
**Two Years Into The Storm Over Pricing To And Collecting From The Uninsured
A Hospital Valuation Expert Examines The Risk/Return Dynamics And Asks:**

**Would Fair Pricing And Fair Medical Debt Repayment Plans
Increase Yields To Hospitals And Simultaneously Mitigate These Controversies?**

**When It Comes To The Uninsured, *Can Fair Pricing Actually Be Good Business?*
Was A Major Opportunity Missed To Set The Stage For Higher Yields From The Uninsured?**

Should Hospital Associations Markedly Change Their Mindsets, Strategies and Actions?

By James Unland, President, The Health Capital Group
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Overview

As the controversies over 501(c)(3) 'charitable' hospitals' pricing, collections and charity care practices that emerged in the winter and spring of 2003 continue unabated – now involving government officials from city councils and county boards to state attorneys general and Congress as well as numerous class action lawsuits -- a hospital valuation expert and risk analyst looks at the fundamental economic and strategic issues, concluding that the risk/return dynamics are out of whack in that hospitals are facing mushrooming, multifaceted troubles over what has been a very low net yield patient population.

After interviewing patient account representatives at hospitals and conducting other research this analyst asks: should attention have been focused at the national and state hospital association levels in 2003 to take steps to increase the net yield to hospitals from the uninsured population through more equitable pricing and better medical debt repayment terms, steps that might have mitigated these controversies?

Many hospitals and hospital associations have been so intent on proving hospitals' legal right to charge 'list price' to and sue the uninsured that they have overlooked a simple yet effective business premise that many hospital patient accounts representatives already fully know: fair pricing and fair payment terms are actually good business. The author asserts that the controversies that emerged in 2003 actually represented a significant opportunity that, with a different approach, would very likely have resulted in hospitals being able to collect significantly more money from the uninsured population while, at the same time, lessening or even avoiding the destructive ramifications that have occurred in the form of investigations, legislation and lawsuits.

However, to realize higher net yields from the uninsured there are important, highly specific leadership steps that need to be taken uniquely at national and state 'association' levels in order to avoid the negative financial consequences of fragmented actions that can cause individual hospitals to become 'magnets' for the uninsured. Steps at the individual hospital level need to be preceded by coordinated leadership at the 'association' level if these difficult controversies are to be transformed into an opportunity for more revenue from the uninsured, an opportunity that existed in 2003 and before.

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I.

A Valuation Expert/Risk Analyst Looks At Risk vs. Return From Two Years Of Trouble

Looking Back Two Years: An Unwelcome Anniversary

It is now fully two years since the modern incarnation of several interrelated controversies began, kicked off in the winter and spring of 2003 by releases of reports from consumer groups and media articles pertaining to hospital pricing, collection and charity care practices with respect to the uninsured and underinsured.²

From city councils to county boards to state legislatures, state attorneys general and into the halls of the U.S. House and Senate, three allegations consistently stand out:

- Hospitals are charging their 'list prices' – prices no one pays³ – to the uninsured.
- Hospitals are using onerous collection tactics, including against low-income people whom they know cannot pay.⁴
- Hospitals are not providing enough 'charity care' and, in some cases, conceal its availability.

Government officials are doing more than just talking. In Champaign-Urbana, Illinois the county Board of Review has recommended the revocation of the property tax exemption of both hospitals there, citing, among other things, hospital pricing and collection policies.⁵ In Minnesota the Attorney General has very publicly moved against two large hospitals systems, in one case going to the extent of making public 40 affidavits with documentation of hospital bills, bankruptcy filings and the like. In several states Attorneys General have, to one extent or another, undertaken investigations and sided with plaintiffs in state class action lawsuits. In Congress several committees in both the upper and lower chambers have undertaken investigations and held hearings; in fact, both Senate and House activity seems to be on the increase.

In addition to governmental activities, numerous class action lawsuits have been filed by the 'tobacco lawyers.' Although nearly all of the federal suits have either been dismissed or withdrawn, the state suits are exhibiting signs of having staying power, and numerous local 'copycat' class actions have been filed.⁶

Powerful Galvanizing Factors: The Human Element In The Context Of An 'Unfairness' Issue

The horror stories of the uninsured have been recounted in local and national print media as well as in televised features. In some areas community groups have entered the publicly available databases of courthouses and unearthed hundreds of lawsuits by local 501(c)(3) hospitals against patients, then crosschecking patients' income and family status to determine whether they should have been eligible for charity care.

Leaving aside the issue of how much 'charity care' so-called 'charitable' 501(c)(3) hospitals⁷ should provide, the allegation of price discrimination – that is, hospitals charging their highest 'list prices' to the uninsured – has provoked community groups and state attorneys general; unlike the Scruggs federal class

² The Access Project and other groups released reports and the first in a series of Wall Street Journal articles came out on 3/13/03: "Jeannette White Is Long Dead But Her Hospital Bill Lives On."

³ Even the uninsured, although charged 'list prices,' seldom end up paying more than a fraction of these charges.

⁴ One of Scruggs' allegations is that hospitals knowingly pursue people they know cannot pay to discourage them from coming back to the hospital.

⁵ For copies of the Champaign County Board of Review's filings email the author at: HealthCapitalGroup@yahoo.com. In their recent filing recommending revocation of Carle Foundation Hospital's property tax exemption, they wrote, among other things: "There is a glaring juxtaposition of a 'charitable' hospital allowing doctors complete access and use of their 'exempt' facilities to pursue private gain while this same 'charitable' hospital continues an unfair policy of overpricing and suing the uninsured. This juxtaposition cannot be ignored, and it violates one's sense of fairness. It is our view that no hospital that permits this fundamental unfairness to exist can be considered 'charitable' or tax exempt."

⁶ Several local circuit courts have ruled that class action trials can proceed, in some instances exhibiting a keen understanding of the realities of hospital pricing.

⁷ Both federal and state tax-exempt status is linked to the ability of an organization to demonstrate a 'charitable purpose.'

actions, which were premised on far-fetched federal legal theories, the consumer fraud statutes at the state law level are expected to cause a number of class action lawsuits to 'have legs' and proceed to jury trials.

Officials at all levels of government have expressed outrage at 'charitable' hospitals' pricing and collection tactics, and their message seems clear: no amount of rationalization by hospitals and hospital associations, blaming government regulations or citing the need for national health reform can counteract the fundamental perception that supposedly 'charitable' hospitals are practicing price discrimination against a population that can least pay list prices, then using onerous collection tactics on people – many of whom would qualify for all or partial charity care in the first place.

It is the basic perception of unfairness repeatedly brought to life in the human voice that, in my view, has galvanized this issue among politicians in a nation where nearly one-third of the population is either uninsured or underinsured,⁸ at a time when public budget deficits and financial stresses make it easy for these politicians to ask the question: exactly what is our society getting from giving hospitals the gift of being tax-exempt?

Risk Analysis: Just How Serious Are The Legal/Regulatory Risks?

Legal and regulatory risks need to be bifurcated into 'federal' versus 'state' in that the two are quite different and need to be separately assessed.

On the federal level, it's clear that the tobacco lawyers' lawsuits aren't going to go anywhere, not surprisingly. The Scruggs team knew their federal arguments were far-fetched going in but wanted to take a crack at consolidating a global settlement with the hospital industry. In Congress activity is proceeding in both the House and the Senate, with the first investigations started in the spring of 2003, then with some hearings in the summer of 2004 and, most recently, hearings and investigations ratcheted up.⁹ Interestingly, much of the initial Congressional activity revolved around collection practices, whereas more recent activity has revolved around the juxtaposition of the 'overpricing' issue against the 'overcompensation of executives' issue.¹⁰

Will anything come of the activities of the Senate Finance Committee and the House Ways and Means Committee? Although I very much doubt that Congress will revoke hospitals' federal tax-exempt status, it is entirely likely that an attempt will be made to force hospitals to change their pricing and collections behavior as well as to provide some minimum amount of charity care.

The state law issues, from the standpoint of sheer legal exposure,¹¹ have been much more potentially consequential from day one than the federal issues. In reviewing the observations that follow, the reader is encouraged to keep in mind that in respect to (a) 'charitable' status, (b) property tax and other state tax exemptions and (c) consumer fraud, many state constitutions and statutes are similar. Some state law issues that come into play are:

Class action lawsuits: there are grounds for such lawsuits at the state law level mainly in the context of 'consumer fraud and deceptive practices' statutes. Unlike the case in the federal class actions, several state judges have refused to dismiss these suits. Many attorneys believe that the greatest legal exposure to hospitals lies in the 'unfairness' prong of consumer fraud statutes in respect to the overpricing allegations. A risk analyst is not comforted by the thought of local citizens telling their horror stories in relation to hospital pricing and collections to local juries.¹²

AGs' investigations: investigations are now underway into hospitals' pricing, collection and charity care practices by state attorneys general, the most widely publicized of which are those of Mike Hatch, the Attorney General of Minnesota, who recently also testified before the U.S. Senate Finance Committee.

Revocations of tax-exempt status: the Champaign County Board of Review's actions in the Provena and Carle Foundation cases and the ultimate outcomes of those cases will, quite likely, reverberate well outside of Illinois. Some jurisdictions are not waiting for the outcome in Illinois to look into these matters themselves.

⁸ Some 50 million people are totally uninsured; another 50 – 70 million are underinsured. Medical debt is a leading cause of bankruptcies.

⁹ Activity in Congress includes the Senate Finance Committee and the House Ways and Means Committee.

¹⁰ A number of federal, state and local governmental bodies have compared hospitals' pricing and collection policies as against what they perceive as high compensation of executives.

¹¹ Class action lawsuit damage awards, attorneys general actions, etc.

¹² In light of the large number of uninsured and underinsured persons in the U.S. it is likely that very few potential jurors do not know someone who is uninsured or who has had trouble with a hospital bill.

State legislation: in Minnesota and a number of other states, legislatures have considered bills to require hospitals to price services to the uninsured at the Medicare or Medicaid levels.

From my point of view at this writing, the most significant risks fall into three areas:

- (a) State and/or federal legislation will require hospitals to price at certain levels to the uninsured, and possibly to provide some yet-undefined baseline percentage of 'charity care.'
- (b) Other municipal and county taxing bodies will move against hospitals' property tax exemptions similarly to what happened in Champaign County, Illinois.
- (c) The local class actions have the potential to be financially damaging to the affected hospitals, particularly those in which Attorneys General join in on the side of the plaintiffs.

An Analyst Looks At Risk Versus Return, Finding It Out of Balance

As a hospital valuation expert and credit analyst, I am now looking at a controversy that has persisted for two years, dissipated enormous energy and money, and that is now multi-faceted and apparently unabated. Instinctively, I'm now evaluating the 'risk/return' dynamics.

Why? Because there is high, ever-expanding regulatory and financial risk to hospitals over a population of people *that, under present pricing/repayment terms, is not really paying a significant portion of their hospital bills to begin with.* The large proportion of hospitals I talk with are collecting a few percentage points of what they charge the uninsured, most often less than 5% net to the hospital.

My concern is to maximize net cash flow *to hospitals*, not to collection agencies or law firms, and to minimize hospitals' financial risk. In looking at a very high risk, very low return picture – a risk/return dynamic utterly out of whack – a good risk analyst wants to take steps to lower the risk, increase the return, or both. In this regard, patient account representatives in hospitals themselves may be providing valuable input when they contend that fair pricing will increase their net yield.

A Risk To Hospitals Not Much Discussed: The Costs When Patients Stay Away From Emergency Rooms

By overpricing to and suing the uninsured, there is a marked risk in that we are developing in this nation a class of people who are afraid to go to emergency rooms for fear of being ripped off from a pricing standpoint or hounded by collectors. The consequences of this have, in my view, not yet been fully appreciated either by public officials or by hospital associations.

For example, have hospitals seriously assessed the added costs *to them* of people not seeking care until their conditions are life-threatening? In other words, if under present law people who present at emergency rooms are required to be treated, then what happens when a patient who is being hounded by collection agents fails to go to the ER until what would have been a \$500 or \$1,000 visit becomes a \$50,000 medical episode when that same patient finally does go to the ER?

In posing this question I fully recognize that in some ways our health care resources are used most inefficiently with respect to many of the uninsured, in that they should have – but often do not have – access to primary care services outside of hospital emergency rooms. Still, the fact of the matter is that for both primary care and specialty care, the ER seems to be the place where many of the uninsured end up going.

As long as federal and state laws compel hospitals to treat all comers (and I do recognize that in this respect hospital in no way operate in a 'free market') the financial incentives would seem to be for hospitals to (a) keep their costs down by, among other things, treating patients at a point in a medical episode when the relative costs are low and (b) collecting more money from patients through fairer pricing and payment terms. The thought of an entire class of people essentially being afraid to go to emergency rooms until medical episodes become very high cost is unnerving to the financial analyst, even leaving aside the public health implications of such a development on any significant scale – and remember that we are talking about roughly one-third of the American population that is either flat out uninsured or underinsured.

II.

Could The Net Yield From The Uninsured Be Increased With A Different Approach? Was An Opportunity Missed In 2003?

Conversations With Patient Account Representatives

Interviews with several hundred hospital patient account representatives have been revealing, particularly in regards to the pricing issue.¹³

Asked whether uninsured patients would 'take their hospital bills more seriously' if told they were being placed on a pricing level commensurate with that of insurance payors more than 90% said "yes." A few were unsure. Not one said "no."

Asked if their hospital would collect more actual money under this kind of pricing to the uninsured, more than 80% said "yes" but, not surprisingly, qualified this answer by agreeing with the statement that 'the repayment terms are crucial' to collecting more money from the uninsured.

Many patient account representatives are aware that their hospitals' senior managements and law firms are intent on establishing their legal right to charge 'list price' to the uninsured and, for this reason, did not want to speak on the record. But their message, in the words of one, was pretty clear: "we aren't collecting much from this population (the uninsured) anyway; we might as well try to price to them more fairly." Another put it more bluntly: "hospitals may have the inalienable legal right to charge the highest prices to the uninsured, but it's better business to price fairly and let them know we're meeting them half way...I think we could collect a lot more money."

Additional comments included consensus on the point that even with discounting to, for example, pricing levels that insurers pay, and even with fairer, more individually tailored medical debt payment plans, hospitals will never collect all medical debt from 100% of the uninsured. Many are too poor and deserve all or partial 'charity care' in concert with discounts, etc. and it is also a fact of life that some people just don't pay regardless of how consumer-friendly the terms are. Thus, a number of patient account representatives said that hospitals should hold the line on certain credit and collection principles, especially if they meet the uninsured more than halfway by virtue of fair pricing and fair payment plans.

The concepts of 'means testing' and 'individually tailored pricing and payment plans' were brought up by some patient account representatives, many of whom also pointed out that the hospital industry is not using the most modern tools of automation, tools that might greatly assist in certain respects. Many felt that a more sophisticated, faster method of dealing with 'two forks in the road' needed to be devised:

-- The first 'fork in the road' is to determine whether a patient is qualified for all or partial charity care; there was consensus that the existing charity care application process is cumbersome for all parties concerned and that, for example, verification of income and number of dependents and credit screening could be automated.

-- The second 'fork in the road' is to determine how much medical debt should be repaid, with the terms of such repayment based on credit and other individual or family-specific credit characteristics; and again, there was consensus that more sophisticated, more automated technologies would greatly help.

This author recognizes what many patient account representatives also pointed out: that both federal and state banking and credit regulations become involved when one starts talking seriously about individually tailored pricing and payment plans, to say nothing of regulations under the purview of CMS and the OIG. In many states, for example, if a hospital starts charging interest for consumer medical debt the organization becomes subject to an array of banking and consumer credit regulations; many hospitals have dealt with this issue by simply not charging interest on the medical debt but, rather, by just structuring a simple schedule of repayment.

The big question to the risk analyst in relation to all of this is: would 'fair pricing' (a) mitigate these controversies and, simultaneously, (b) *increase the financial yield* from the uninsured, recognizing the probability that even at 'discounted' prices the net yield from this group may always fall below optimum levels?

A related question is: would any of these controversies have gotten to this point had hospitals and, in particular, hospital associations advocated re-pricing to the uninsured two years ago, plus taken a few other proactive steps?

¹³ Interviews conducted by the author from September 2004 through March 2005.

The Problem Of Uncoordinated, Scattered Action By Hospitals: A Challenge To Hospital Associations' Leadership

At least as grave a concern as the attacks by politicians and regulators on hospitals is the challenge of what happens when one hospital attempts to 'do the right thing' in regards to highly specific steps and others in its market do not. The recent breakdown of the so-called 'Mississippi settlement' in the Scruggs litigation illustrates the problem, the North Mississippi Medical Center reporting that it had become a 'magnet' for the uninsured because it had, among other things, re-priced services to the uninsured at Medicare price levels and other hospitals in the region had not.

Except for in Minnesota,¹⁴ hospital associations have not taken on this challenge, either at the state or national levels, in respect to promulgating specific 'fair pricing' standards. The author realizes that if fair pricing standards are not properly formulated there might be antitrust concerns. Nonetheless, I believe that 'general policy guidelines' in the context of encouraging hospitals to price to the uninsured at or near the level of *their own specific insurance payors* would not be considered 'price-fixing.'¹⁵

Although some guidance on charity care policies and, to some extent, collection policies has been forthcoming from the AHA, CHA, HFMA and local hospital trade organizations by virtue of encouraging hospitals to review these policies, *decisive, specific and coordinated* guidance on pricing to the uninsured and on other elements of these incendiary controversies – viewed by a risk analyst as a high risk/low return caldron of trouble – has been largely absent.

It may sound politically correct for hospitals' trade associations to encourage hospitals to individually review their policies, but the practicalities of hospital markets, community relations and risk management favor coordinated action, especially in regards to pricing and charity care standards.

Could Lemonade Have Come From Lemons With Proper Leadership Two Years Ago?

What frustrates a risk analyst most is not the unknown risk – which, by definition is 'unknown' and, thus, unworthy of anxiety – but known risks that go unaddressed by people who should be able to fathom risks and mitigate or eliminate them.

Looking back to March and April of 2003, when the first series of *Wall Street Journal* articles and other reports on hospitals' treatment of the uninsured came out, the risk analyst wonders whether most, if not all, of these mushrooming controversies could have been avoided, for from day one these issues had 'high risk' and 'potentially explosive' written all over them.

If *industry-wide* fair pricing standards, collection standards and charity care guidance (that is, the provision of 'charity care' in the context of a hospital's resources) had been assertively promulgated in a coordinated manner by, for example, the American Hospital Association, the Catholic Hospital Association and the Healthcare Financial Management Association in the spring of 2003,¹⁶ one wonders whether any class action lawsuits would have occurred, whether any hospital would be having its tax-exempt status challenged and whether governmental bodies from city councils to attorneys general to Congress would be investigating the industry – and all this over a population of people, the uninsured, whose net yield to hospitals was known to be (and still is) quite low.

Did anyone think to make a try at actually *increasing the net yield from the uninsured through fair pricing and fair payment standards*? Consider for a moment if, in the spring of 2003, the three above-mentioned hospital trade organizations had taken the following steps:

- Make forthright public statements indicating that, yes, the adaptations and readaptations by hospitals to the reimbursement environment have led to 'list price' getting way out of whack, a situation that has unintentionally harmed uninsured people; in this regard, state that specific steps will be taken asap to rectify this situation.
- Reach out to national patient advocacy groups such as the Access Project and exchange views and information, taking a philosophy that these groups are, to a great extent, in a position to assist the industry. Encourage local hospitals to reach out to local community groups and get dialogue going.

¹⁴ Several major hospital systems have agreed to re-price to the uninsured population and to take other steps to mitigate the controversy. See: www.healthbusinessandpolicy.com/Minnesota.htm (note: the link is case sensitive).

¹⁵ Even if, for some reason, there were to be FTC/antitrust issues, I am confident that the details of policy guidance language to the hospital industry could be worked out with the FTC.

¹⁶ Inclusive of appropriate meetings between the trade associations and government agencies to clarify regulatory ambiguities.

- Encourage ALL hospitals to price to the uninsured at a level close to or at the level their insurers pay, and alert the private payors that this is not an excuse to renegotiate their contracts.
- Move quickly to resolve ambiguities and contradictions in CMS and OIG regulations and, if necessary, meet with the FTC and any other relevant government agencies, including Congress.
- Make forthright public statements indicating that hospitals' practices of sending patient accounts to collection agencies would be replaced by more careful deliberation and more individually tailored, fairer medical debt payment plans and that necessary regulatory and legislative steps (if necessary) would be taken to accomplish this.
- At the level of national hospital associations – particularly those mentioned above – start researching ways to help all hospitals and patients in respect to helpful technologies and better, more automated access to crucial databases with the purpose of addressing the aforementioned fork-in-the-road decisions: (a) whether a patient qualifies for all or partial charity care and (b) structuring patient-specific medical debt repayment plans.

The goals would have been:

- (1) Transform patient advocacy groups from adversaries into allies, at both the national and local levels, for they can provide translation and other services to hospitals, plus the support of these same groups will be needed to effect national health care payment reform, something we all know is needed.¹⁷
- (2) Forthrightly and urgently address all of the numerous federal regulatory ambiguities in regards to charging, pricing and collecting and, in this regard, bringing the right parties together with qualified experts – a step that, unfortunately, still needs to take place.
- (3) Take the opportunity to tell Congressional committees how they can help in regards to resolving regulatory ambiguities and related confusion.
- (4) Combine talent and resources to greatly modernize the entire patient intake/patient credit analysis process, perhaps even creating a national resource/database.
- (5) Address the issue of matching a person's financial situation with repayment plans that at least have a chance of being affordable.
- (6) Establish parameters for deep discounting in special circumstances where people fall outside of 'charity care' but still cannot be expected to pay revised prices.

The end goals would be to: (a) mitigate and/or eliminate the controversies and (b) establish ways for hospitals to actually collect more money. The commotion of 2003 presented a golden opportunity to reach out to the uninsured and to community groups and establish the kind of rapport that, in the end, yields more net cash flow, to say nothing of building a constituency to advocate desperately needed healthcare reform.

The Case of Champaign County, Illinois

On a smaller scale, many of the steps that are recommended above took place in Champaign, Illinois between Provena Covenant Medical Center and the community group there.

Prior to the spring of 2003 relations between hospital and the community group had been strained, to say the least. The hospital and the community group were in litigation. Relations between the hospital and the county Board of Review were also strained, the hospital basically stonewalling the county tax board and, later, losing its property tax exemption.¹⁸

Then a new CEO came to Provena Covenant. He reached out to the community group, which had been releasing reports and holding press conferences concerning the negative effects on the uninsured of overpricing to and suing them. They agreed that it was in no one's best interest to foster a public health problem with people afraid to go to the emergency room, nor was it in the hospital's best interest to send so many patients to collections. They formed a Joint Medical Debt Committee and, clearly, both the hospital executives and members of the community group began to learn from each other and work together.

¹⁷ This is not a pipe dream. Controversial though the events in Champaign County, Illinois were under the hospital's previous administration, a new CEO entered the scene at Provena Covenant Medical Center and by the late summer of 2003 had made great progress in transforming the community group there from an adversary to an ally, and I have extensive on-the-record audio interviews to prove this.

¹⁸ The Illinois Dept. of Revenue made its decision in February 2004; the case is on administrative appeal.

The hospital learned that community groups can actually assist hospitals in respect to their relations with the uninsured. Whereas in years past Provena Covenant Medical Center had been suing hundreds of patients annually, in 2004 they sued only one patient. The community group there has provided translation services and has encouraged its constituents – the uninsured – to take the hospital’s good faith efforts seriously. They were transformed from being a hospital adversary into being an ally.

At this writing, the hospital and the community group continue to work together. But what ‘broke the ice’ was the hospital CEO reaching out to the head of the community group and admitting that there were unintended negative consequences stemming from years of adaptations and readaptations to a reimbursement environment that caused pricing and collection policies to get out of hand.¹⁹ In addition, he and others at Provena owned up to serious ‘community relations’ mistakes.

My contention is that owning up to mistakes and taking steps to address those mistakes – combined with the kind of fair pricing that patient account managers believe would cause the uninsured to take their hospital bills more seriously – would, with some of the other steps cited above, result in a much higher net yield to hospitals from this population, particularly if fair repricing were combined with reasonable payment plans.

I am not for one minute contending that hospitals would ever or will ever capture anywhere near total billings to this population. Nonetheless, I wholeheartedly agree with the message sent by patient account managers: fair pricing is good business, and combined with other steps will lead to much more money coming into hospitals, a result that I, as a hospital valuation expert and credit analyst, find highly appealing.

There is one bit of bad news in Champaign County, which speaks to my point about the need for leadership at the hospital association level: the other hospital there has not matched the specific steps that Provena Covenant has taken (and, coincidentally, is having its own property tax exempt status challenged²⁰). My point being: *it is the consistency of policies in respect to pricing and collecting to the uninsured across market areas that makes them ‘work’ from a practical standpoint.*

The ‘Minnesota Agreement’: A Hospital Association Gets Involved

Although the hospitals in Minnesota were very likely forced to ‘go to the party’ by the very active interventions of Attorney General Mike Hatch, it can be said that a major state hospital association did address specifics in the areas of pricing and collections to the uninsured even though totally voluntary, proactive steps would have been preferable in my view. Nonetheless, in early May 2005 the Minnesota Hospital Association, in conjunction with a number of large not-for-profit hospitals and hospital systems, came to an agreement with the Minnesota Attorney General²¹ that was memorialized in a court order. Without going into great detail, that agreement contained the following key provisions:

- **Repricing to insurance company levels:** Hospitals would price to the uninsured population as follows: “The Hospital shall not charge a patient whose annual household income is less than \$125,000 for any uninsured treatment in an amount greater than the amount which the provider would be reimbursed for that service or treatment from its most favored insurer...The Hospital shall apply the same percentage discount to its charge description master for uninsured treatment that it would apply to charges incurred by a policyholder of its most favored insurer.”²²
- **Collection practices:** Significant changes are made in hospitals’ collection practices, including with respect to (a) patient notifications, (b) patients’ rights to speak directly with hospital personnel and (c) approval by hospital executives of all collection practices exercised by outside collection agencies.
- **Accountability on the part of hospital management:** hospitals’ management is held accountable for remaining directly involved in respect to pricing, collections and charity care. The agreement requires that management take specific steps, on a regular basis, to review all of these areas, again including steps to review the behavior of collection agencies.

¹⁹ At one point in early 2004 just after Provena’s property tax exemption was revoked by the Champaign County Board of Review and the Illinois Dept. of Revenue, I surveyed a number of hospital CFOs, not one of whom could tell me whom their hospital was suing or why. The ‘collection’ process was on automatic pilot with unintended consequences that even many CFOs did not fathom.

²⁰ In April 2005, the Champaign County Board of Review filed a brief to the Illinois Dept. of Revenue in this regard.

²¹ Mike Hatch is the Minnesota AG; for a copy of the agreement with the author’s comments see: www.healthbusinessandpolicy.com/Minnesota.htm (note that this link is case-sensitive).

²² Excerpted from section 33 of the agreement/order of the Ramsey County Second Judicial District Court, filed May 5, 2005. Again, refer to the above link to see a copy of the actual agreement and the author’s detailed comments.

Other provisions of the agreement specify that the board of directors/trustees of hospitals become directly involved in reviewing all of the above policies.

The major breakthroughs in this agreement are: (a) its specificity in respect to pricing and collections, (b) accountability on the part of hospital executives to know what they are doing and why with respect to the uninsured, (c) accountability on the part of the board of directors/trustees and (d) addressing the issue of fairness in respect to both pricing and the ability of patients to work directly with hospitals.

Interviewed by phone, an official of the Minnesota Hospital Association stated that it was the Association's goal to mitigate these controversies while, at the same time, enable hospitals to collect more money from the uninsured population.

That's right...collect more money!

III.

Conclusions and Recommendations

Even though on the surface the events in the winter and spring of 2003 caused many hospitals and hospital trade associations to go on the defensive, these events actually represented a unique series of opportunities to bring to the forefront a national issue and address that issue in a way that, ultimately, would benefit hospitals and patients alike.

Overpricing to and suing the uninsured has not and never will generate large amounts of revenue to hospitals; my interest is 'net cash flow' coming into hospitals – not collection agencies and not law firms. Even more, the proliferation of a class of people afraid to go to emergency rooms that, under current law, must treat them sooner or later, is not good for those people or for those hospitals.

Hospital associations recently supported the "Cover the Uninsured Week" but I have found that among advocates for the uninsured this support is viewed as hypocritical as long as hospitals practice the essential unfairness of overpricing to and then suing them, even leaving aside the glaring juxtaposition of these practices alongside hospitals' and hospital associations' own mission statements.

Unfortunately, during the past two years there has been an enormous amount of energy, effort and money spent on proving 'the inalienable right' of hospitals to overcharge and sue the uninsured in various litigation and administrative venues. To the astute risk analyst, the controversy over the uninsured – a high risk/low return population – is an unnecessarily destructive controversy now fraught with multifaceted negative ramifications, up to and including inquiries into the tax-exempt status of hospitals themselves.

One cannot turn back the clock, but perhaps one can acquire a more dispassionate, businesslike and less defensive demeanor and do the things that should have been done in 2003 to get serious dialogues going with both advocates for the uninsured and the necessary governmental agencies. It is not too late for a change in attitude and actions by hospitals and, in particular, the national hospital trade associations.

A good start might be to listen to the common sense of hospitals' own patient account representatives who send a message about the link between the perception of fairness and good business. The American people are not stupid; the inherent unfairness of the current situation has resonated with the public, the press and the politicians. But Americans are also a forgiving people, able to give those who own up to their mistakes a lot of leeway.

My interest is in: (a) getting more money paid into hospitals by the uninsured by virtue of treating them more equitably and (b) positioning hospitals and the uninsured to be allies in the struggle for true national health care payment reform, the need for which in so many ways these controversies evidence.