HEALTH POLICY

Learning from the Legal History of Billing for Medical Fees

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INTRODUCTION: When patients pay for care out-of-pocket, physicians must balance their professional obligations to serve with the commercial demands of medical practice. Consumer-directed health care makes this problem newly pressing, but law and ethics have thought for millennia about how doctors should bill patients.

HISTORICAL BACKGROUND: At various points in European history, the law restricted doctors' ability to bill for their services, but this legal aversion to commercializing medicine did not take root in the American colonies. Rather, US law has always treated selling medical services the way it treats other sales. Yet doctors acted differently in a crucial way. Driven by the economics of medical practice before the spread of health insurance, doctors charged patients according to what they thought each patient could afford. The use of sliding fee scales persisted until widespread health insurance drove a standardization of fees.

CURRENT PRACTICE: Today, encouraged by Medicare rules and managed care discounts, providers use a perverse form of a sliding scale that charges the most to patients who can afford the least. Primary care physicians typically charge uninsured patients one third to one half more than they receive from insurers for basic office or hospital visits, and markups are substantially higher (2 to 2.5 times) for high-tech tests and specialists' invasive procedures.

CONCLUSION: Ethical and professional principles might require providers to return to discounting fees for patients in straitened circumstances, but imposing such a duty formally (by law or by ethical code) on doctors would be harder both in principle and in practice than to impose such a duty on hospitals. Still, professional ethics should encourage physicians to give patients in economic trouble at least the benefit of the lowest rate they accept from an established payer.

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Many physicians (like many lawyers) lament a crisis of professionalism in their calling. Romanticizing the past, they say "We used to be a profession, but now we're a business." Every profession always includes elements of both altruism and self-interest, of service to others and service to self, of professionalism and commercialism. No profession ever finds an ideal balance of these elements. Nevertheless, most professionals agree with R.H. Tawney that while they "may, as in the case of the successful doctor, grow rich[,]... the meaning of their profession, both for themselves and for the public, is not that they make money, but that they make health, or safety, or knowledge, or good government, or good law."[1]

Few things present the professionalism problem as directly as the issue of setting and collecting fees. This old problem is today newly prominent. Insurance once softened things, but the latest, greatest idea for rationalizing and containing medical expenditures makes it freshly hard. The idea is "consumer-directed health care" (CDHC). It couples high deductibles with tax-sheltered "health savings accounts" (HSAs) to encourage patients to select providers wisely and choose treatments thriftily. Deductibles are an old idea, but now they are much bigger—as high as $5000–$10,000—and even managed-care plans use them. If such insurance catches on as quickly as promoters expect, payments from patients could account for much of office-based physicians' income. This reform works, then, by pushing the issue of cost regularly into the professional relationship. It thus obliges doctors to reconcile "making health" and "making money."

Consumer-directed health care claims to be boldly new, but patients have paid out of pocket since medicine began. The world has changed so much that historical precedents cannot be decisive, and an article this size cannot hope to capture a fully nuanced view of history. But doctors for millennia have thought hard about what it means to depend on patients for their income while serving patients as professionals, and the law has thought hard about whether to treat professions like ordinary businesses.[2,3] So, what can be learned from legal history about these timeless features of doctor–patient relationships?

US LEGAL HISTORY

Centuries ago, English physicians (like barristers) could not legally bill for their services or sue to collect fees. Instead, following the supposed Roman practice, patients paid "honoraria" that were supposed to be given voluntarily.[4–6] Thomas Percival's influential *Medical Ethics* (which he considered to be a treatise on "medical jurisprudence") delicately called medical payments "pecuniary acknowledgements" received "as a point of honour," and he expatiated on the British rule precluding physicians from suing to collect fees.[7] This honorarium rule applied only to physicians, and not to surgeons[6] (who sometimes also treated animals). But just as the honorarium principle distanced professionalism from commercialism, the law's treatment of

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surgery as a "public calling" emphasized the professions' differences from businesses, since courts could limit surgeon's fees to "reasonable" amounts.[6,8] The honorarium and "public calling" principles both reflected the special constraints on professionals even in commercial moments.

The legal rules that differentiated professions from businesses did not survive the trip to the American colonies. Rather, medical practitioners could invoke standard contract and commercial-law principles to collect fees. In colonial Massachusetts, for instance, a court ruled physicians' "drugs and attendance had as fixed a price as goods sold by a shopkeeper" and that "the custom here had always been in such cases" for the physician to sue on the contract even though that would "not do" in England.[9] Nor did Americans follow the "public calling" principle. A 1901 case, for example, held that in "obtaining the state's license (permission) to practice medicine, the state does not require, and the licensee does not engage, that he will practice at all or on other terms than he may choose to accept." Analogies to "the obligations to the public on the part of innkeepers, common carriers, and the like, are beside the mark."[10] The abandonment of the "public calling" and honorarium principles, then, gave doctors more authority to set and collect fees.

These 19th century rules still govern US physicians, and the law still treats selling medical services the way it treats other sales. The 1901 case still states the prevailing position, codified in the AMA's Code of Medical Ethics since 1923, that a "physician is free to choose whom he will serve." So too for patients' obligations to pay. As Professor Jacoby observes, "patients and providers assume legal rights and duties defined by a system of commercial debtor-creditor laws that generally cannot and do not account for the health-related origin of the debt or its implications for the debtor's health."[11]

THE ORIGINS AND DEMISE OF THE SLIDING SCALE

Although American law freed physicians to pursue the "making money" side of their profession more than English law, physicians appeared to honor the "making health" side by departing from commercial practice in a crucial way. Before the spread of health insurance, doctors frequently charged patients according to what the doctor thought each patient could afford, despite persistent efforts by medical societies to standardize fees. In 1931, for example, 1 physician's median fee for treating acute diabetes was $402, but his charges ranged almost fivefold (from $232 to $1052). Physicians who treated acne with x-rays billed rates ranging threefold, from $70 to $210.[12] For a major operation, surgeons often charged 1 month of the patient's salary.[13,14]

Sliding fees were so much the doctors' norm that they became a legal rule.[15,16] Then as now, patients generally did not contract in advance to a set fee. Rather, the patient's legal obligation to pay was implicit, and "reasonableness" was the standard should a disagreement reach a court. Judges thought that if the sliding scale was standard, it was reasonable. As a California court put it in 1931, "there is evidence of a recognized usage, which has grown into a custom, to graduate professional charges with reference to the financial condition of the patient...."[17]

Sliding scales had a "making money" aspect since doctors had market reasons to use them. When competition was fierce and medical services dubiously helpful, many doctors had to drop their fees to get business. Collectively, doctors fought these market forces by promulgating recommended fee schedules through their medical societies.[18] These rarely worked in the 19th century's beleaguered medical market, but over the 20th century licensure laws and the reform of medical education constricted the supply of physicians and their growing skills multiplied the treatments physicians offered.[19] These developments engendered market conditions that gave doctors more leeway in setting prices. They increasingly exercised their market power by charging (bluntly put) "what the traffic will bear,"[20] meaning what desperate patients would pay for life and limb. Thus the scale slid up more than down.

Lawsuits over the reasonableness of fees reflect the practice of using a sliding scale to soak the rich. For example, the physician who treated W.C. Fields for several weeks of hospitalization for pneumonia sued for $12,000 in fees.[21] (The doctor's task was not eased by Mr. Fields' "habit of drinking whiskey day and night, consuming from one to two quarts each twenty-four hours.") The doctor charged Mr. Fields 1 month's income. The court accepted the ability-to-pay principle but lowered the bill only because Mr. Field's monthly income that year was nearer $7,000.

Sliding fees may have once helped doctors serve the professional goal of "making health" by having the rich in a sense subsidize care for the poor. However, in the early 20th century, much charity care in cities became institutionalized through free clinics ("dispensaries") and, later, nonprofit hospitals.[22] By mid-century, sliding fees began to look like "a device for raising fees above the standard [rates]... rather than for lowering them for the poor, their major historical justification."[23] Yale law professor Walton Hamilton explained in 1932 that "'charity work' and 'the sliding scale' came into existence together; they are complementary aspects of the single institution of the collective provision of the physician's income...." However, that scale was "easily capable of abuse. Above all, it s significant that the connection between the two has been broken, and that the older justifications are no longer relevant."[24]

Eventually, changing economic conditions weakened the sliding scale, and health insurance sounded its death knell.[23,25,26] By 1962, physicians on average charged high-income patients (>$10,000/year) only 40% more per visit than low-income patients (<$2,000/year).[27] The last reported court decision applying the sliding scale was in 1960.[28] The modern judicial view repudiates these precedents: Charging the rich to subsidize care for the poor "has little application to... modern practice [b]ecause of the advent of medical insurance and Medicare... [and] the different perception of doctors concerning the practice of medicine...."[29]

It is ironic that the AMA's Code of Ethics did not recognize the sliding fee until it lay dying. The Code's 1957 revision said physicians' fees "should be commensurate with the services rendered and the patient's ability to pay," but this exhortation did not survive the 1980 revision. Sliding scales flourished not because of ethical edicts but because they were an economic advantage or even necessity. When the cross-subsidies of insurance premiums replaced the cross-subsidies of the sliding fee scale, the tentative professional ethic of that scale yielded to the market ethic of standard fees. Insurance drove a standardization of fees, which prevented not only surcharges, but also some discounts. For instance, the federal government prohibited physicians from waiving the portion of their fees payable by Medicare patients (lest patients be encouraged to overuse Medicare).[30] Far from being professionally admirable, varying charges for insured patients could constitute fraud.

THE MODERN PERVERSION OF THE SLIDING SCALE

The sliding scale originally permitted doctors to serve the purpose of their profession—"making health"—for the poor as for the rich. It has become a way of "making money." Today, a perverse new sliding scale charges the most to patients who can afford the least.[31,32] Insurers negotiate with doctors and hospitals for low rates for covered patients, and doctors and (especially) hospitals try to recoup what they cede in this bargaining by charging uninsured patients more. Nationally, insurers pay hospitals only about 40 percent of their listed charges,[33] so that hospitals on average charge uninsured patients 2.5 times more than insured patients. This disparity has been swelling: Since the early 1990s, hospitals' list prices have risen almost 3 times more than their costs, and their markups over costs have more than doubled, from 74% to 164%.[34] Of course hospitals cannot fully collect these fees: Hospital administrators generally report recouping only about 10% of their charges to uninsured patients,[30] and hospitals provide much uncompensated care, especially to uninsured patients.

Higher charges for the uninsured are partly encouraged by Medicare rules that pay hospitals extra for their costliest cases only if hospitals bill *non*-Medicare patients full list prices. Also, higher list prices let hospitals claim more credit for free care. Whatever the cause, hospitals routinely charge uninsured patients several times more than they receive from insured patients. This practice is unfortunate even for profit-making hospitals, but it is bizarre for tax-exempt "charitable" hospitals.

Physicians' pricing disparities are slighter but still substantial. One study calculated that physicians charge 79% more than they receive from insurers.[35] Thirty years ago, before aggressive managed care discounts, markups over Medicare and private insurance were roughly 25–50%.[36]

Differentials vary. A comprehensive study in the 1980s found physicians marking up fees for invasive procedures more than twice as much (relative to resource costs) as fees for ordinary office visits, with imaging and laboratory procedures falling in between.[37] Similarly, today, primary care physicians typically charge one third to one half more than they receive from insurers for basic office or hospital visits (i.e., insurers get discounts of 25–33%).[38–40] However, markups are substantially higher for high-tech tests and specialists' invasive procedures. Across a range of specialty services, physicians charge roughly 2 to 2.5 times what insurers pay.[38–40]

If only the wealthy uninsured were charged higher fees, the new sliding scale might serve professional goals of "making health." However, many hospitals apply extreme markups to the wealthy and the poor alike. When uninsured patients cannot pay, hospitals send accounts to aggressive collection agencies that exploit all their legal options, including home foreclosures and personal bankruptcies.[41,42] The Community Tracking Survey reports an "alarming" increase (from 1 of 4 in the 1996–1997 survey to 1 of 3 in the 2004–2005 survey) in the proportion of physicians who refuse discounted or free care to impecunious patients.[43] No wonder illness and its treatment contribute to more than half the personal bankruptcies in the United States.[42]

Although managed care and business realities explain these pricing practices, they corrode the core purpose of the medical profession—"making health." But what is to be done? If public policy embraces consumer-directed health care, should doctors and hospitals feel liberated to charge what the market will bear, or do they have heightened fiduciary responsibilities to "make health" by helping patients who cannot afford care?

RESURRECTING THE PROGRESSIVE SLIDING SCALE?

An idealist might invoke law or ethics to *require* providers to return to discounting fees for patients in straitened circumstances. So far, this is being considered only for tax-exempt hospitals. Assailed by legislatures and lawsuits,[44,45] many hospitals are adopting "patient-friendly" billing practices that adjust fees to accommodate patients' finances.[46] The American Hospital Association, for instance, advises hospitals "to offer discounts to patients who do not qualify under a charity care policy for free care...,"[47] and the AHA reports that some hospitals discount fees depending on household incomes.[48] A few states require this by statute.[42]

Are physicians under similar obligations? Imposing such a duty formally (by law or by ethical code) on doctors would be harder both in principle and in practice than to impose such a duty on hospitals. In terms of principle, for example, doctors, unlike tax-exempt charitable hospitals, do not commit themselves to serve the community at large. Practically speaking, requiring doctors to reduce fees for poorer patients might lead doctors to refuse to accept them as patients. Moreover, hospitals are better equipped than doctors to determine patients' financial status. When the progressive sliding scale flourished, family doctors who treated patients in their homes had intimate, direct, and long-standing knowledge of patients' circumstances, knowledge physicians generally lack today. Furthermore, discussing patients' finances easily slides into negotiating over what patients can or will pay, a conversation that is necessary to prevent misinformed or biased decisions[49,50] but which both doctor and patient will find painful.

On the other hand, it is ethically troubling for physicians to raise fees for uninsured patients simply to make up for losses from better-protected patients. Pricing differentials might be justified to reflect differing administrative costs and any economies of scale, but these are in the range of only 10–25%.[51] A good starting place then would be for physicians to find practical ways to travel a middle road. For example, they can work with patients to find the thriftiest route to good care. Also, they can give patients in economic trouble the benefit of the lowest rate they accept from an established payer.

Perhaps all these problems could best be ameliorated by universal health insurance but we live in the world as it is, not as we wish it were. In this imperfect world, while law and formal ethical codes should not require doctors to adjust fees for patients who cannot afford the care they need, voluntarily assuming such an obligation is one of the profession's highest ideals. Even businesses often assume obligations to contribute to their communities. Professionals surely have weightier obligations. The state grants professions a monopoly in services essential to life, and professionals can often charge monopoly prices in consequence. Professions expect to govern themselves, and they welcome the respect professions receive. Most of all, as the AMA's 1923 code of ethics said, "A profession has for its prime object the service it can render to humanity; reward or financial gain should be a subordinate consideration."

The legal history of physician fees reflects this long-standing admiration of the primacy of professional service over financial reward and the long-standing struggle to find a way to maintain

this commitment in practice. We leave it to others to consider what additional lessons might be drawn from this history of physicians' fees. Like any history of a complex social arena, what actually happened, why it happened, and what that means today in various circumstances could all be legitimately contested. Therefore, in the end we limit ourselves to the advice given by an influential physician at the turn of the century, that "When you are in doubt what to charge, look around you [to what other doctors charge], then upwards [toward God], then make out your bill at such figures as will show clean hands and a clear conscience."[52]

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