

BILLING AND COLLECTION LAWSUITS:

WHAT HOSPITALS NEED TO KNOW AND PREPARE FOR

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I. BACKGROUND FACTS

A. The Uninsured

1. Estimates vary as to size of uninsured population
 - a. Census Bureau estimates 43.6 million persons uninsured for the entire year of 2002
 - b. The Congressional Budget Office reports that the Census Bureau number more accurately reflects the number of persons uninsured at some point during the year
2. The size of the insured population is significant and it is growing. Estimates are that the uninsured population increased by one-half percent from 2001 to 2002, an increase of 2.4 million people.

B. Charging the Uninsured

1. Hospitals charge self-paying patients based on their charge masters – what is called derisively "list prices"
 - a. "Charge masters" evolved in the pre-PPS era.
 - b. By contrast, it is estimated that in 2002, payers negotiated payment schedules that were between 42 – 47% of charges.
2. Self-pay patients are "currently being charged 2 to 4 times what people with health insurance coverage pay for hospital services."
 - Dr. Gerard Anderson, Professor, Bloomberg School of Public Health, Johns Hopkins School of Medicine, testifying before the U.S. House of Representatives, June 24, 2004

C. Regulatory Environment

1. Anti-kickback statute.
2. Excess of usual charges exclusion authority.
3. Bad debt reimbursement.

II. THE ISSUES

A. The Perfect Storm – a convergence of the following forces is setting up the hospital industry for turbulent times:

1. Demographic forces

a. Aging baby boomers (increasing demand for services and outstripping resources)

2. Economic Forces

a. Growing federal budget deficits (Medicare and Medicaid in trouble)

b. Reduction in employer medical coverage

- Less benefits to workers

- No benefits to retirees

c. Increase in no benefits jobs

- Part-time and contract workers

d. Cost pressures on hospitals – increased costs of equipment, labor, regulatory compliance, litigation

3. Political Forces

a. State and local government challenging property tax exemptions – hospitals losing halo effect; governments need new source of revenue

b. An easy issue to demagogue – victims are more visible than accounting/budgeting issues

4. Public Perception: gouging the uninsured

a. Charging rack rates only to uninsured

b. Oppressive collections practices

c. Invisible charity care policies

B. Resulting Challenges

1. Tax-exempt Status: Re-thinking tax-exempt status

- a. Federal level – should charity care replace community benefit
- b. State and local – mandating charity care
2. Other specific challenges
 - a. Class Action
 - b. Property tax exemption challenges
 - c. Legislative initiatives
 - Changing the exemption standards
 - Payments in lieu of taxes
3. How to handle the uninsured
4. How to measure charity care/undercompensated care
5. Review billing and collection practices
 - a. Is collection litigation worth it?
 - b. Standards for commencing litigation

III. WHAT THE REGULATORS ARE SAYING

A. Davidson Letter and Response

1. President of AHA alleges regulatory barriers to discounts for the uninsured.
2. Response from Tommy Thompson, Secretary of Health and Human Services-
 - a. "[H]ospitals can provide discounts to uninsured and underinsured patient who cannot afford their hospitals bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing obligations."
 - b. Urges action to assist the underinsured and uninsured

B. HHS Guidance

1. OIG position paper

- a. No OIG authority prohibiting or restricting hospitals from offering discounts to uninsured patients who are unable to pay their bill.
 - b. No risk of exclusion for submitting bills or requests for payment to Medicare or Medicaid for amounts that are substantially more than providers or suppliers usual charges – assurance that until a final regulation is promulgated OIG will maintain an enforcement policy that "when calculating their 'usual' charges for purposes of [the exclusion statute], individuals and entities do not need to consider free or substantially reduced charges to (i) uninsured patients or (ii) underinsured patients who are self-paying patients for the items or services furnished.
 - c. Guidance to hospitals
 - Good faith determination of financial need -- typical factors local cost of living, patient's income, assets and expenses, patient's family size and scope and extent of medical bills
 - Use of reasonable set of financial guidelines based on objective criteria appropriate for the applicable locality
 - Uniform application of guidelines
2. Question and Answer Guidance – www.cms.hhs.gov/FAQ-uninsured.pdf
- a. No prohibition against waiving collection of charges to an indigent uninsured individual.
 - b. Hospitals may offer discounts to patients with large bills.
 - c. Collection efforts can be foregone for a Medicare patient that is indigent or medically indigent and if the hospital determines no source other than patient is legally responsible for unpaid deductibles and co-insurance the amount may be claimed as a Medicare bad debt.
 - d. Documentation required to support bad debt reimbursement; providers should follow guidance in the Provider Reimbursement Manual.
 - e. Hospitals are not required to take low income patients to court or seize their homes or send claims to a collection agency when hospital bills are not paid. However, providers must bill the patient for the debt and make some reasonable effort to collect and collection practices should be uniform as to Medicare and non-Medicare patients.

3. Testimony before the U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, June 24, 2004
 - a. Herb Kuhn, Director of CMS
 - Provider reimbursement rules for Medicare and Medicaid “should in no way restrict the ability of hospitals and providers to offer free or discounted care to patients who do not have coverage under these two programs.”
 - Focus on 3 issues: discounts in general, discounts to Medicare covered indigent and bad debt/collection practices.
 - discounts permitted generally
 - discounts to Medicare patients permitted where: indigency determinations are made the same as for “non-Medicare patients;” indigency determination is documented; and, once indigency is determined, collection efforts cease.
 - Medicare bad debt reimbursement rules do not require aggressive debt collection practices but uniformly applied, reasonable, prudent practices
 - “Without question, a hospital can provide free care or discount charges to uninsured or underinsured patients.”
 - b. Lewis Morris, Chief Counsel, HHS Office of Inspector General
 - Similar to testimony of Herb Kuhn
 - Greater discussion of legal issues

IV. POLICIES

- A. American Hospital Association -- Hospital Billing and Collection Practices – Statement of Principles and Guidelines
 1. Treat all patients equally and with dignity.
 2. Serve emergency health care needs of all.
 3. Assist patients who cannot pay.
 4. Balance service to the financially needy with fiscal responsibility.
 5. Provide more information about hospital charges.

6. Offer discounts to patients who do not qualify for charity care.
 7. Ensure fair and consistent collection practices.
- B. HFMA -- Principles and Practices Board Statement Number 15
1. Distinguishes charity care from bad debts --
 - a. Bad debt = unwilling to pay; charity care = unable to pay
 - b. It is necessary to differentiate charity service from bad debts because:
 - charity service represents the consumption of valuable resources that must be managed wisely.
 - charity service is one of the important indicators of the fulfillment of an organization's charitable purposes and, therefore, should be clearly identified and disclosed
 - provider eligibility for certain financial assistance is dependent on identification of charity service.
 - bad debt expense is a measure of the effectiveness of the organization's credit and collection process.
 2. Criteria for determining eligibility for charity service --
 - a. individual or family income (HFMA, P & P Stmt 15, § 2.4)
 - b. individual or family net worth (HFMA, P & P Stmt 15, § 2.5)
 - c. employment status and earning capacity (HFMA, P & P Stmt 15, § 2.6)
 - d. family size (HFMA, P & P Stmt 15, § 2.7)
 - e. other financial obligations (HFMA, P & P Stmt 15, § 2.8)
 - f. the amount and frequency of bills for healthcare services (HFMA, P & P Stmt 15, § 2.9)
 - g. other sources of payment for the services rendered (HFMA, P & P Stmt 15, § 2.10)

- C. Healthcare Association of New York State – Financial Aid/Charity Care Policy at New York’s Not-for-Profit Hospitals
1. Establishes a set of principles
 - a. Hospital bills not an impediment to service
 - b. Financial aid policies consistent with mission and values of the hospital
 - c. policies clear, understandable and communicated
 - d. debt collection practices consistent with mission and values of the hospital
 2. Proposed a set of guidelines
 - a. Establish financial aid program to assist low-income, uninsured individuals
 - Clearly state eligibility criteria for financial aid
 - Provide assistance to at least persons below 200% of the Federal poverty level
 - b. Establish policy of discounts for low-income uninsured –discounts could be applied to other payer rates or be applied to charges if “discount scales are regularly monitored and adjusted to ensure that the resulting discounted charge is not inconsistent with prices charged to a typical, insured patient.”
 3. Implementation
 - a. Communication to patients
 - b. Appropriate staff to administer and training of staff
 - c. Administer fairly and consistently
 4. Fair and consistently applied reasonable collection policies
 - a. establish payment plans
 - b. legal action where reasonable in light of patient’s assets
 - c. no foreclosure on primary residence

- d. make sure reasonable efforts were made to offer financial assistance
 - e. instruct collection agencies to follow mission and values of hospital

- D. Illinois Hospital Association and Metropolitan Chicago Healthcare Council Task Force on Charity Care and Collection Practices for the Uninsured
 - 1. Describes background to issues regarding the uninsured.
 - 2. Establishes provider AND patient responsibilities; typical patient responsibilities include cooperation in determining net worth, available assets or eligibility for government payment programs.
 - 3. Establishes charity care guidelines:
 - a. hospital should have policy to evaluate and determine a patient's eligibility for financial assistance;
 - b. Policy of availability of charity care will be communicated to all patients;
 - c. Patient to receive "full (100%) discount if he or she can demonstrate family income at or below 100% of Federal poverty guidelines and hospitals encouraged to offer discounts where income greater than 100% but equal to or less than 200% of Federal poverty guidelines.
 - 4. Establishes collection practices guidelines:
 - a. establish a reasonable payment plan;
 - b. offer prompt payment discounts;
 - c. not pursue legal action for non-payment against charity care patients who have clearly demonstrated that they have neither sufficient income or assets to pay;
 - d. not place a lien on principal residence.

- E. Creating Your Own Policy
 - 1. Determine financial need in a reasonable and objective manner.
 - 2. Factors for determining financial need:
 - a. local cost of living;

- b. patient's income, assets and expenses;
 - c. patient's family size;
 - d. scope and extent of patient's medical bills.
3. Guidelines based on objective criteria.
 4. Communicate policy to patients.
 5. Uniform application of guidelines.
 6. Patient financial status may change over time.
 7. Document determinations of need.
 8. Criteria for when discounts will be offered to patients who do not qualify for charity care.
 9. Clear billing formats and processes.
 10. Fair and consistent collection practices.

V. CLASS ACTION AND ONE SYSTEM'S RESPONSE – NORTH MISSISSIPPI MEDICAL CENTER

- A. Theory of class action: hospitals have breached an implied agreement to provide affordable health care to all members of the community; the implied agreement allegedly arises out of hospitals receipt of tax-exempt status Federal, state and local governments.
- B. Remedies sought by class action plaintiffs:
 1. Injunctive relief:
 - a. ordering hospitals to cease charging uninsured patients the charges listed in the charge master, charging uninsured patients higher rates than charged to insured patients and using aggressive collection tactics;
 - b. ordering hospitals to provide “affordable medical care” and charge uninsured no more than insured patients.
 2. Monetary damages: a “constructive trust” (i.e., in effect a bookkeeping entry) in an amount equal to savings attributable to federal, state and local income tax exemption, plus any additional amount necessary, dedicated to providing affordable medical care.

B. North Mississippi Medical Center Settlement

1. NMMC is part of the largest rural hospital/health system, North Mississippi Health Systems which includes 6 hospitals.
2. NMMC had NOT been sued as part of the class action.
3. Terms of settlement:
 - a. family of 4 with annual income up to \$36,000, which is 200% of the Federal poverty level, will pay \$10 a visit for hospital, clinic and outpatient services;
 - b. family of 4 with annual income up to \$72,000, which is 400% of the Federal poverty level, will get discounts of 15 to 50% off rates that hospitals charge Medicare;
 - c. no liens on principal residence;
 - d. hospital will not seek payments exceeding 10% of family income;
 - e. retroactive—patients treated in last 3 years may apply to have bills reduced or erased or even get money back.
4. Estimated value of settlement is \$150 million over 10 years.
5. Shortly after the settlement was reached, NMMC announced a one year moratorium on any construction projects.