

BALANCING MARGIN AND MISSION: HOSPITALS ALTER BILLING AND COLLECTION PRACTICES FOR UNINSURED PATIENTS

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A barrage of publicity about aggressive hospital billing and collection practices and a spate of lawsuits alleging hospitals overcharged uninsured patients have put hospitals in a harsh national spotlight. In the wake of a campaign by hospital associations to encourage hospitals to create formal policies for billing uninsured patients, many hospitals have modified billing and collection practices for low-income, uninsured patients, according to the Center for Studying Health System Change's (HSC) 2005 site visits to 12 nationally representative communities. Almost all of the hospitals interviewed that had adopted more generous charity care policies indicated expenses previously classified as bad debt have shifted to charity care write-offs. To date, these changes have had little impact on hospital bottom lines, and the impact on access to care for uninsured people remains unclear.

Spotlight Falls on Hospital Billing and Collection Practices

Rising health care costs, escalating health insurance premiums, a growing number of uninsured people and increasing patient cost sharing are sparking greater levels of medical debt among the U.S. population, with uninsured people almost twice as likely to have medical debt problems as insured people.¹ In recent years, national media coverage has spotlighted some hospitals' aggressive billing and collection practices for uninsured patients, resulting in increased scrutiny by policy makers. Among the more extreme measures to collect overdue debts, some hospitals have placed liens on patients' homes.²

Under the federal Emergency Medical Treatment and Labor Act (EMTALA),³ all Medicare-participating hospitals with emergency departments must provide stabilizing care to patients with an emergency condition, regardless of the patient's ability to pay. However, the law does not provide payment for services provided to uninsured patients or govern how hospitals bill and pursue payment for services provided

under EMTALA. Moreover, the scrutiny of hospital billing and collection practices goes beyond emergency care.

Hospitals in more than 50 health systems across the country were named as defendants in class-action lawsuits led by well-known plaintiffs' attorney Richard Scruggs—who led the legal battle against the tobacco industry—alleging not-for-profit hospitals of “profiteering” by charging uninsured patients full billed charges for care, when other payers, including private insurers, Medicare and Medicaid, receive large discounts from billed charges.⁴ Other suits, separate from the Scruggs' cases, also have been filed against both not-for-profit and for-profit hospitals, alleging similar concerns.

Half of the 12 nationally representative communities included in HSC site visits had at least one hospital named in the class-action suits (see Data Source and Table 1). Virtually all of the suits against hospitals filed in federal court have been dismissed without merit. In some cases,

judges have chastised plaintiffs' attorneys for trying to use the courts to solve the problem of uninsurance in America. For example, a U.S. District Court judge in New York dismissed a lawsuit against New York-Presbyterian Hospital saying, “Plaintiffs here have lost their way; they need to consult a map or compass or a Constitution because plaintiffs have come to the judicial branch for relief that may only be granted by the legislative branch.”⁵ However, state court action on these cases is still possible.

Hospital Associations Encourage Billing and Collection Change

Collectively, U.S. hospitals in 2003 provided \$24.9 billion in uncompensated care, or 5.5 percent of all hospital costs, according to the American Hospital Association (AHA).⁶ Uncompensated care includes charity care provided to poor uninsured patients and debts of individuals and third-party payers that are never collected by hospitals. With an estimated 44.8 million

uninsured Americans, hospitals treat uninsured patients every day. Many uninsured patients are poor and unable to afford care, while others may have the resources to pay for their care, leaving hospitals the task of determining who is financially needy.

As scrutiny of hospital billing and collection practices heated up in 2003, the AHA asserted that federal regulations made it difficult for hospitals to provide discounts to uninsured patients. Pending clarification from regulators, the AHA issued guidance in December 2003 outlining how hospitals could assist low-income patients in paying for hospital care. The recommendations broadly addressed communicating with patients effectively, helping patients qualify for coverage, ensuring hospital policies are applied accurately and consistently, making care more affordable for low-income patients, and engaging in fair billing and collection practices.⁷

In some cases, state and local hospital associations crafted guidelines to assist member hospitals. For example, the Hospital Association of New York State recommends that hospitals offer discounts for patients with incomes up to 200 percent of the federal poverty level, or \$38,700 for a family of four in 2005, and that discounts should generally reflect prices similar to those paid by insured patients. Most individual hospitals interviewed in the 12 HSC sites reported current or planned compliance with these types of guidelines.

In 2004, upon request for guidance by AHA, the U.S. Department of Health and Human Services clarified that Medicare regulations do not prohibit hospitals from providing discounts for uninsured or underinsured patients.⁸ Congressional hearings also were held to examine hospital billing practices for the uninsured.

Community Reactions and Hospital Responses

In general, the HSC site visits revealed little pressure at the local level for hospitals to change their billing and collection practices. Market observers perceived that the issue had not garnered much attention among the general public in most of the HSC communities, with some exceptions, particularly in communities with a history of consumer involvement and advocacy.

Table 1
Nonprofit Class Action Lawsuits Regarding Provision of Charity Care for Uninsured

HSC COMMUNITY	DEFENDANT
CLEVELAND	<ul style="list-style-type: none"> • CATHOLIC HEALTHCARE PARTNERS, COMMUNITY HEALTH PARTNERS HOSPITAL AND SURGICAL CENTER • CLEVELAND CLINIC FOUNDATION, CLEVELAND CLINIC HEALTH SYSTEM
LITTLE ROCK	<ul style="list-style-type: none"> • BAPTIST HEALTH
MIAMI	<ul style="list-style-type: none"> • BAPTIST HOSPITAL OF MIAMI, INC. AND BAPTIST HEALTH SOUTH FLORIDA, INC.
NORTHERN NEW JERSEY	<ul style="list-style-type: none"> • SAINT BARNABAS
PHOENIX	<ul style="list-style-type: none"> • BANNER HEALTH
SEATTLE	<ul style="list-style-type: none"> • PROVIDENCE HEALTH SYSTEM

Source: Not-for-Profit Hospital Class Action Litigation Web site, <http://www.nfplitigation.com/>

However, most hospitals reported that media attention to the issue, as well as encouragement from state and local hospital associations, persuaded them to adopt voluntary guidelines for providing free or reduced-cost care to uninsured patients.

In every HSC community, most hospitals have either recently changed their pricing, billing and collection policies or tried to improve the clarity of the information provided to patients. Most of the hospitals interviewed had increased the income threshold for full charity care or discounted services. It is now common policy for hospitals to provide charity care to uninsured persons with incomes under 200 percent of poverty and offer sliding-scale discounts beyond this income threshold, in some cases up to 400 percent or 500 percent of the poverty level. For example, Baptist Health System of South Florida recently increased its charity care income threshold from 200 percent to 300 percent of poverty and reportedly is considering increasing charity care eligibility to 500 percent of poverty.

Other hospital responses include prompt-pay discounts for self-pay patients—at any income level—with the most generous discount for payment at the time of service. Hospitals vary in how their discounting policies are applied. Often, discounts are taken off of full charges and may bring prices down to those negotiated with major private insurers or government programs, thus extending a sizeable discount

to uninsured patients.

The impact of more generous pricing or discounting policies on access to care for the uninsured remains unclear. Market observers in some communities believed that charity care is now easier to obtain and that hospitals' efforts to better identify people upfront who are eligible for charity care has helped patients and spared them the aggressive collection practices some hospitals used. However, in some cases, hospitals have adopted more generous pricing policies but also have engaged in other activities to manage their payer mix that inhibits access to care for some uninsured. For example, Jackson Memorial Hospital in Miami and Harborview Medical Center in Seattle, both county-owned hospitals, have started limiting care provided to out-of-county residents for non-emergency care and are working to attract more private-pay patients.

Why Community Concerns Vary

Several factors appear to influence the level of concern about hospital billing and collection practices for uninsured patients across the 12 communities. Market observers in some communities believed that the existence of state charity care laws or uncompensated care pools lessened attention to the issue. For example, Washington requires individuals with incomes up to 100 percent of poverty to be eligible to receive full charity care, and hospitals must provide discounts to patients with incomes between

100 percent and 200 percent of poverty. Given these requirements, the state hospital association indicated that individual hospitals' charity care policies are likely to be less of an issue.

In Massachusetts, hospitals and health plans pay into the state uncompensated care pool, and funds are redistributed to hospitals and community health centers based on the amount of free care they provide. Uninsured people with household incomes up to 200 percent of poverty are eligible for full charity care, with discounts for people up to 400 percent of poverty. New Jersey has a similar state charity care pool and standards, requiring discounts for persons between 200 percent and 300 percent of poverty. However, a market observer in New Jersey cautioned that a limitation of the state's charity care law is that charges for some services, such as physician fees, anesthesiology and radiology fees, are separate from hospital charges and may be ineligible for discounts—a likely circumstance in other places as well.

Additionally, in communities with a major public hospital or institution that serves a disproportionate share of low-income, uninsured patients, there may not be as much pressure for other hospitals to change billing policies. For example, in Indianapolis, a market observer attributed the lack of attention to hospitals' billing and collection policies to community expectations that Wishard Memorial Hospital, the county-owned safety net hospital, will care for most uninsured patients. In contrast, Jackson Memorial Hospital in Miami was confronted by an advocacy group about its billing and collection practices, despite the hospital reportedly collecting less than 10 percent of what it is owed by uninsured patients for services.

Similar to Miami, in communities with strong consumer advocacy groups—Boston, Cleveland and Orange County, Calif.—hospital billing and collection practices have gained more attention. For example, the Latino advocacy group, Consejo de Latinos Unidos, criticized investor-owned Tenet Healthcare Corp., which has several hospitals in Orange County, for overcharging uninsured patients and aggressive collection of Latino patients' delinquent bills. In response to these complaints and other

problems Tenet faced with federal regulators and investors, the hospital system settled the suit, agreeing to new standards for billing and collection practices for uninsured patients. In addition, the same advocacy group has accused Miami hospitals of overcharging uninsured patients.

In the few states that have had proposed legislation to govern hospital pricing, billing or collection standards, hospitals may feel more pressure. Market observers in southern California attributed hospitals' recent changes in part to the threat of state legislation.

Hospital Financial Implications

Most changes in billing and collection policies have had negligible impact on hospital finances to date. Uncompensated care is comprised of both bad debt and charity care. Almost all of the hospitals interviewed that had adopted more generous charitable policies indicated that expenses previously classified as bad debt have shifted to charity care write-offs, with little impact on hospital bottom lines.

Implementing billing and collection policy changes was less costly than expected by some hospitals. Also, in Indianapolis, a hospital leader reported that easing collection practices reduced administrative hassles and costs. However, some hospitals have incurred additional expenses by hiring more financial staff to assist patients with billing and collection policies and to help uninsured patients enroll in public coverage programs, in part to improve reimbursement. For example, a Syracuse hospital hired three financial counselors to help patients with billing issues and apply for public health insurance coverage.

Some hospitals appeared to be making changes quietly, possibly to avoid attracting more uninsured patients, leading some advocacy groups to criticize hospitals for failing to adequately promote their new policies. In Cleveland, the Universal Health Care Action Network Ohio reportedly has been working to get hospitals to disclose their charity care policies and improve communications with consumers. In addition, Cuyahoga County, Ohio, is including information in its *Guide to Free and Affordable Healthcare* on what documentation is needed to seek reduced cost or free



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Data Source

Every two years, HSC researchers visit 12 nationally representative metropolitan communities to track changes in local health care markets. The 12 communities are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. In 2005, HSC researchers interviewed hospital executives, hospital associations, policymakers and advocates about state and local interest in hospital pricing, billing and collection practices for uninsured persons and recent changes made by hospitals to their policies.

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care in hospitals in the county.

On the other hand, some hospitals have publicized their new policies. For example, Partners HealthCare's new billing policies for uninsured patients that include discounts ranging from 15 percent to 50 percent off of full charges was recently highlighted in a *Boston Globe* article.⁹

Policy Implications

Increased scrutiny of hospitals' billing and collection policies appears to have spurred changes by hospitals. For the most part, hospitals are quietly making changes on their own rather than being forced by courts or regulators, and their efforts appear to have defused the relatively low level of concern evident in most HSC communities.

Although federal lawsuits against not-for-profit hospitals have been unsuccessful to date, plaintiff attorneys are continuing to raise the issue in state courts. Moreover, renewed Congressional interest in examining tax-exempt status in the health care industry could revive attention to activities of not-for-profit hospitals and their provision of charity care and other community benefits.

It is noteworthy that these changes in hospital billing policies are occurring at a time when many hospitals report continued increases in uncompensated care, including in their emergency departments and outpatient services. These increases are not a result of changes in hospital billing practices per se, but rather because of increases in the number of uninsured people in the community and decreased access to many outpatient providers, particularly specialty physicians. Many private physicians reportedly are more reluctant to treat low-income patients,¹⁰ and while hospitals may offer an open door to uninsured patients, uninsured patients can't get care if doctors won't treat them.

Policy makers should not lose sight of the fact that as providers of last resort, many hospitals are absorbing the problems associated with diminished access to care for uninsured persons. Ensuring reasonable billing and collection practices is important, but it is not a substitute for addressing these more fundamental problems with access to care.

Notes

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