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INTRODUCTION

Standard hospital practices generate billions of dollars of artificially inflated debt for the uninsured each year. The indebtedness falling in the gap between charge levels and what patients can afford is simultaneously painful to patients and worthless to providers. Fortunately, the dysfunctional nature of this debt – bloated, unintended, unvalued, uncollectible – creates an opportunity for hospitals to solve a problem of their own making.[1]

Two distinct phenomena are at play. First, hospital rates are set at unduly high levels for reasons that have little to do with the uninsured. Underpayment by Medicare and Medicaid, and the seemingly benign tradition of billing all accounts based on a single set of charges, inevitably produce cost-shifting and disproportionate debt for the uninsured. Patients become collateral damage in a price-setting process aimed primarily at propping up revenues from the shrinking number of commercial payers that pay hospitals based on a percentage of charges. Second, hospitals fail to identify millions of charity-worthy patients who do not successfully navigate the financial assistance application process.

Remarkably, hospitals have solutions on both fronts. The key to solving this crisis is shifting the focus away from intractable problems – *e.g.*, high health care costs – and concentrating instead on the ability of individual hospitals to reduce the personal liability borne by the uninsured. Specifically, inflated charges can be addressed with **uninsured discounts**, and the "falling through the cracks" problem can be reduced, even totally solved, using robust **presumptive eligibility** techniques.

As discussed below, by increasing utilization of two proven remedies hospitals can deliver real relief, while reducing their legal exposure for burying patients in inflated debt.

I. UNINSURED DISCOUNTS – MAXIMUM RELIEF AT LITTLE OR NO EXPENSE

At its core, a hospital's patient accounting function captures the charges for all services provided to the patient, establishes the starting balance based on the chargemaster rates, and posts payments and adjustments (write-downs) in order to "bring the account to zero." The dollars falling in the spread between the original balance and what is paid by

[1] CGP advocates on behalf of uninsured patients with respect to hospital affordability issues. This paper does not address the challenges posed by copay/deductible obligations of patients with insurance or government benefits.

Medicare, Medicaid, and commercial payers are adjusted off and disappear. But for uninsured patients who do not secure financial assistance, the full balance lives on as inflated personal debt.

Hospital financial officers understand how little is collected from the uninsured – pennies on the dollar is often a fair characterization – and they know the folly of billing the uninsured for the full charge amount. The "softness" of the dollars of receivables falling in that spread – irrelevant on most paid accounts, uncollectible on others – creates a powerful opportunity to eliminate massive debt through the use of an uninsured discount. This particular type of discount, which is used at many hospitals, is broad and automatic (or at least presumptive), and does not depend on completion of an application for financial assistance or calculation of household income.

Under the Affordable Care Act, the federal government made a nominal attempt to counteract the inequities of payment disparity through limited use of mandated discounts. Pursuant to IRS regulation (26 CFR § 1.501(r)-5), each non-profit hospital must cap the amount billed to "any individual who is eligible for assistance under its financial assistance policy" at no more than the "amounts generally billed" (AGB), *i.e.*, the average percentage of total charges paid by the hospital's primary payers (Medicare, Medicaid, commercial payers).[2] Clarifying a potential ambiguity, this "limitation on charges" discount applies to accounts of patients who are **determined** eligible for assistance.

The AGB regulation has proven weak for multiple reasons. First, although payment disparity affects the entire industry, the federal AGB limitation only applies to non-profit hospitals. Beyond that, calling for a discount at least to the AGB level only helps the small pool of patients who receive **partial** financial assistance. In addition to being irrelevant to those patients who secure 100 percent write-offs, the AGB restriction offers no relief to (i) the large numbers of patients who are ineligible for financial assistance, and (ii) those who would have qualified based on their financial circumstances but failed to jump through the hoops of the application process.

The regulatory effort may have fallen short, but the value of discounting is clear, and the benefits are easily realized. With knowledge of its collection track record, a hospital can use a one-sentence uninsured discount provision to slash debt with little or no sacrifice of revenues. In fact, the cost-benefit analysis is so straightforward that whether a hospital uses an uninsured discount serves as a litmus test of its sensitivity to the plight of the uninsured.

With so much patient debt made up of these almost illusory dollars of receivables, CGP set out to determine the extent to which hospitals are using uninsured discounts to flush those dollars out of the system. We reviewed the outward-facing website profiles and

[2] In the hospital finance world, the "amounts generally billed" label is a misnomer since the "billed" amount is always the sum of the itemized charges at the standard rates, regardless of payer or eventual payment amount. The AGB regulation describes an average "payment" or "reimbursement" amount, not an average "billed" amount.

financial assistance policies of over 3,000 hospitals. Based on that review, we categorized hospitals and their uninsured discount policies, as follows:

Hospitals	Policy
62%	no uninsured discount
19%	discount similar to managed care reimbursement, or to AGB
10%	discount to a stated percentage of charges (average 57%)
4%	discount to an unstated amount
5%	ambiguous (*e.g.*, possible discount, or discretionary)

These results are disappointing. First, with roughly 2/3 of hospitals not extending any automatic uninsured discount, most patients who do not secure financial assistance end up owing 100 percent of the billed charges. In stark contrast, across our broad sampling, we found that hospitals accepted an average of 21 percent of charges from Medicare, and an average of 28 percent from all institutional payers (Medicare, Medicaid, commercial payers). Hospital leaders understand that the rate setting process creates unwarranted debt for the uninsured. A hospital that imposes debt on the uninsured for 100 percent of charges, while accepting far less from institutional payers, should expect backlash.

CGP is optimistic that, if hospitals engage on the issue, they will structure uninsured discounts that are tailored to the realities in their communities. An uninsured discount tied to cost, Medicare payment, or the average payment level for all institutional payers, would represent a low bar for reform, and still deliver massive debt relief. Most industry insiders would acknowledge that even steeper discounts – for example, to a level slightly higher than a hospital's historical return on uninsured receivables – would generate even greater relief with little impact on net revenues.

II. HOSPITALS ARE UNDERUTILIZING PRESUMPTIVE ELIGIBLE TECHNIQUES TO IDENTIFY FACTUALLY ELIGIBLE PATIENTS

Why do so many factually eligible patients fail to secure available assistance? Many application processes are rigid, even intimidating, reflecting a preoccupation with the patient's obligation to fully cooperate, complete the application, disclose every source of income, submit documentation, and prove eligibility almost beyond a reasonable doubt. No one should be surprised that a system that depends on patient engagement, compliance, and a calculated income figure would serve as a barrier to millions of patients. That conclusion is further supported by these data points:

- Per the U.S. Department of Education, 20 percent of consumers are functionally illiterate and cannot complete an application process.
- Per the Federal Reserve, 26 million people live in the "financial shadows," with little means of completing applications and submitting required documentation. The heaviest concentration is in minority, low-income, and young populations.

- Per the Employment Policy Institute, 33 percent of the uninsured are high school dropouts, compared to 7 percent of insured individuals.
- Per the Federal Reserve, 8.7 percent of families do not have bank accounts.
- Per the CFPB, 26 million U.S. adults, about one in ten, are "credit invisible" with no credit record, and another 19 million cannot be scored due to their thin or out-of-date credit histories.

Beyond these subsets, many patients fail to complete applications for a host of other reasons – *e.g.*, they are poor recordkeepers, they object to the hassle and the perceived invasion of privacy, they fear that information could be used against them in the collection process, they worry about jeopardizing their immigration statuses, or they see the application process as futile and are resigned to the consequences of crushing debt.

The causes can be debated, but the existence of the problem cannot be disputed. In fact, the government has imposed a reporting requirement in order to highlight and quantify this precise phenomenon. Under federal law, non-profit hospitals receive tax exemption in exchange for providing "community benefits," including charity care, which are reported on IRS Form 990, Schedule H. In addition to data relating to documented financial assistance, on Schedule H (part III, section A, line 3) the federal government requires each non-profit hospital to estimate the cost of care provided to factually eligible patients who did not receive financial assistance.[3] The wording of line 3 is ambiguous, certainly to laypersons, but the accompanying instructions are quite clear, as follows (emphasis added):

> Line 3. Provide an estimate of the amount of bad debt reported on line 2 that reasonably is attributable to **patients who likely would qualify for financial assistance** under the hospital's financial assistance policy as reported in Part I, lines 1 through 4, **but for whom insufficient information was obtained to determine their eligibility**. … Organizations can use any reasonable methodology to estimate this amount, such as record reviews, an assessment of financial assistance applications that were denied due to incomplete documentation, analysis of demographics, or other analytical methods.
>
> Describe in Part VI the methodology used to determine the amount reported on line 3 and the rationale, if any, for including any portion of bad debt as community benefit.

Without question, Schedule H calls for an estimate of the cost of services for **patients who would have been determined eligible** for assistance if the hospital had collected more information.

[3] Line 3 reads: "Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit." (Part III, Bad Debt, Medicare & Collection Practices, Section A (Bad Debt Expense), line 3).

Based on our review of Schedule H submissions, including the line 3 estimates, we assess that, in a single year, non-profit hospitals imposed over $20 billion in unintended debt on factually eligible patients. Since the same phenomenon also exists in the for-profit hospital sector, that figure undoubtedly understates the size of the problem.

Reform efforts in recent years have shown that effective presumptive eligibility techniques are critical to fixing this breakdown. Many hospitals have incorporated the concept into their financial assistance policies. Their approaches generally fall into the following categories:

- **Discretionary** – Some policies simply announce the hospital's broad discretion to determine eligibility without a completed application.

- **Attestation** – A financial assistance plan may waive the normal application requirements based on the patient's attestation of low income/resources.

- **Life circumstances** – A hospital may classify accounts as charity care when patients are, for example, homeless, mentally ill, bankrupt, or deceased.

- **Eligibility for other means-tested programs** – Financial assistance is often extended to individuals who have already qualified for some other identified government programs (*e.g.*, WIC, TANF, SNAP, subsidized housing).

- **Income and propensity-to-pay scoring tools** – Multiple tools, often offered based on credit reporting data, provide hospitals with a patient's individualized financial score based on a "snapshot" of his or her financial circumstances.

- **Predictive analytics** – Certain vendors offer sophisticated analytics as a means of processing vast amounts of data (publicly regulated data, not social media) in order to determine whether individual patients are likely to qualify for financial assistance under the hospital's eligibility guidelines.

These techniques offer widely varying effectiveness in reaching patients who are non-compliant or living in the financial shadows. For example, waiving the application requirement only for the homeless is highly restrictive. Extending assistance to patients based on their enrollment in some other means-tested program makes sense, but relief still depends on a patient's completion of an application process. Credit scoring and propensity-to-pay tools are inherently limited and, in the case of credit scoring, they miss an estimated 40-50 million U.S. adults who do not have credit scores. A catch-all waiver based on the hospital's discretion obviously could fall anywhere on the spectrum of effectiveness.

The use of predictive analytics plainly represents the gold standard for presumptive eligibility. In fact, some hospitals have reported to IRS that, using analytics, they are able to identify all factually eligible patients, even without completed applications.

As part of our review of the practices of hospitals we categorized and rated the strength of their approaches to presumptive eligibility, as follows:

Hospitals	Characterization of reliance on effective presumptive eligibility
33%	no apparent use of presumptive eligibility
10%	weak use of presumptive eligibility
12%	moderately strong use of presumptive eligibility
45%	strong use of presumptive eligibility

By our assessment, hospitals with a "strong" approach rely on a combination of analytics and/or scoring tools, the patient's enrollment in other means-tested government programs, and life circumstances (*e.g.*, homelessness, mental illness, death without estate).

In summary, some hospitals have solved the financial assistance delivery breakdown, others use partial measures, and many have not even tried. These findings support the conclusion that reliance on presumptive eligibility is still new enough, and still under-valued enough, that major debt relief and improved affordability can be generated by persuading more hospitals to get on board, and by urging all providers to be more aggressive.

III. USE OF THESE SOLUTIONS CAN REDUCE LEGAL EXPOSURE

Not surprisingly, the obvious unfairness of billing the uninsured at full chargemaster rates has triggered many litigation challenges. Any analysis of the prospective risk of litigation to hospitals should consider two separate categories of legal claims – (i) the traditional arguments, often framed in terms of contract or restitution, that a hospital has over-charged individual patients, and (ii) the totally distinct claim that a hospital has failed to use an uninsured discount as mitigation for artificially inflated rates.[4] Whether a hospital uses an uninsured discount is largely irrelevant to the first category of litigation, but almost dispositive with respect to the second set of claims.

By way of background, at least in cases where the patient has not negotiated a price and signed a binding contract, courts routinely conclude that the patient owes the reasonable value of the services provided, not the billed chargemaster rates.[5] In a case involving a single patient account, and a manageable number of billed charges, it is conceivable that the litigants could efficiently present evidence aimed at proving the reasonable value of the services provided. That analysis would likely look at the prices charged by other hospitals,

[4] Similar reasoning would apply to arguments based on a hospital's failure to use presumptive eligibility techniques.
[5] For a discussion of these issues, see George Nation III, *Contracting for Healthcare; Price Terms in Hospital Admission Agreements*, 124 Dick. L. Rev. 91 (2019) (https://ideas.dickinsonlaw.psu.edu/dlr/vol124iss1/4). The article argues that, in the absence of an enforceable contract, the amount due should be the fair market value of a hospital's services, represented by the average paid to the provider by other payers (*e.g.*, the hospital's AGB).

the amounts paid to the hospital by other payers, the hospital's cost structure, and other indicators of the value of the services. Presenting the evidence might be expensive, but in a narrowly defined case the odds of showing that the charges are excessive would be high.

However, since this approach focuses on the difference between specific billed charges and the reasonable value of the underlying services, the plaintiff's burden necessarily grows as the number of accounts and billed charges increases. Not surprisingly, this account-specific strategy has made it especially difficult for plaintiffs to challenge hospital charge levels in class action lawsuits.

Hospitals should expect that future legal challenges to the unfairness of hospital billing will be structured to avoid these obstacles. An alternative strategy would shift the attention away from individual accounts, and focus instead on a hospital's policies. Since the only reason that hundreds of hospitals use uninsured discounts is out of fairness to the uninsured, it is easy to argue that any hospital that does not use an uninsured discount – *i.e.*, that imposes debt at the undiscounted level of full billed charges – is perpetuating the unfairness of inflated charges to patients.

The resulting litigation would look very different. We have seen that the traditional allegations create the almost insurmountable challenge of calculating the difference between the billed charges on an entire class of individual accounts and the reasonable value of the underlying services. By contrast, future plaintiffs using the alternative strategy would allege that a hospital's failure to use an uninsured discount constitutes an unfair business practice in violation of consumer protection laws. The issue would be the fairness of a policy, not the reasonable value of specific hospital services. Litigation based on this approach would present the following substantive allegations:

- With a single set of charges, but with payments being accepted at different levels, a hospital necessarily has to adjust, or write down, its charge balances on individual accounts in order to reconcile its nominal rates with affordability considerations (*i.e.*, what the payer can or will pay). Is it an "unfair business practice" for a hospital to adjust the charge balance on Medicare accounts, adjust the balance on Medicaid accounts, adjust the balance on commercial payer accounts, and adjust the balance on accounts of the uninsured who secure financial assistance, but **not** use an uninsured discount to adjust the balance on accounts of all other uninsured patients?

- Is it an "unfair business practice" for the defendant hospital not to adjust uninsured accounts as a matter of fairness when hundreds of other hospitals have implemented uninsured discount policies for that precise purpose?

In order to determine the damages suffered in litigation based on this alternative strategy, the court could consider evidence of the reimbursement levels received by the hospital from other classes of payers, as well as the discount levels in place at other hospitals. Based on

that evidence, the court could arrive at a reasonable uninsured discount level for that hospital. Once established, that discount could easily be applied to all accounts included in the class.

IV. HOSPITALS CAN EASILY MINIMIZE THE RISK OF MORE GENEROUS FINANCIAL ASSISTANCE REFORMS

Hospitals need not worry that aggressive discounts or presumptive eligibility techniques might backfire, encouraging patients to over-utilize services, or disincentivizing people from buying insurance or applying for Medicaid.

First, it is well understood that lack of insurance is a function of affordability, not choice. People will want insurance if they can get it, and they will still view Medicaid as a desirable fallback. The benefits of full coverage for patients, and of expanded reimbursement for hospitals, will always incentivize patients and hospitals to prefer more durable coverage over episodic financial assistance for individual hospitalizations.

Beyond that reality, hospitals enjoy the flexibility to protect themselves and support positive incentives. Most hospitals would not be overly concerned about the revenue implications of discounting uninsured balances to the average percent of charges paid by their institutional payers (*e.g.*, to the AGB), or even further. Every hospital can directly address that risk as it decides on a discounting policy. With charge levels so high, and the amounts currently paid by the uninsured so low, there is plenty of room to extend steep discounts without hurting revenues or disrupting patient incentives.

The same is true with presumptive eligibility. For many years hospitals around the country have employed a variety of presumptive eligibility techniques. With customary due diligence, hospitals can weigh the expense, feasibility, and effectiveness of their options.

Although our review of financial assistance policies revealed little of this concern, hospitals can also control the risk of extending relief to undeserving patients by framing their uninsured discounts and other assistance as “presumptive,” or by reserving discretion to tailor relief to individual circumstances. The simple fact that hundreds of hospitals already employ uninsured discounts and presumptive eligibility should offer assurance to hospitals contemplating use of these measures.