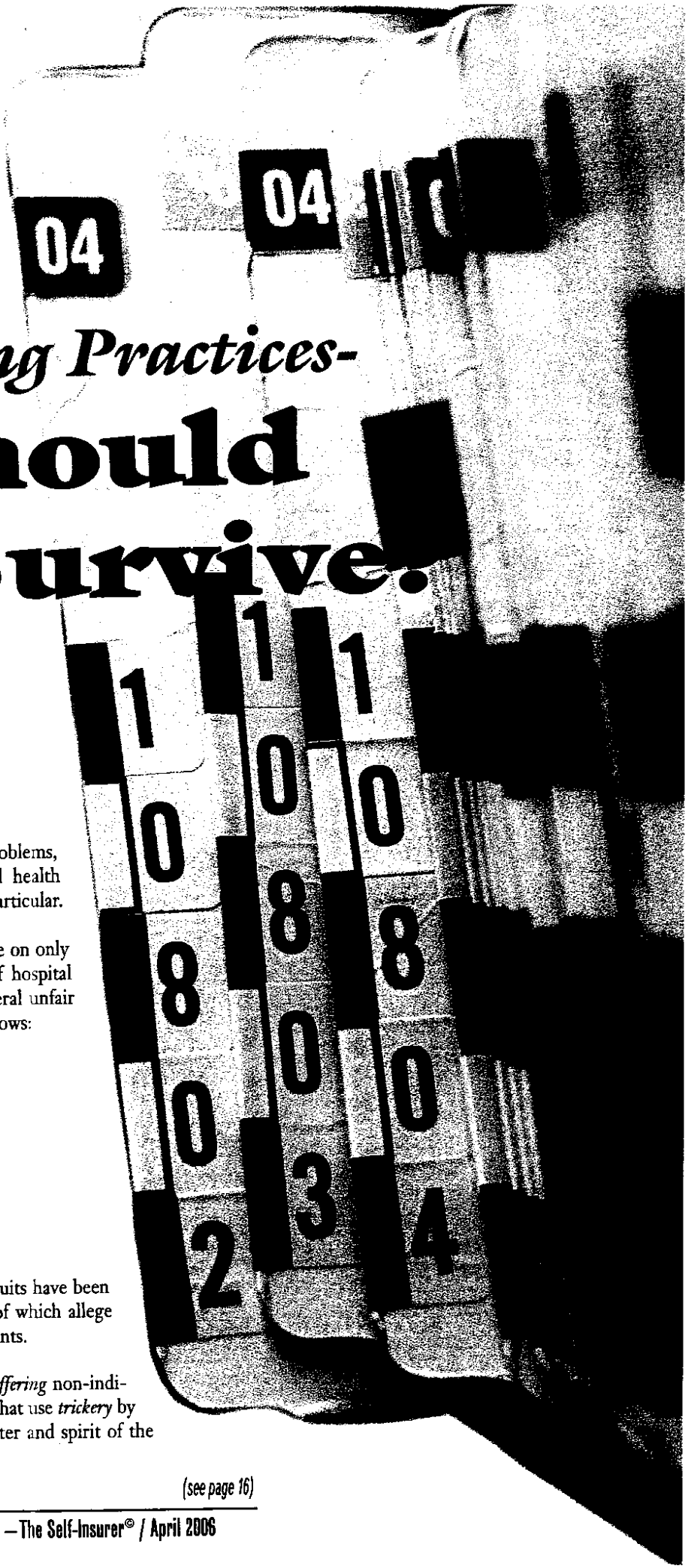
Editors note: The following article presents an interesting view on this subject that we felt we should share with our readers. The opinions reached are those of the author alone and do not imply any opinion on the part of the officers, directors or members of SIIA or the SIPC.



Hospital Billing Practices- Can/Should They Survive?

By Carlton Harker, FSA, MAAA

Introduction

I enumerate in Exhibit A some of our current problems, which impact unfavorably on employer-financed health care plans in general and/or self-funded plans in particular.

Since I am limited in space, I will offer a brief critique on only one of these problems, namely the current spate of hospital billing class action lawsuits and possible state or federal unfair competition issues. My critique will be offered as follows:

- Understanding the litigation
- Unfair competition aspects of the problem
- Participant involvement
- Suggested solution
- Conclusion.

Understanding the Litigation

Overview

It has been reported that as many as 48 class action suits have been filed against approximately 370 hospitals nearly all of which allege billing abuses involving non-indigent uninsured patients.

The emotional issues are generally stressed. The *suffering* non-indigent uninsured is *fleeced* by the *bloated*-rich hospitals that use *trickery* by their *overpaid* hospital officers all contrary to the letter and spirit of the hospital's tax-exempt mandates.

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It has been reported that the IRS is, or soon might be, conducting an investigation into the tax-status of some of these nonprofit hospitals.

Typical Class Action Suit

The typical class action suit complains that uninsured patients at a nonprofit hospital were victims of a scheme by which they were billed much higher charges than those for either Medicare-paid or employer-paid patients. Being non-indigent, such patients failed to qualify as charity patients. As a result, such patients were presented with bills far in excess of what would be deemed fair or reasonable.

Specific alleged infractions of the law generally include:

- Violation of the state's unfair trade practice laws
- Not following letter and spirit of the hospital's IRC §501(c)(3) mandates
- Federal Emergency Medical Treatment and Active Labor Act violations
- Breach of contract, unjust enrichment, civil conspiracy, concealed action, etc.

Relevant Rhetoric is Ugly

Charges being leveled against the hospitals, outside of the courtroom, are becoming rather strident. Some samples:

1. "Billing abuses and wrongdoings are widespread throughout the nonprofit hospital industry."
2. "We are becoming painfully aware that many nonprofit hospitals, benefiting from the cross-pollination of information from the AHA are not meeting the needs of the communities they serve but rather are catering to the special interest groups."

Response of the Hospitals

The hospitals have been offering a calm, lucid and effective defense to date.

Comments

I am concerned with these class action lawsuits for the following reasons:

1. They will not go away and will eventually end up in the Supreme Court (in all likelihood) with an unpredictable conclusion. This we do not need with our many present challenges.
2. The class action suits might be modified to include price discrimination and/or restraint of trade infractions as a part of their complaints.
3. These multiple class actions joined with the consensus that our present hospital billing system is in disrepair could be one more argument for Congress to adopt a single payer system.
4. Hospitals could be financially harmed in a significant way.

Unfair Competition Aspects of the Problem

It appears to me that there is a problem with hospital bill pricing but many of the class action suits do not stress the real problem; i.e., unfair competition (or possibly antitrust) infractions. I suggest that the matter be viewed from three perspectives:

1. The rule
2. The activity
3. The infraction.

The Rule

Our primary focus is on 15 USC ch. 2 §45 which forbids unfair methods of competition or unfair/deceptive acts or practices which affect commerce. Our lesser interest is on 15 USC ch. 1 §§1 and 13 which address the possible antitrust implications of the price discrimination.

The Activity

Hospital A, profit or nonprofit, has a chargemaster, which declares a market basket of procedures to be a $8,000 in value and for which the hospitals cost is $5,000; the hospital is reimbursed as follows:

■ Medicare	$4,500
■ Blue Cross	6,000
■ Network A	6,500
■ Network B	7,000
■ Network C	7,500
■ Non-indigent uninsured	9,500
■ Indigent uninsured	0

The Infraction

When the *activity* is measured against the *rule*, we find the following:

<u>Price discrimination in products and services.</u> There is price discrimination (and potential unfair competition) without any need for discussion.

<u>Economic justification of such discrimination.</u> I would believe that the hospital discounts typically given from its chargemaster cannot be economically justified.

<u>Restraint of trade as an end result or motive.</u> Either (a) there is a free and open competitive environment for the consumer with ample marketplace choices in which event it may be argued that the consumer is not harmed by the choices made, or (b) the consumer is so constrained that there are no ample marketplace choices in which event it may be argued that the consumer may be harmed by the choices offered. I believe that (b) is the correct choice for these reasons:

1. The consumer may obtain health care only through the consumer's physician because of the nature of the relationship, the nature of the disease or similar reasons.
2. The consumer may obtain health care only through Hospital A; the consumer has no choice in where the hospi-

tal care is given because the physician has practice privileges only in Hospital A.

3. On hospital admission, the consumer is powerless to bargain for prices, argue for *most-favored nation* terms, be offered network choices, etc. The consumer signs a *blank check* to Hospital A to pay what Hospital A says will be the charges. Such consumer has no access to a *sticker price* and is figuratively in the financial clutches of Hospital A.

Over-arching and compelling reason. In light of Hospital A's conflicted interests with Medicare Outlier adjustments, recovery from Medicaid filings and for-poverty care reimbursement, it is doubtful that Hospital A is due much slack should the unfair competition decision go against it.

Participant Involvement

One young couple found out the hard way that a hospital may be a dangerous place. The facts were these:

1. Rather than use a network hospital, the couple opted to use a more convenient out-of-network hospital for their maternity stay.
2. Their preemie proved to be costly for its 20-day stay with a resulting hospital bill of $900,000 of which only $650,000 was accepted by the plan as reasonable and customary.
3. The hospital insisted on balance billing so as to gain the financial advantage with the hospital's Medicare Outlier filing (and other advantages relative to charity charge-offs).
4. The preemie did not survive leaving the couple with both a child loss and a bankruptcy filing.

Thus it is that hospitals are marvelous centers for healing but they can also (a) bankrupt you and (b) give you health problems that you did not have when you were admitted (staph, e.g.).

Suggested Solution

It is my suggestion that the laws or regulation of each state which presently govern hospitals be modified so as to accomplish at least two things:

1. An annual report, jointly-prepared by an independent accountant *and* an independent economist, which would show, for an industry-accepted market basket of hospital procedures the following data:
   a. **Hospital-Specific Data**
   - Chargemaster $8,000
   - Hospital costs 5,000

   b. **Market basket-Specific Charges**

Payer-Network	Actual	Cost Justified
Medicare	$4500	$6,000
Blue Cross	6000	6500
Network A	6500	7000
Network B	7000	7200
Network C	7500	7800
Uninsured		
Non-indigent	8500	8000
Indigent	0	0

2. An amendment to the financial responsibility provision of the Consent to Treatment Contract might read as follows:

I have received a certified statement of hospital charges for a market basket of hospital procedures; I understand the basis of my charges will be according to my billing class which is Network A.

My financial obligation will be determined by the actual services provided by the hospital but the basis of such determination (when applied to such market basket of services) will be the actual charges of $6,500 which compares to the Hospital sticker price of $8,000.

Conclusions

My critique, skimpy though it is, permits me to make a few conclusions:

1. We must take these class actions seriously because they offer the single-payer advocates a good argument for their agenda.
2. The real problem, not generally grasped, is that our oligopolistic hospital industry cannot sustain the unfair competition activities introduced in the last decade under the name of managed care. We must with some haste either (a) make the hospital industry more competitive or (b) modify their pricing practices. Only (b) has any reasonable hope for success, in my judgement.
3. Prospective patients should realize that the Consent to Treatment Agreement could be the cause of their bankruptcy or worse.

Exhibit A

List of Some of Our Current Problems

- Growing consensus is that our health care system is broken; burdens on employers are becoming unsustainable; health care costs are estimated to be 20% of GDP by 2015.
- Managed care as a cost control mechanism has collapsed.
- Hospital administrators are openly admitting that their billing systems are broken, perhaps beyond repair.

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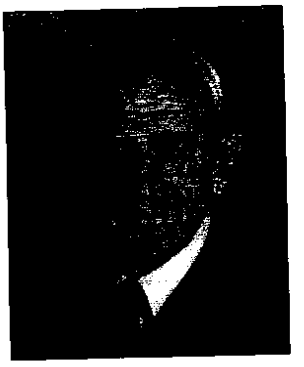
- Hoped-for patient-protection and tort reform legislation is not on the horizon.
- The number and aggressiveness of vendors each with their own song and conflicted interests are increasing.
- Ravages created by the proliferating hospital billing class actions lawsuits might become comparable to the tobacco-litigation industry problems.
- The general health financing industry attitude is that it is above the reach of the antitrust laws.
- To-date, stop-loss has not self-corrected many of its inherent drawbacks thereby making it part of the problem rather than part of the solution.
- New paradigm of consumer-controlled care is not being taken seriously in that such will only work if the system is competitive which is not a reasonable expectation.
- Upcoming baby-boomer financial demands will add to the costs. Exponential technical advances all with much higher costs will add to the costs.
- Cost-shifting by Medicare to the private system (lowering hospital reimbursements, e.g.) will accelerate as Medicare Part D costs are felt. Accelerating cost-shifting as the rolls of the uninsured increase will be expected.
- The government reserve requirements for retirees (GASB 43 and GASB 45) will be a train wreck financially adding to our numerous other problems.

That's my opinion. To share yours, contact the Editorial Dept. listed on page 1.



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