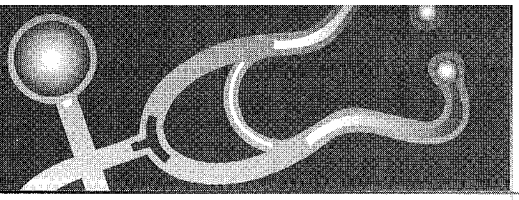

Health Policy and Employee Benefits

Hospital Pricing and the Uninsured

Caryl E. Carpenter, MPH, PhD

The pricing policies and collection practices of U.S. hospitals have been undergoing considerable scrutiny recently, including in an article featured in the March 2004 issue of this Journal.[1] In my opinion, the authors of this article imply, in general, that many hospitals are guilty of overcharging uninsured patients and using overly aggressive collection practices. They base their argument on largely anecdotal information that does not present the complete picture of hospital financial condition and policies. The authors oversimplify what has become a very complex and challenging public policy issue.

The authors are not alone, however, in their criticism of hospital billing and collection practices. Congress has been investigating this issue as well. The House Energy and Commerce Oversight and Investigations Subcommittee, chaired by U.S. Rep. Jim Greenwood (R-PA), has been conducting hearings to investigate how hospitals determine their charges for uninsured patients.[2] The House Ways and Means Oversight Subcommittee has been investigating a related issue, looking specifically at whether not-for-profit hospitals are meeting their charity care obligations as tax-exempt institutions.[3]

Hospital billing and collection practices have been challenged in court as well. More than 350 hospitals have been sued in recent months in both state and federal courts for alleged overcharging of uninsured patients and aggressively pursuing collection from those patients.[4] Plaintiff hospitals in these suits have included both for-profit and nonprofit institutions. Richard Scruggs, a Mississippi attorney, has filed class-action suits that assert hospitals have violated their charitable obligations by charging uninsured patients high prices while negotiating deep discounts with private and public payers.[5]

Setting Hospital Prices

Critics of hospital policies have asked, "Why do hospitals charge the uninsured so much?" The process by which hospitals set their prices (charges) is complex. It's not surprising that the process has caused so much confusion and misunderstanding. In general, prices for hospital services are set as they are for any good or service—to cover costs plus profit. Even nonprofit hospitals must produce a positive bottom line to assure they have adequate capital for reinvestment in the increasingly costly assets required to provide good patient care. (Unlike for-profit hospitals, nonprofits cannot distribute profits to individuals.) What makes hospital pricing so confusing is that hardly anyone pays what hospitals charge for their services (which is what prompted Rep. Greenwood to then wonder why hospitals charge so much).

Hospital charges (prices) must also cover losses that hospitals incur when third-party payers (most often Medicare and/or Medicaid) pay less than costs and when uninsured patients do not pay for their care. For example, in 2000, the average Medicare payment-to-cost ratio for most types of hospitals was below 100, i.e., Medicare payment rates were below the costs of hospital production. In that same year, the average Medicaid payment-to-cost ratio was below 100 for all types of hospitals and the share of care that was uncompensated ranged from 4.7% to 7.2%. These data come from a study by the Lewin Group that included all acute care hospitals in the United States.[6]

Further complicating the hospital pricing process is a long-standing tradition of cross-subsidization among hospital services.[7] Some services offered by hospitals are often money losers. These include services such as emergency rooms, trauma units, and burn units. In many hospitals they also include pediatric and maternity services, depending on the population served. To continue offering what most would consider essential services, hospitals must make money on other services. In recent years those have typically been services such as cardiology and orthopedics. Contrary to what the authors of the Journal article imply, it is not that simple to reallocate resources within a hospital away from the unprofitable services to the profitable ones. Nonprofit hospitals are expected to offer essential services whether they are profitable or not.

Hospital charges also are influenced by third-party payment policies. Many managed care plans have paid hospitals based on a discount from charges. These policies created incentives for hospitals to increase their charges, which, in turn, led many

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health plans to change their payment methods. There are still some Medicare payment rates that are based, in part, on charges. This also creates an incentive to raise hospital prices.

All of these factors explain why hospital prices are often high relative to cost. But the question remains, why do hospitals charge uninsured patients so much? For many years hospital pricing practices were governed by Medicare policies that stated that hospitals could not have different charges for different classes of patients.[8] Therefore, every patient was charged the same price, even though today most third-party payers don't pay based on charges. Hospitals assumed that they would be in violation of Medicare policy if they charged an uninsured, self-pay patient less than the standard charge. Bruce Vladeck, former Medicare administrator, recently confirmed this interpretation of Medicare policy.[9]

In February, Health and Human Services Secretary Tommy Thompson issued a statement to clarify current Medicare policy.[10] He stated that from Medicare's perspective offering a discount to an uninsured patient is no different than giving an allowance to a third-party payer. The lower-of-cost-or-charge principle that governed Medicare policy in the past no longer applies. Hospitals are free to establish their own indigency policies.

The problem remains. If some third-party payers reimburse hospitals less than costs and some uninsured patients pay less than cost or nothing at all, those costs must be shifted to someone. Third-party payers will not absorb them. So those uninsured patients who can afford to pay out-of-pocket (an admittedly tiny group) will still be charged very high prices.

Uncompensated Care

Uncompensated care is the general expression used for services provided that no one pays for. Uncompensated care includes two groups of patients. The first are charity care patients. They are patients who are determined, prior to the provision of service, to be too poor to pay for their care. There are no standard criteria for what constitutes "too poor." Some hospitals consider someone eligible for charity care if their family income is below the federally defined poverty line; others may qualify those with incomes below 150% of the poverty line; still others may use their own income criteria, unrelated to the federal definition of poverty. Regardless of the criteria used, patients who qualify for charity care are not billed for services. Hospitals do not expect to receive payment for these patients.

The other group of patients included under uncompensated care are those who are billed for services but do not pay the bill, in full or in part. Included in this group are some Medicare beneficiaries who are billed for deductibles, coinsurance and/or copays but do not pay them. These are patients who do not qualify for charity care. They may be uninsured or underinsured and low income but still not meet the hospital's criteria for free care. These patients are the ones who may be subjected to aggressive collection practices. If the hospital does not collect from them, their charges may be written off as bad debt.

Questions remain regarding the criteria used by some hospitals to determine who qualifies for charity care. Some have argued that families with incomes two, three, or even four times the federal poverty level still cannot afford to pay for a stay in the hospital, even a short one. Since there are no national criteria for determining charity cases, there's no basis for arguing what criteria hospitals should use.

The American Hospital Association and the Healthcare Financial Management Association have recently published advisories regarding the issue of charging uninsured patients.[11] Both groups agreed that hospitals should assure that written policies regarding discounts or charity care are readily available and consistently applied.

Tax-exempt hospitals

As noted above, one Congressional committee has been investigating the practices of private, nonprofit hospitals. The vast majority of hospitals in the United States are private nonprofits. They may have a religious affiliation or be secular institutions. They are not owned by any part of government or investors. A private, nonprofit, tax-exempt institution is expected to provide community benefits in exchange for its tax exemption.

Before the 1960s, many people, particularly the elderly and the poor, did not have insurance and could not afford to pay for hospital care. Providing free care to the indigent was the primary charitable activity of private, nonprofit hospitals. In fact, many hospitals that were built or expanded with

federal money from the Hill-Burton Act of 1946 were expected to document the provision of charity care.

After the passage of Medicare and Medicaid legislation in the mid-'60s, nonprofits were still expected to provide charity care, but many of the people who qualified for charity care in the past now had public health insurance. So the concept of "community benefit" was expanded.[12] Current tax laws generally require that exempt hospitals provide some charity care, which is often translated as emergency services, regardless of the patient's ability to pay. However, there are other services, besides charity care, that are now used to justify tax exemption. These include training of clinical professionals, biomedical research, community health activities including health fairs and free health screenings, community health education, and the provision of unprofitable services.[13]

Some industry observers argue that hospitals have not provided benefits equivalent to the value of their tax exemption, even using the expanded definition of community benefits. A number of municipalities have challenged the tax-exempt status of community hospitals, seeking to collect property taxes from those institutions that did not appear to be meeting their charitable obligations.

A study by Herzlinger and Krasker[14] concluded that there were few differences between nonprofits and for-profits in terms of the provision of community benefits. However, in a follow-up study using the same data set as Herzlinger and Krasker, Arrington and Haddock[15] found there were two types of nonprofit hospitals and those two types behaved differently when it came to community benefits, including charity care. Nonprofit hospitals located in rural areas or inner cities provided substantial community benefits; whereas nonprofits in affluent suburbs did not. Recent Congressional investigations of billing and collection practices in nonprofits have not drawn a distinction between hospitals that have a more affluent population base and those that do not.

Who Will Pay for the Uninsured?

The problem of the uninsured is one that will not be solved by changes in hospital billing practices. The number of uninsured or underinsured Americans fluctuates from year to year, but has been over 40 million for more than a decade. As employers make cutbacks in employee health benefits, the number of uninsured is likely to grow.[16] As the number grows, the ability of hospitals to offer meaningful discounts to uninsured patients will decline. There clearly is room for improvement in hospital policies and practices regarding the uninsured. However, hospitals cannot compensate for the failure of public policymakers, particularly at the federal level, to find a way to provide coverage for all citizens in the wealthiest country in the world.

The major party candidates in the 2004 presidential election have proposed some solutions.[17] President Bush proposes to extend coverage to 4.5 million more Americans. Senator Kerry proposes to expand coverage to 95% of Americans. The Bush proposal focuses on the purchase of insurance by individuals

through tax-deductible health savings accounts and tax credits. In contrast, Kerry's primary focus is on making employer-purchased insurance more affordable by subsidizing high-cost cases for employers. Both candidates acknowledge that the problem of the uninsured must be addressed through public policy. Changing hospital billing and collection practices will not solve the problem. ■

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