Perspectives

Predatory Hospital Billing: Dynamic Cost Shifting to the Uninsured

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Over the past year, aggressive billing practices have been exposed at a number of hospitals in the United States. Despite the fact that a widower had paid $16,000 of his late wife's bill of $18,740, some 20 years after the incurrence of the bill a teaching hospital held a lien on his home for $40,000 in interest.[1] Many years earlier the hospital had seized his bank account, and now the 77-year-old man was destitute. Only tremendous publicity caused the hospital to back down.[2] That same week, another nonprofit teaching hospital reportedly drove a 25-year-old uninsured woman from New York City while dunning her for a $19,000 bill for a two-day stay for an appendectomy.[3] In California, a patient was forced into bankruptcy in 2000 by a for-profit hospital from a day-and-a-half stay in the hospital that did not include any surgery but totaled $48,000 in hospital bills.[4] These have become common stories as hospitals aggressively market, bill, collect, and foreclose, just like any other corporation. The uninsured are facing the brunt of the hospital industry's billing practices.

The magnitude of this problem was recently spotlighted by the release of the Census Bureau's data on uninsured persons in America. In 2001, an estimated 41.2 million people had no health insurance, representing 14.6% of the overall population.[5] Among the poor, about 30% did not have coverage, despite Medicaid. The numbers are on the rise in the face of increasing unemployment and decreasing government revenues.

The fact that hospitals run as a business comes as no surprise to anyone, given that hospitals were declared businesses by court decision in 1960.[6] As long as America continues to treat medical treatment as a commodity, this will be so. However, the greatest iniquity in our healthcare system as described in these three cases is that the persons with the *least* ability to pay (i.e., uninsured and poor) are regularly charged the *most* in America's hospitals today.

My purpose is to explore how hospital billing in the United States became so unequal and delineate the ethical dilemma it now poses.

Hospitals in America

Hospitals in the United States are divided into three categories.[7]

Municipal

Municipal hospitals include those run by federal, state, and local governments. Federal hospitals deal with exclusive populations such as the military, veterans, and Native Americans, and the bill is paid entirely by the federal government. State and local facilities are usually not exclusive, and

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the governments usually only contribute a small portion to the entire budget of the hospitals. According to 2000 statistics by the American Hospital Association, municipal hospitals represent about 20% of the total number of hospitals in America.[8]

For-Profit

For-profit hospitals represent about 30% of U.S. hospitals and are a growing portion.[9] Proprietary hospitals were quite common in the early part of the century but had decreased significantly in the first half of the century.[10] As a business form, they were revived with the advent of Medicare and Medicaid.[11] They are investor owned and intend to make a profit to distribute to the investors.

Nonprofit

Nonprofit hospitals represent about half of the hospitals in America.[12] Most were founded by religious or other charitable institutions, but many are no longer affiliated with the original group which founded them. Numbers have been shrinking as the move to convert to for-profit hospitals has occurred in the last 20 years.[13] Nonprofit hospitals are tax exempt but may not distribute any profits.[14]

Charitable Care in Hospitals in the United States

Hospitals in the United States were originally founded on the alms-house paradigm from England. Primarily founded by charitable organizations, they provided free care with doctors who worked for charity.[15] Gradually, as insurance began to spread, especially with the establishment of Blue Cross in Houston in the early 1930s, patients became responsible for their hospital bills.[16]

With the passage of the Hospitals Survey and Construction Act of 1946 (i.e., the Hill-Burton Act), hospitals were given federal money to be built or expanded.[17] The major goal of the act was to increase the number of hospital beds in America to 4.5 per 1,000 people, particularly in rural America.[18] Although charitable care was not the primary goal of the Hill-Burton Act, it did provide that "a reasonable volume of hospital services to persons unable to pay therefore, but an exception shall be made if such a requirement is not feasible from a financial standpoint."[19] Thus, charitable care was clearly encouraged but not mandatory.

The courts reinterpreted the Hill-Burton Act in 1970 to require a certain percentage of charitable work to be done by any hospital that had accepted Hill-Burton funding.[20] By 1972, rules were in place requiring 5% of all hospital billing to be charitable care.[21] The courts again visited this subject in 1985, when the State of Utah wanted to know exactly what they were getting in return for the tax-exempt status of a hospital.[22] This was reinterpreted by the federal government in the 1990s to include other things that a hospital might do to benefit a community. To qualify for tax-exempt status, currently, a nonprofit hospital must have an independent board of directors, an open medical staff, nondiscriminatory treatment of Medicare and Medicaid patients, and an open emergency room. They are not required to do a specific amount of charitable work.

Hospital Billing: Who Pays Whose Share?

With the passage of Medicare and Medicaid in 1965, there was suddenly coverage for a large percentage of the

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uninsured population in America.[23] When it went into effect in 1967, the government was only trying to achieve the payment of the hospitals' and physicians' bills for acute hospitalization. This was achieved through retrospective payments of the hospital costs—that is, the government paid the bill of the elderly. Although the framers were quite adamant that they would not pay anyone else's costs, Medicare did quite well at reimbursing hospitals for the care that the patient received. Indeed, they were able to get past the objections of the American Medical Association by promising to pay fees and increase them for inflation. The original bill had said that they would not regulate medicine, but of course, they quickly began to do so.[24] There was no price control, however, and very quickly costs escalated out of control.

Hearings had been held on Diagnostic Related Groups (DRGs) as early as 1971 in an effort for cost containment.[25] In the early 1980s, as double-digit inflation was rampant, healthcare costs still outstripped this.[26] Something clearly needed to be done. The government did not need to negotiate with the hospitals. They could mandate what the government would pay. After a few states tested it, prospective pricing finally came into being in 1984.[27] Within a short period of time, the amount that the government paid for Medicare and Medicaid patients was not sufficient to cover their costs. To make up the difference, other payers were charged more, thus the term "cost shifting."[28]

Cost Shifting

To some extent, cost shifting had existed before this because costs for indigent patient care had to be covered somehow. Donations to hospitals have not made up a substantial portion of their income for many years, on average less than 1% now.[29] So, to pay for indigent care, paying customers have been charged more, much like overhead.

The concept of cost shifting has been used in a number of business areas but always refers to charging others to pay for others not paying their share. Although a number of hospital apologists have tried to claim that it does not exist in the hospital industry, this argument has never been logical.[30] As of 1994, Medicare and Medicaid were only paying 70% and 62%, respectively, of patients' actual hospital costs.[31] Hospitals cannot continue to operate with deficit spending indefinitely, yet a relatively small number of them have gone out of business. They are making up the difference somewhere.

At least one hospital administrator was honest enough to describe how he did it,[32] and others have studied the situation.[33, 34] It has been estimated that, in 1992, private payers were subsidizing 14% of others' hospital costs.[35]

Clement went even farther, distinguishing between static cost shifting—the government paying less than full costs—and dynamic cost shifting—the raising of prices to some payers because others have lowered their payments.[36] This is an irrelevant distinction. The import is to whom the costs are shifted and who that affects.

When Meyer and Johnson discussed cost shifting during the implementation of prospective payments by Medicare, they anticipated that insurance companies would be charged more to make up the difference.[37] It was not until 2000 when Wielawski finally pointed out that cost shifting was also gouging the uninsured.[38] It might be considered as the natural consequence of market forces. The government imposes its price list each year by virtue of its sovereign right. Hospitals

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may lobby for changes, but Congress decides how much will be spent and the Center for Medicare and Medicaid Services decides how. Insurance companies realized that they were paying more than their fair share of hospitals' overall costs, and because they are not donative companies, they have used their buying power to force better prices with the hospitals. The one group that has no power to help negotiate their hospital costs is the one who can least afford to be charged extra—the uninsured.

Legality

When someone is admitted to a hospital, he is required to sign forms accepting responsibility for his hospital bill, despite not knowing the price. The type of hospital makes no difference here: all hospitals require this. Some hospitals even list their policies in print and on the Internet.[39] Thus, within the limits of the law, legally, patients become responsible for their healthcare bill, regardless of how high it might rise and regardless of their ability to pay.

The Social Security Act under which Medicare and Medicaid function makes it illegal for hospitals to bill patients any more than what the government allows, usually making the patient liable for only 20% of the allowed.[40] Health maintenance organizations and insurance companies frequently have contracts limiting the amount that their patients can be billed, even if they do not cover the full amount of the hospital bill. Legally, then, the uninsured patient becomes legally responsible for the full bill, unless the bill is so high that they can then qualify for a Medicaid spend-down card or they become so disabled that they qualify for Medicare and Social Security.

Consequences

Given that the uninsured become legally responsible for a hospital bill of which they may have no idea how much it will be, they may be stuck with financial disaster. Indeed, even as bankruptcies are up in the face of the poor economy, about half of all personal bankruptcy in the United States are due to hospital bills, estimated at over 500,000 per year.[41] Statistics about the number of homes lost to hospitals is difficult to find, but the devastation in peoples lives can be seen as tremendous, just from the bankruptcies.

Ethics

Economic justice can be mentioned only to note its lack of position in the judicial history of the United States.[42] As Professor Charity Scott stated, "Justice is an ethical concept of universal fairness for and among individuals."[43] Can any hospital justify overcharging a class of patients who can least afford it? Perhaps the for-profit, proprietary hospitals could make an argument for it. Under the economic theories of Milton Friedman, their only responsibility as a business is to make money for the investors.[44] Of course, even for-profit hospitals have significant responsibilities to their patients. As a class, they provide about as much charitable care as the nonprofit hospitals do, so many such hospitals could probably justify it.[45]

Public hospitals would have a hard time justifying such actions also, because they provide services for their constituencies with public money. Obviously, the military, Indian Health Service, and veterans hospitals do not practice cost shifting because they do not bill their patients. If a hospital supported by a city, county, or a state government practiced such

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billing practices, this could be a real moral dilemma. Bankrupting one taxpayer to pay the costs of another could be seen as truly capricious. But the examples in the literature do not include any municipal hospitals. I suspect that the billing practices of state-run hospitals, especially those affiliated with medical schools, may not be very different than the rest of the nonprofits, but this should be looked at in the future.

Nonprofit hospitals are the crux of this ethical question. They have been cited as cost shifting significant burdens onto the shoulders of one portion of the uninsured patients, causing incalculable financial suffering. Some might try to argue, under Rawls, that for the greater good of society, charging some more to keep the hospitals solvent would justify such actions.[46] I think not. Rawls specifically argued that "social and economic inequalities are to be arranged so that they are to the greatest benefit of the least advantaged."[47] The dehumanizing effect on this defenseless, unempowered group would never face up to the rigors of Kant's Principle of Reversibility or the virtue ethics of Aristotle that people should not be treated in this manner.[48,49] The ends do not justify the means, even in trying to keep a hospital open.

The Code of Ethics of the American College of Healthcare Executives has the stated purpose of guiding the conduct of its members. The stated objectives of the profession "are to enhance overall *quality of life, dignity, and well-being of every individual* needing healthcare services; and to create a more equitable, accessible, effective and efficient healthcare system" (pp. 168–9).[50] Cost shifting to poor patients does not meet these objectives.

Nonprofit hospitals already reap huge economic rewards through the tax exemption by the IRS. This deprives federal and state governments of income tax revenue, and localities lose sales and property taxes. Many authors have attacked nonprofit hospitals in the last 20 years for not providing enough charitable care or community benefit to justify their tax exemption.[51,52] If, in addition to not providing significant charitable care, they also price gouge some of their indigent patients, they should not deserve tax benefits from society.

Conclusions

It is rare in a discussion of medical ethics that the discussion turns to business ethics. It has been long known that healthcare in America is not close to being a free-market economy. The government interventions with their price controls have contributed to distorting it significantly. Additionally, the lack of perfect knowledge for the consumers keeps the market imperfect. As long as the patients do not know what their hospital costs are going to be and cannot compare between institutions, this will not change. But this is an important point to bring out: healthcare in America charges patients in a manner disproportionate to their ability to pay. I do not think that hospitals set out to deliberately discriminate and economically harm this class of patients. It has evolved slowly over the past 35 years of Medicare and Medicaid payments. It is indicative of how sick our healthcare system in America has become. If this is what hospitals are doing, one can only wonder what is happening in other parts of the healthcare system. Something needs to be done about it. Indeed, Connecticut has now passed a bill to alleviate this problem, and California has had a similar type bill introduced.[53] The hospital lobbyists are still trying to fight it. It may be a step in the right direc-

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tion. But until there is universal coverage, cost shifting to the indigent is one practice that is ethically abhorrent and should be eliminated now.

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