaller size and volume, geographic isolation, and the type of population served, so that rural Medicare beneficiaries have access to hospital care. Medicare's payments to hospitals with a high number of low-income patients are intended to help compensate these hospitals for the higher costs of treating these patients.

The fact remains, however, that reducing or eliminating bad debt reimbursement would disproportionately affect hospitals that treat high numbers of low-income Medicare beneficiaries – safety-net hospitals and rural hospitals. Inner-city urban communities have large numbers and high proportions of Medicaid recipients and uninsured residents, and are also highly likely to have large numbers and high proportions of low-income Medicare beneficiaries. Rural areas have a high proportion of low-income residents. Hospitals in the highest quartile of disproportionate share hospital (DSH) patient percentages have Medicare bad debt reimbursement as a percentage of their Medicare revenue that are 2.5 times higher than hospitals in the lowest quartile of DSH patient percentages, on average. In addition, rural hospitals have Medicare bad debt percentages that are 60 percent higher than urban hospitals, on average.

Criticism: Medicare should not subsidize Medicaid. Medicaid programs will not meet their cost-sharing obligations associated with "dual-eligible" seniors (low-income seniors who are eligible for both Medicare and Medicaid) as long as Medicare provides payments.

AHA Response: When Medicare pays for dual-eligible bad debt, it is not subsidizing the Medicaid program. Rather, when Medicaid pays less than the full deductible and coinsurance due, the remaining balance becomes the responsibility of the beneficiary. However, hospitals are statutorily prohibited from billing dual-eligible beneficiaries for this balance; any hospital that does so is subject to sanctions. Therefore, the unpaid amount becomes bad debt by default. When Medicare pays for this bad debt, it is making the payment on behalf of the beneficiary, not the Medicaid program.