

The Hospital Billing and Collections Flap: It's Not Over Yet

Some Federal Suits Have Been Dismissed, But New Challenges are Coming from the States

Carol Pryor

Over the last few years, hospital billing and collections policies and practices toward uninsured and underinsured patients have come under increased scrutiny, attracting the attention of advocacy groups, the media, and federal and state legislators and regulators. A number of developments have converged to bring this issue to the fore.

In January 2003, my organization, The Access Project, released the results of a survey of almost 7,000 uninsured patients in 18 states who received ambulatory care at local safety-net hospitals and clinics. One startling finding was that nearly half of the respondents reported owing money to the facility where they received care; this jumped to nearly two in three respondents who received care in hospital emergency rooms, and more than a quarter of those with such debt said it would deter them from seeking future care at the facility.¹

These results first alerted us to the widespread nature of the problem of medical debt and its impact on access to health care. Since that time, a wealth of data has further documented the scope and consequences of the problem. In March 2004, a national survey found that two out of five adults have medical bill problems or accrued medical debt.² Most recently, researchers reported that medical problems contribute to approximately half of all personal bankruptcies.³

Of course, hospital bills are only one source of medical debt. About the same time, however, that The Access Project began documenting the issue of medical debt generally, the Connecticut Center for a New Economy released a report on the billing and collections practic-

Carol Pryor is senior policy analyst at The Access Project, a national health care access research and advocacy organization. She has written several reports on medical debt, including a study published by The Commonwealth Fund on public and private policies that may contribute to the medical debt problem. She can be reached at 617/654-9911 x227 or by email at carol@accessproject.org.

CCH INCORPORATED

es of nonprofit Yale-New Haven Hospital, which focused attention on hospitals' role in the problem. The report revealed that in spite of having access to over \$35 million in "free bed funds" to support free care for the uninsured, the hospital was billing many low-income people who should have been eligible for assistance and then hounding them for payment. Collections tactics included wage garnishments, bank executions, liens, and foreclosures on homes.⁴

This story came to national attention when the Wall Street Journal featured it in a front page story in March 2003.⁵ Many more stories followed in the journal and other media.

Not only were the aggressive collections practices of some hospitals documented, but the general public also became aware for the first time of a fact that is well-known in the industry — that the uninsured, because they do not have access to the discounts negotiated by private insurers and government payers, are often expected to pay two or three times more than the insured for the same services.⁶ In June 2004, the Oversight and Investigations Subcommittee of the House Energy and Commerce Committee held hearings to investigate hospital pricing for the uninsured; witnesses called to testify included the CEOs of five major hospital systems.

The Centers for Medicare and Medicaid Services (CMS) also weighed in on pricing for the uninsured, issuing a guidance on Medicare regulations that many providers cited as requiring them to bill the uninsured at full charges while accepting discounted payments from other payers. In February 2004, in response to a letter from the American Hospital Association, Secretary of Health and Human Services (HHS) Tommy Thompson wrote:

"Your letter suggests that HHS regulations require hospitals to bill all patients using the same schedule of charges and suggests that as a result, the uninsured are forced to

pay 'full price' for their care. That suggestion is not correct and certainly does not accurately reflect my policy...hospitals can provide discounts to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing obligations. Nothing in the Medicare program rules or regulations prohibits such discounts."⁷

CMS later also made clear that discounts offered by a hospital to all uninsured patients, not just those demonstrating financial need, would not affect Medicare payments to hospitals for outlier or new technology cases under Medicare's hospital inpatient and outpatient prospective payment systems.⁸

The Office of the Inspector General (OIG) also stated that discounts for uninsured patients would not violate requirements in the Social Security Act that providers not submit bills for payment to Medicare or Medicaid for "amounts that are substantially more than the provider's...usual charges."⁹ In addition, the OIG said that until and unless a new rule is finalized, it would not include free or substantially reduced charges for uninsured patients (or underinsured patients who must pay for certain services out-of-pocket) when calculating a provider's usual charges.

While a few ambiguities in the regulations remain, especially for the limited number of health care providers still subject to CMS's lower of cost or charges (LCC) principle,¹⁰ the HHS and OIG statements essentially removed the federal regulatory justification that hospitals have used to explain their failure to offer free or discounted care to the uninsured.

At the same time, legislative and regulatory challenges to hospitals' practices at the state and local levels began to occur. In Connecticut, following the Yale-New Haven revelations, legislation was passed in

July 2003 that required hospitals to notify patients about their charity care programs and to determine their eligibility for free bed funds before filing collection lawsuits against them; it also restricted the interest rates hospitals could charge on unpaid bills.¹¹ In Illinois, in February 2004, the state upheld a decision by Champaign County to revoke the local property tax exemption of Provena Covenant Medical Center, in part because of its past aggressive debt collection practices towards needy patients.

More recently, a law was proposed in California that required hospitals to give patients notice about their rights and financial options when seeking care, allowed patients to negotiate payments and payment plans before their bills were sent to collections, and limited the rates hospitals could charge to income-eligible patients. The bill was passed by the legislature but subsequently vetoed by the governor, who nonetheless stated, "It is my expectation that all hospitals in the state uphold their important commitment to the voluntary guidelines [published by the California Hospital Association] and that they are applied evenly, consistently and without hesitation."¹²

What perhaps has created the most anxiety in the hospital industry, however, is a spate of federal lawsuits filed against over 40 nonprofit hospital systems by Richard Scruggs, the class action attorney who successfully sued big tobacco companies. The suits allege that nonprofit hospitals are violating their obligations as tax-exempt charitable institutions by overcharging uninsured patients, failing to inform them of the availability of charity care, and then aggressively pursuing them for collection.

Scruggs claimed that federal courts had jurisdiction to hear the cases because the hospitals had entered into an implied contract with the U.S. government obligating them to provide affordable medical care to financially needy patients in exchange for substantial federal tax exemptions; the suits also claimed that as third party beneficiaries of these contracts, financially needy

patients had standing to sue the hospitals in federal court. Although one of the cases in Mississippi has entered the discovery phase, many of the suits have been dismissed not based on the facts of the cases but because federal courts have denied the existence of an implied contract between the hospitals and the federal government and thus have determined that federal courts do not have jurisdiction to hear the cases.

The issue has not gone away, however, and hospitals should not breathe a sigh of relief. While some federal courts have declined to act, Scruggs and other attorneys have begun to file cases in state courts, where their claims may have a stronger legal grounding. In addition, some attorneys general, who have the authority to monitor charitable organizations, have begun to direct attention to the charity care and billing practices of nonprofit hospitals in their states.

In Illinois, for example, the state's Consumer Fraud and Deceptive Business Practices Act explicitly defines practices that violate public policy as unfair and thus illegal under the Act. Illinois courts also have explained that, as a matter of public policy, the state exempts nonprofit hospitals from taxes in order that they can provide free or reduced price charity care to uninsured and underinsured patients who could not otherwise afford needed care. Attorneys in Illinois have thus filed suit against Advocate Health Systems Care Network and Advocate Health and Hospitals Corporation under the Consumer Fraud Act.

While the facts in the case are similar to those cited in the federal suits — for example, that Advocate charged the highest and inflated prices to the uninsured, failed to routinely inform them about free or reduced price charitable care, and used abusive practices to collect on their unpaid bills — the legal basis differs; the primary complaint is that these practices violate public policy and are thus illegal under the consumer law.

Indeed, the complaint alleges that Advocate would be in violation of public policy and engaging in unfair practices even if it

charged the uninsured the same rates as the insured because the care would still be unaffordable to low-income and middle-income patients. As a remedy, the attorneys seek not only compensatory and punitive damages but also the removal of the current members of the board of directors or election of new directors “to ensure that Advocate can be operated in the future in compliance with the Consumer Fraud Act and in a manner appropriate to a religious and charitable, tax-exempt institution.”¹³

The judge has not yet ruled on whether the portion of the case based on the consumer law will go forward, but there are some indications that a favorable ruling may be forthcoming. The Illinois Attorney General has filed an Amicus Curiae brief refuting Advocate’s claim that the Consumer Fraud Act does not apply to health care providers and opposing the hospital’s motion to dismiss.¹⁴

In addition, another judge in the same court recently allowed a similar case against Our Lady of Resurrection Medical Center to go forward. The judge not only refused to dismiss plaintiffs’ claims under the Consumer Fraud Act but also a contract claim alleging that when a price for services is not agreed to, the hospital cannot charge more than the amount it customarily accepts from other payers for these services.¹⁵

In Minnesota, a federal suit against Fairview-University Medical Center was dismissed, although the plaintiffs’ attorneys expect to file replacement suits in state court.¹⁶ At almost the same time, however, Attorney General Mike Hatch released a highly critical compliance review of Fairview Health Services charity care and collections practices, which was widely reported on in the press.¹⁷

The review points out that under Minnesota state tax law principles, nonprofit organizations must prove that their activities are charitable in nature in order to receive tax exemptions. Factors determining an organization’s charitable nature include whether its stated purpose is to help others

without immediate expectation of material reward and whether the recipients of the charity are required to pay for assistance.

With respect to hospitals, the review says, “It is not enough for a hospital to simply have a charity care policy; rather the hospital must also advertise and promote the policy so that those in need of assistance are actually aided by it.” It also makes clear that writing off bad debt cannot be considered a charitable activity and mentions that courts have considered hospitals’ medical debt collections practices in determining their charitable status.

The review then goes on to describe in considerable detail Fairview’s minimal charity care contributions as a percentage of its annual revenue, its failure to adequately promote or implement its limited charity care policies, and the aggressive and sometimes illegal practices of its debt collection agencies. These practices included sending bills to collectors and suing patients rather than billing their insurance companies or fixing billing errors and referring patients to collections who were making regular payments according to an agreed-on-payment plan.

One noteworthy aspect of the review is its focus on the responsibility and potential liability of nonprofit hospitals’ boards of directors. It points to directors’ fiduciary obligation to ensure that their organizations are adhering to all laws and living up to their charitable missions and then cites the failure of Fairview’s directors to review and monitor the hospital’s charity care and debt collections practices.

“...Fairview provided no evidence that its board of directors ever met to review the organization’s charity care practices for 1998 to 2004...During this period of time, the board spent considerable effort trying to justify its executive compensation packages for the IRS...In contrast, Fairview produced not a page, not a sentence, not a word that appears to meaningfully discuss its charity care policies until the AGO [Attorney General’s Office] Compliance Review was undertaken.”

Similarly it states, "By not establishing the organization's [debt collection] policies and by allowing the cavalier treatment of its patients, Fairview's board of directors has not acted in a manner consistent with the fiduciary duties of care and obedience." Beyond the board's fiduciary obligation, the review points out that if an organization promotes its charitable mission to raise money through tax-deductible donations, and then fails to conform to the mission, it may be engaging in fraud or misrepresentation under Minnesota statutes.

So far, while the hospital industry has been barraged by negative publicity, except in Connecticut the furor has not resulted in legislation. It seems clear, however, that if the industry doesn't address the issues that have been raised, the states or federal government may take further action. In California, legislation regulating charity care practices has been re-introduced. In Congress, the chairman of the subcommittee investigating hospital overcharging of the uninsured suggested that if hospitals didn't fix the problem within a year, Congress might be forced to act.

Hatch, in Minnesota, has not yet sued Fairview or other health care institutions over charity care but held out the possibility of state action. "We'd rather have them get in compliance with what we think the law requires, but it is something that we might pursue legislatively."¹⁸

While many hospitals have reacted defensively to scrutiny of their billing and collections policies, some have begun to respond more positively. For-profit HCA and Triad Hospitals have announced revised charity care policies based on patients' income and, more recently, discounts for all self-pay patients regardless of their ability to pay. Triad introduced and then discontinued the across-the-board self-pay discount for fear it would impact Medicare reimbursements. It announced in January, however, that it will reinstate the policy as of April 1, 2005, based on the CMS clarification that such discounts would not adversely affect the reimbursements.¹⁹

Perhaps most impressive, however, is the change at Provena Covenant Medical Center in Champaign County, Illinois. After losing its local property tax exemption, and with a new CEO, the hospital decided the best course of action was to begin to work with the community on developing and implementing its charity care and debt collection policies. It began meeting regularly with representatives of Champaign County Health Care Consumers (CCHCC), a local health care advocacy group that had originally raised the issue of inadequate charity care and abusive billing and collections practices at Provena and other local hospitals.

The group worked with Provena Covenant to rewrite its policies and procedures and develop methods for actively informing patients about them — including placing ads in local newspapers, translating brochures into multiple languages, and displaying posters prominently within the hospital, including in the bathrooms. CCHCC now supports Provena Covenant's effort to regain its tax exemption for the period after these changes were introduced. According to Claudia Lennhoff, Executive Director of CCHCC, "At this point I certainly would not be suing Provena Covenant based on their current charity care and debt collection practices. In fact, this hospital is on its way to being a positive role model for the hospital industry."²⁰

This review of developments related to hospital billing and collections policies makes it clear that hospitals are hardly out of the woods in terms of the negative publicity around the issue, or the potential for legal, legislative, and regulatory responses to their practices. Whereas attention has recently been focused on the federal lawsuits, greater challenges may now be occurring at the state level, through lawsuits, oversight, and legislation.

Hospitals need to focus serious attention on revising, clarifying, and publicizing their financial assistance policies and, just as importantly, on effectively monitoring their implementation. The collaboration between Provena Covenant Medical Center

and Champaign County Health Care Consumers shows that reaching out to community partners in a meaningful way may be hospitals' most productive course of action.

Researchers have long known that physicians' best defense against malpractice suits is having good relationships with their patients – even when doctors make mistakes, patients are less likely to sue if they feel they have been treated with respect. For hospitals, the message might be that their best defense against lawsuits over their billing and collections practices toward the uninsured and underinsured is not hiring more lawyers but rather having a good relationship with the organizations in their communities that work with and represent those most at risk of suffering the consequences of unaffordable hospital bills.

Endnotes

1. D. Andrulis, L. Duchon, C. Pryor, N. Goodman, Paying for Health Care When You're Uninsured: How Much Support Does the Safety Net Offer?, The Access Project, January 2003.
2. S.R. Collins, M.M. Doty, K. Davis, C. Schoen, A. L. Holmgren, and A. Ho, The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey, The Commonwealth Fund, March 2004.
3. D. U. Himmelstein, E. Warren, D. Thorne, S. Woolhandler, "Illness and Injury as Contributors to Bankruptcy," Health Affairs, February 2005.
4. G. Rollins, Uncharitable Care: Yale-New Haven Hospital's Charity Care and Collections Practices, Connecticut Center for a New Economy, January 2003.
5. L. Lagnado, "Twenty Years and Still Paying," Wall Street Journal, March 13, 2003.
6. J. Appleby, "Hospitals Sock Uninsured with Much Bigger Bills, Insurance Companies, Medicare Get Huge Discounts Individuals Can't," USA Today, February 25, 2004. S. B. Miller, "Probing Disparity in Healthcare Bills," The Christian Science Monitor, May 19, 2003.
7. Letter from Tommy G. Thompson, Secretary of Health and Human Services, to Richard J. Davison, President, American Hospital Association, February 19, 2004, www.hhs.gov/news/press/2004pres/20040219.html.
8. The FAQ can be found at http://www.cms.hhs.gov/providers/FAQ_Uninsured_Additional.pdf.
9. *Hospital Discounts Offered To Patients Who Cannot Afford To Pay Their Hospital Bills*, HHS Office of Inspector General, <http://oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA021904hospitaldiscounts.pdf>.
10. C. MacKelvie, M. Apolskis, J. Unland, "Recent Hospital 'Charity Care' Controversies Highlight Both Ambiguities and Outdated Features of Numerous Government Regulations," Journal of Health Care Finance, January 2005, <http://www.healthbusinessandpolicy.com/MacKelvieEtAlArticle.pdf>.
11. An Act Concerning Hospital Billing Practices, Substitute Senate Bill No. 568, Public Act No. 03-266, <http://www.cga.ct.gov/2003/act/Pa/2003PA-00266-R005B-00568-PA.htm>.
12. Governor Schwarzenegger's statement can be found at http://www.health-access.org/docs/UpdatesAlerts/SB_379_veto.pdf.
13. Vanessa Cristiani et al v. Advocate Health Systems Care Network, Inc. and Advocate Health and Hospitals Corporation, First Amended Complaint, 03 L 014635, (Cook County Circuit Court).
14. V. Cristiani et al v. Advocate Health Systems Care Network, Inc. and Advocate Health and Hospitals Corporation, Memorandum of Law of Amicus Curiae, State of Illinois, 03 L 14635, (Cook County Circuit Court, June 28, 2004).
15. Servedio v. Our Lady of Resurrection Medical Center, 04L 3381 (Cook County Circuit Court, January 6, 2005).
16. W. Wolfe, "Suit Over Care for Poor is Thrown Out," Star Tribune, February 2, 2005.
17. Compliance Review: Charity Care and Collections Practices, AG: #1348658-v1.
18. W. Wolfe, op.cit.
19. Triad Announces Policy, Preliminary Results and Guidance, News Release, January 25, 2005, http://www.corporate-ir.net/ireye/ir_site.zhtml?ticker=TRI&script=410&layout=-6&item_id=666057.
20. CCHCC Reacts to National Class Action Suits Filed Against Hospital Systems for Charity Care Failures and Discriminatory Pricing, Press Release, Champaign County Health Care Consumers, June 189, 2004.

This article is reprinted with the publisher's permission from the JOURNAL OF HEALTH CARE COMPLIANCE, published by CCH INCORPORATED. Copying or distribution without the publisher's permission is prohibited. All views expressed in the articles and columns are those of the author and not necessarily those of CCH INCORPORATED or any other person.