Chapter 6

The American Hospital: Charity, Public Service, or Profit Centre?

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The United States has the most expensive health system in the world, costing over 17% of the country's gross national product. Of the nation's total health costs, slightly less than half is paid through the public sector (especially the programmes Medicare and Medicaid), and slightly more than half through the private sector (especially private insurance companies). The largest portion of health spending (33%) goes to hospitals, about 80% of which are designated non-profit. U.S. hospitals receive 60% of their income from taxpayer funds, and have an average profit margin of 8%. Despite its massive health expenditure, 27 million people in the U.S. have no health insurance.[1]

This brief statistical overview highlights some of the major paradoxes of the American health care and hospital systems. As Rosemary Stevens writes in her unsurpassed study *In Sickness and in Wealth*, '[t]he essential dilemma for American hospitals is that they are both public and private.'[2] The vast majority of hospitals are privately owned and operated, but receive a large part of their revenues from public spending. In addition, hospitals work both to serve the

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public, and to generate profits. The complex funding mechanisms and contradictory missions of U.S. hospitals have resulted in high costs and serious obstacles to universal access.

This chapter examines one particular aspect of the paradox: U.S. hospitals' obligations to serve those who cannot pay. While hospitals' commitment to the poor has changed dramatically since the nation's founding, these institutions are still expected to provide some uncompensated care, or 'charity', for the many Americans who fall through the system's gaping holes. The paradox has only intensified as hospitals partially transformed from charities to profit centres, and as funding sources moved from voluntary donations to patient fees and public and private insurance. After briefly tracing the history of these transformations, this chapter will focus on the period since 1970 to examine how the public, media, and government have responded to the tension between hospitals' profit-making and charity-giving roles. The failure of the United States to adopt universal coverage has led to the continuing practice of channeling public funds to private institutions that provide what is still called 'charity care.'

The Hospital Paradox

Hospitals in the United States fall into three general categories: voluntary (now called non-profit), public, and for-profit. The first voluntary hospitals, based on the British model of private 'non-profit institutions funded by philanthropy or patients' contributions',[3] opened in Philadelphia and New York in the two decades before the American Revolution. Public institutions run by local governments also have a long history in the U.S., including almshouses or poorhouses (which sometimes served a health care function), municipal and county

hospitals, and state insane asylums. The federal (national) government funded marine hospitals for the care of sick and disabled sailors and, by the twentieth century, a system of hospitals for veterans. A third category, proprietary or for-profit hospitals, emerged in the late nineteenth century. Until the 1970s, most proprietary hospitals were small, and owned by physicians.[4]

But these categories do not capture the complex and shifting mixtures of funding sources and patient populations that characterise most hospitals in the U.S. The voluntary hospital, especially, has been a tangle of contradictions. Founded to provide free care to the indigent poor, by the late nineteenth century most had also begun accepting paying patients (in part to fund their charity services). And, although heavily dependent on individual donations, voluntary hospitals were never entirely private; state and local government contributions to these types of hospitals were common throughout the 1800s. Private charity coexisted with traditions of local government responsibility for paupers or the indigent that dated back to the Elizabethan Poor Law.[5]

Despite this long tradition of public support, voluntary hospitals vigorously asserted their autonomy from government interference, particularly their right to choose which patients to accept. This was especially true in the case of racial segregation: the widespread refusal of voluntary hospitals to accept patients of colour led to the establishment of separate institutions, owned and run by African Americans, by the late nineteenth century.[6] The ideology of voluntarism also played a powerful role in the defeat of proposals for compulsory health insurance legislation in the 1910s, when it was invoked by hospitals, physicians, and business leaders alike, who all insisted that government intervention would erode individual choice in medical care.[7]

Hospitals' mixing of public and private intensified during the Great Depression, when private voluntary hospitals insisted that they deserved increased funding from the government to meet the heavy

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demand from patients who could not pay. Some threatened to close their doors if state subsidies were not forthcoming. In 1934, the American Hospital Association declared that 'local government funds should be used to pay for service in voluntary hospitals' because 'the care of the indigent sick is the fundamental responsibility of government bodies.' Government responded, and by 1935, the amount received by U.S. voluntary hospitals from state and local tax funds had surpassed their receipts from private charitable giving. But the increase in government funds did not disturb the voluntary hospitals' private orientation, and indeed inspired them to reassert it. As one administrator said, hospitals should 'welcome governmental assistance to aid us in rendering help, but never permit Government to control us.'[8]

This blend of public funding and private control would find its greatest expression in the post-war federal hospital construction programme known as Hill-Burton, which emerged out of fight for national health insurance led by President Harry S. Truman from 1945 to 1950. Conservatives in Congress sought to forestall a national programme by supporting only one part of the proposal, hospital construction, that would expand access but fall far short of universal coverage. The Hill-Burton Act aimed to use federal, state, and local funds to build new hospitals in the 40% of U.S. counties that lacked them. By the end of the twentieth century, Hill-Burton would help finance 6,800 hospitals, health centres, and nursing homes in 4,000 communities around the country. Although the post-war hospital system was built with government dollars, Hill-Burton preserved hospitals' managerial autonomy by law, and even allowed Southern hospitals to continue the practice of Jim Crow racial segregation until the mid-1960s.[9]

Since Truman's national health insurance proposal was defeated, hospital construction was not accompanied by any provision for people to pay for care in the new hospitals. Hospitals themselves

had already invented the Blue Cross system of service benefits for hospital care, at the beginning of the Great Depression. Throughout the 1940s and 1950s, private health insurance, including Blue Cross, Blue Shield for physicians' fees in the hospital, and commercial indemnity insurance, paid for a large and growing portion of care in hospitals (and inarguably helped encourage overuse of hospitals and subsequent inflation of hospital costs).[10] Labour unions, which had previously supported national insurance, in the 1950s decided to focus on obtaining Blue Cross or commercial hospitalisation coverage for their members through collective bargaining. This shift, alongside federal regulations that gave favorable tax status to employer-provided insurance, unintentionally created the distinctive U.S. system of health insurance tied to employment.[11]

But private health insurance left out large portions of the population: the poor, workers in jobs without benefits, and especially the elderly. Hospital and insurance officials warned that if a way was not found to cover these vulnerable groups, the government would have to step in. Their predictions came true when Medicare (social insurance coverage for people age 65 and over) and Medicaid (state-federal coverage for the poor) were approved by Congress in 1965 as part of President Lyndon B. Johnson's 'Great Society'.[12]

While bringing health coverage to millions for the first time, Medicare also proved to be a financial windfall for hospitals. Thanks to extensive lobbying by the medical profession and hospital industry, the legislation expressly forbade any regulation of physicians' fees or hospital costs. Hospitals would charge Medicare 'retrospectively' (after services were delivered) for what hospitals themselves deemed 'reasonable costs', plus an additional 2% (known as 'cost plus'). In the decade following Medicare's passage, the average cost per patient per day more than doubled, and hospitals' total assets rose from $16.4 billion to $47.3 billion. Alongside the growing costs of

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medical care in general (due to new technologies and treatments, higher labour costs, and overall inflation), Medicare payments to doctors and hospitals helped drive the rise in national health expenditures from $198 per capita in 1965 to $336 by 1970.[13]

The American Medical Association had hired actor Ronald Reagan in 1961 to decry the Medicare proposal as a herald of socialism.[14] But, as Rosemary Stevens has explained, Medicare's massive infusion of government funding had the ironic effect of making hospitals behave even more like private businesses. 'Market-oriented behavior,' Stevens writes, 'was a rational response by hospitals to the structures and incentives built into Medicare' that allowed hospitals to bill for whatever and how much they wished. One result of Medicare's 'golden river of money' was to 'bring hospitals into prominence as enterprises motivated by organizational self-interest, by the excitement of the game, by greed.'[15]

Medicare's largesse also encouraged for-profit hospitals to enter the game. To the nation's small sector of physician-owned proprietary hospitals were added new, massive investor-owned hospital chains, which appeared for the first time in the late 1960s directly as a result of Medicare's willingness to reimburse at cost plus— 'Essentially, the federal government gave hospitals a blank check', as business writers Sandy Lutz and E. Preston Gee put it. Copying the business model of successful hotel and fast-food chains, a new investor-owned hospital sector grew quickly. By 1971, the for-profit Hospital Corporation of America (later known as Columbia/HCA) owned 23 hospitals, and competed with 37 other investor-owned health care conglomerates.[16]

In 1980, Arnold Relman, editor of the influential *New England Journal of Medicine*, warned of a new 'medical industrial complex', 'a large and growing network of private corporations engaged in the business of supplying health-care services to patients for a profit.' Relman saw dangers in the inherent contradictions between health care as a market product and as a public good. He argued that

corporate health care was at odds with the goals of cost control and improved health outcomes, because profit-making providers had no incentive to reduce utilization or to treat uninsured or very sick patients. Finally, the medical-industrial complex (as President Dwight D. Eisenhower had earlier cautioned of the military-industrial complex) could exercise 'unwarranted influence' in politics, and especially might use its new power to block regulation and comprehensive reform.[17]

Relman was certainly correct that for-profit providers would build powerful lobbying organizations and hold considerable influence over health politics.[18] But in contrasting corporate hospital chains with a non-profit sector that served as the bastion of public service and patient-oriented care, Relman's picture of the medical-industrial complex missed an even more momentous transformation: non-profit hospitals were rapidly adopting the practices of their for-profit competitors.[19]

Medicare's funding structure, as noted earlier, had already encouraged non-profits to seek ways to maximise reimbursements. As large corporate chains began to compete for patients and Medicare dollars, non-profit hospitals joined the cutthroat business game of the 1980s. Policy scholar Bradford R. Gray has noted that non-profits increasingly behaved more like for-profits throughout the decade, including moving into activities previously anathema to the charity sector like advertising and marketing, borrowing to fund capital improvements, subcontracting services, and merging and acquiring other hospitals. 'Business terminology and business thinking have pervaded the non-profit hospital world', Gray concluded in his 1991 study.[20]

One result of this increasing business orientation was a shift in hospitals' rhetoric about their role in the community. For example, Children's Memorial Hospital, a longstanding charitable institution

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in Chicago, issued a new mission statement in 1980 intended to 'bring Children's into the reality of the eighties.' Replacing its 1886 statement that Children's was 'dedicated exclusively to the free care and treatment of children from three to thirteen years of age', the reworded mission promised '[t]o provide infants and children the maximum quantity and quality of comprehensive health care within the available resources of the hospital.'[21]

Health writer Elisabeth Rosenthal describes a similar change of language in her description of a non-profit Catholic hospital's 'journey from charity to profit.' In the 1980s, Providence Hospital in Portland, Oregon altered its mission statement to include 'stewardship' of resources alongside more traditional religious hospital notions of justice and compassion. The Catholic nuns who ran Providence went to school for business degrees, increased the size of administration, and hired professional 'coders' to maximise Medicare billings. The hospital used borrowing and profits to invest heavily in capital 'improvements', including a lobby that welcomed patients with 'marble columns', 'a fountain with jumping salmon', and 'expensive art'. In 2013 Providence's chief executive officer was paid $3.5 million a year.[22]

In that same year, 7 of the 10 most profitable hospitals in the U.S. were 'non-profit'.[23] What, then, is the distinction between for-profit and non-profit hospitals? How have the majority (around 80%) of hospitals remained officially 'non-profit',[24] even as their profit-seeking behaviors vastly increased? In order to retain the desirable legal designation of tax-exempt charitable organizations, non-profit hospitals have had to meet certain requirements, known variously as 'charity care', 'community service', 'community benefit', and 'uncompensated care' obligations. While rooted in hospitals' charity origins, these requirements and their definitions have changed significantly over time.

Caring for the Poor: From Charitable Mission to Regulatory Requirement

'Charity' meant two somewhat different things in early U.S. hospitals. Hospitals themselves sought charitable gifts from wealthy donors and the general public to maintain buildings, pay staff, and establish endowments. At the same time, voluntary non-profit hospitals existed to *provide* charity to the deserving poor. Pennsylvania Hospital was founded in 1757 'for the relief of the sick and miserable', and its seal depicted the story of the Good Samaritan.[25] This dual charitable tradition—as receiver and giver of charity—continued even as voluntary hospitals increasingly admitted paying patients starting in the late nineteenth century.[26]

The definition of a charity hospital has never been fixed. For the nineteenth and good part of the twentieth century, hospital charitable status was based on a vague notion of 'public benefit'. As Rosemary Stevens describes it, hospitals 'did not have to offer services necessarily, or even primarily, to serve the poor… It was assumed, rather, that the act of benevolence itself…should be recognized' by charitable exemption.[27] In 1956 the Internal Revenue Service issued more specific standards for charitable hospitals, requiring them to provide 'free or reduced-care to patients unable to pay', but only within the hospital's financial ability. A little over a decade later, in 1969, the IRS eliminated this 'charity care standard' altogether, and issued a new 'community benefit standard' that allowed hospitals offering services to the community, such as an emergency room, to receive the charity designation even if they did not provide free care.[28] This change came in response to lobbying by the American Hospital Association, which had 'pushed hard for a Congressional amendment to the tax laws that would give hospitals tax exempt status' without requiring that they give free care to the poor. The Senate defeated the amendment, but it was promulgated as an IRS regulation instead, not requiring Congressional approval.[29]

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Earlier, the Hill-Burton Act had created a requirement that hospitals must provide a 'reasonable volume of services' to 'persons unable to pay therefore' in order to be eligible for federal hospital construction funds. These conditions, which became known as the 'uncompensated care' and 'community service' clauses of Hill-Burton, were a nod to congressional advocates of universal access, but at the same time preserved hospitals' traditional autonomy in choosing to provide free care to those who could not pay. But the Hill-Burton Act offered no mechanism to enforce these requirements, and they went virtually ignored for two decades.

The passage of Medicare and Medicaid, alongside the surging movement for racial equality in the 1960s, led to new demands that hospitals actually meet their charity care and community service obligations. The struggle to racially integrate American hospitals had proceeded later but more swiftly than school desegregation. In 1963, a federal court ruling (*Simkins v. Cone*) declared that the Hill-Burton Act's funding of segregated hospitals violated the Fourteenth Amendment of the Constitution guaranteeing equal protection.[30] The Civil Rights Act of 1964 banned federal funding for entities that practiced discrimination, and but it was Medicare in 1965 that finally forced hospitals to stop blatant racial segregation, since hospitals found to be discriminating would be denied the new Medicare funds.[31]

Civil rights laws, however, focused entirely on *de jure* racial discrimination and did not attempt to address the poverty that disproportionately affected African Americans. Anti-poverty advocates saw greater potential in the federal-state Medicaid programme, created in 1965 alongside Medicare. Medicaid was intended to provide comprehensive health coverage to the poorest of the poor—those who were already receiving welfare (public assistance), particularly single mothers with small children. But Medicaid fell far short of universalism in two ways. First, states could decide their own eligibility requirements, and these requirements could be so stringent as to exclude many low-in-

come people. Medicaid therefore did not eliminate the need for charity or indigent care, and in fact led to a new definition of 'indigent' as a patient too poor to pay for medical care, but ineligible for Medicaid. Second, physicians and hospitals were not required to accept patients with Medicaid (neither were they required to accept Medicare patients, but Medicaid reimbursement was far lower).[32] Because the poorest were in so many areas of the country disproportionately women of colour, hospitals' ability to refuse Medicaid patients in effect allowed them to continue to practice racial and economic discrimination.

In 1970, a landmark lawsuit in New Orleans, Louisiana challenged hospitals' refusal of low-income people. Crusading civil rights attorneys brought the suit, *Cook v. Ocshner*, as a class action on behalf of a group of poor African-American women who had been turned away from New Orleans hospitals, either because they could not pay a cash fee or because they were Medicaid recipients. The suit targeted ten hospitals that had received a total of $18 million in Hill-Burton funds. The Louisiana district court ruled that the hospitals' policy of 'sparingly admitting or refusing Medicaid patients clearly discriminated against a very substantial segment of the public and violated the 'community service' obligation under the [Hill-Burton] Act.'[33]

In response to *Cook v. Ochsner,* the federal government created new regulations in 1972 requiring Hill-Burton hospitals to devote three per cent of their operating costs to uncompensated care (the original proposal was for five per cent) and to open their doors to patients with Medicaid coverage. But would hospitals comply? Legal aid attorneys predicted that '[c]onsumers will undoubtedly still have to take an active role in enforcing the [free care and community service] requirement… after all[,] the requirement has been around for years, but the major enforcement activity came only after several lawsuits by poor consumers.'[34]

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Holding Hospitals Accountable: Citizen and Government Action

Cook v. Ochsner was just the beginning of a surge of consumer and civil rights activism directed toward hospitals in the 1970s. The next section of this chapter discusses how activist groups and state and local governments responded to the growing tension between hospitals' public-service and profit-making roles by insisting that hospitals fulfill their obligations to provide some care to the poor. As Medicare, Medicaid, and Hill-Burton seemingly increased hospitals' accountability to the public and to the taxpayer, the rise of profit-seeking by hospitals (both non-profit and for-profit) brought these longstanding contradictions into even sharper relief, and new types of activism emerged in response.

Social movements—struggles for change 'from below'—have played a critical role in the United States health system. The civil rights insurgency of the 1950s and 1960s that led to sweeping legal and political changes also spurred reforms like Medicare and Medicaid, which were intended in part to bring the benefits of medical progress to the poor, elderly, and minority groups on a basis of equality. Medicare and Medicaid raised expectations that hospitals would play a role in addressing racial and economic injustices. These expectations led to citizen action that focused on hospitals' obligations to low-income Americans. In 1973 the Health Policy Advisory Committee (Health/PAC), a New Left group dedicated to health care justice, called on advocates for the poor to 'attack… private hospitals when they take public money but leave behind the public responsibility to care for everyone.'[35]

Social activism directed towards hospitals also surged in the late 1960s and 1970s because of a brief period of institutional support from a government agency, the Office of Economic Opportunity (OEO),

which had begun providing legal services to anti-poverty organizations as part of Lyndon Johnson's War on Poverty.[36] OEO attorneys worked with activists from the emerging welfare rights organizations of the early 1970s to bring suits against hospitals that discriminated against the poor. This was the approach that had led to court victories in the *Cook v. Ochsner* case.

While *Cook* invoked Hill-Burton to demand that hospitals treat Medicaid and low-income patients, another legal strategy pointed to non-profit hospitals' tax-exempt status. In a 1971 case, OEO attorneys and citizens' groups in Kentucky filed a lawsuit not against individual hospitals, but against the departments of Treasury and Internal Revenue in Washington, D.C., 'for illegally granting tax exempt status as 'charitable' institutions to hospitals which refuse to treat people who can't pay.' The citizens groups involved in the suit, ranging from welfare rights and tenants' organizations to the Association of Disabled Miners and Widows, alleged that a woman died giving birth at home after the tax-exempt Prestonburg General Hospital 'refused to admit her without a $259 deposit and refused to accept a check for that deposit… The same hospital refused to treat a 5-year-old boy's broken leg because the parents had no money.'[37] By filing suit against the government rather than specific hospitals, though, the plaintiffs overreached, at least according to the U.S. Supreme Court, which ruled they had no standing to sue.[38] Later attempts to use charity tax status to demand care for the poor would focus primarily on individual hospitals (see below).

Activists also demanded strong enforcement of the new 1972 Hill-Burton uncompensated care and community service obligations. In a speech to hospital leaders, Richard H. Mapp of the Urban League, a prominent civil rights group, called the new regulations 'a minimum effort, but it was nonetheless a welcomed effort after a quarter-century of inaction.' Mapp attacked the hospital lobby's undue influence in

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Washington, demanding that lawmakers 'giv[e] as much consideration to the needs and concerns of the poor as is given the hospitals and powerful medical groups who often place their own welfare above the welfare of those less fortunate than they.'[39]

But hospitals continued to find ways to evade free care requirements. In 1975 an investigation of Hill-Burton hospitals in 11 Southern states found virtually no enforcement and little provision of free care, concluding that 'it is clear that the [Hill-Burton charity care] regulations are little more than empty words…'[40] Consumer activists and advocates for the poor continued to press for stronger regulations and launched campaigns to inform patients of their rights to demand free care from hospitals. The community group Alabama Coalition Against Hunger in 1980 distributed 11,000 wallet cards to inform consumers of the Hill-Burton free care regulations. According to organisers, 'Our basic goal…was to make Hill-Burton a household word.'[41]

But Hill-Burton activists had only partial success. In 1978, 73% of hospitals in California, for example, failed to meet the free care regulations. By 1981 that number had decreased, but not by much: 45% of hospitals in the state were still out of compliance, due to 'loopholes, sloppiness and even outright lying', according to health advocates. When a 'flood of groups' including civil rights, senior citizens, and feminist health organizations testified for stronger enforcement, 'a minor furor' ensued when it was revealed that 'San Jose's O'Connor Hospital had no knowledge it was a Hill-Burton facility, despite its receipt of $1.6 million in Hill-Burton funds.'[42] That a hospital itself was unaware of its obligations and its funding source, despite activists' attempt to make Hill-Burton a 'household word', points to the daunting complexity of U.S. hospital financing and its byzantine regulatory regime—obstacles not only to enforcement, but to basic public understandings of how hospitals function, and corresponding difficulties for social movements to effect change.[43]

In the budget-cutting frenzy of the 1980s, the Reagan administration reduced Medicaid reimbursements so severely that hospitals drastically increased 'patient dumping', the practice of transferring uninsured or Medicaid patients from private to public hospitals. In 1984 the city of Chicago experienced a 500% increase in such transfers, from less than 100 to 600-700 a month.[44] Dumping became so widespread that in 1986 Congress created the Emergency Medical Treatment and Active Labor Act (EMTALA), requiring hospitals to examine and stabilise all patients who arrived at the emergency room. While EMTALA reduced but did not completely end the practice of patient dumping, the law cemented the emergency room's role as the only place in the U.S. health care system where access is legally required. EMTALA did not create a new obligation to provide free care; it only requires hospitals to wait to bill patients until after they are stabilised. Since it also tended to increase costs by encouraging expensive emergency room visits, EMTALA was not seen as a victory by health justice advocates.[45]

In the 1980s and 1990s, hospital activists confronted the growing power of the for-profit sector as private corporations like Columbia/Hospital Corporation of America (HCA) acquired hospital systems throughout the country. In Houston, Texas, for example, for-profit giant Humana operated three hospitals, eight clinics, and the group health insurance plan and HMO (Health Maintenance Organization) that financed patient care in all its facilities. This health-care consolidation, reminiscent of the age of Rockefeller, came under criticism by local physicians (and the Health/PAC advocacy organization, which referred to the situation as 'Humana-izing Health Care'). In response, Humana agreed to lease out management of the clinics, but retained control over its hospitals and health insurance plans.[46]

Advocates feared that the growing power of for-profit hospital corporations would lead to further abrogation of hospitals' responsibilities to the poor. In Kentucky, Humana's corporate home

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state, the firm owned seven hospitals but refused to pay into a state 'Fair Share' fund to 'spread the burden of caring for the uninsured.' Humana insisted that it contributed to care of the poor 'by paying taxes on the money it makes, and by treating indigents at [Louisville's] University Hospital.' Indeed, Humana paid the state $6 million annually to rent the formerly non-profit University Hospital. But a newspaper investigation found that almost the entire $6 million actually went right back to Humana in the form of state payments for indigent care. Humana Chairman David A. Jones defended his company's practices, stating that '[i]ndigent care is a societal problem that must be solved by government, not the hospital industry.' The Louisville *Courier-Journal* pointed out that Humana earned $193 million in profits in 1984 and paid Jones $18.1 million, making him the second-highest paid executive in the country.[47]

Humana would eventually sell its hospitals and move into the more lucrative health insurance business, but its rival Columbia/HCA soon took its place as the for-profit nemesis of the consumer movement. By the mid-90s Columbia/HCA owned 350 hospitals throughout the country and took in $20 billion in revenues. As the chain continued to aggressively pursue new acquisitions, some communities began to push back. Rhode Island's attorney general cancelled Columbia/HCA's attempted 1997 purchase of a non-profit hospital after protests by senior citizens and nurses' organizations and an investigation by state representative Patrick J. Kennedy (son of Edward Kennedy and nephew of JFK).[48]

When advocates failed to prevent for-profit acquisitions, they demanded promises of continued charity obligations from the new owners. In the late 1990s HCA/Columbia acquired two major nonprofit hospitals in San Jose, California and proposed merging them. Consumer groups sought a commitment to 'more free medical care for San Jose residents as part of the hospital transfer.'[49] When two for-profit giants

(Vanguard and Tenet) vied to purchase non-profit Allegheny Health Network's bankrupt chain of Philadelphia hospitals in 1998, protesters under the banner of 'Coalition for Patients Not Profits' declared 'We must send a loud and clear message to the new owner of Allegheny that we intend to protect our indigent poor.' The Coalition, which included senior citizens, welfare rights, and provider groups, demanded that the new owners not close hospitals or reduce service and 'maintain an obligation to provide care for the indigent.'[50]

Absent Hill-Burton funding and tax exemptions, for-profit hospitals had no official or enforceable requirements to provide care to the uninsured (except for emergency care). When for-profits entered hospital markets, activists and local governments tried to extract guarantees of commitment to the poor via ad hoc agreements and simple promises. Such arrangements were even more difficult to enforce than the anemic Hill-Burton and IRS requirements. As with non-profits, some for-profit hospitals provided a notable amount of free care, some (like Humana) very little (exact amount are impossible to measure due to, of course, little to no enforcement and scattershot reporting requirements).[51] In the new millennium, debates over the for-profit sector's contribution to charity care faded as public attention turned to new scandals. In 2000, Columbia/HCA paid $95 million to settle multiple accusations of fraud, which included massively overbilling Medicare and providing financial rewards to physicians who referred patients to HCA hospitals. Leaders of HealthSouth Corporation, which owned rehabilitation hospitals and clinics throughout the U.S. South, actually went to prison in 2006 for accounting fraud and bribery.[52]

Despite their aggressive acquisitions and high-profile antics, for-profit hospitals did not come to dominate the U.S. health system. After many selloffs, and with some big players (such as Humana) abandoning the industry altogether, today for-profits constitute only about 25% of all community hospitals.[53] The tension between hospitals'

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charity and profit missions would reach a boiling point not in the for-profit sector, but the non-profit, as the revenue-maximizing behavior of an esteemed academic medical centre led to a public outcry.

The scandal involved the Yale-New Haven Medical System in Connecticut, which included Yale University's storied hospital and medical college as well as other non-profit hospitals around the state. In the 1990s, Yale-New Haven adopted new, aggressive collections tactics to recoup money owed by former patients. These practices became national news when the *Wall Street Journal* reported the story of a 77-year old New Haven man who still owed the hospital tens of thousands of dollars for his late wife's cancer treatment. Yale-New Haven 'sued him, put a lien on his house and seized most of his bank account.'[54] The hospital system took uninsured former patients to court, garnished up to 25% of their paychecks, and even forced them to foreclose on their homes. Connecticut labour unions and anti-poverty advocates who publicised these stories emphasised how Yale-New Haven's harsh tactics stood in sharp relief against its status as 'a non-profit, charitable teaching hospital…the largest, most prestigious hospital in the state and the largest 'safety-net' provider of healthcare to the poor and uninsured in the city of New Haven.'[55]

The publicity led to protests that were 'long, loud, and visible.' A health care workers union erected a large billboard, that could be seen from the main hospital's windows, containing only the word 'SHAME.' The state attorney general and lawmakers stepped in, and soon the hospital system changed its billing practices and, in 2005, replaced its entire leadership. Today, Yale-New Haven has become a model of cooperation with the local community, including providing funding for clinics and donating land for low-income housing.[56]

But the lessons of Yale's scandal did not change much behavior in the non-profit hospital sector. Throughout the 2000s, non-profits' profit-seeking, charity-minimizing actions continued to elicit shock

from the public, media, and local politicians. For example, a 2005 investigation by the *Salt Lake Tribune* found that the Intermountain Hospital Corporation (IHC), which operated 19 hospitals and numerous clinics in the state of Utah, filed 723 debt-collection lawsuits in a single year. Intermountain, which included the University of Utah hospital, was a fully non-profit chain. 'Charities shouldn't sue people', health activist Steven DeVore told the *Tribune*. DeVore lobbied unsuccessfully for state legislators to revoke IHC's tax-exempt status.[57]

To counter arguments like DeVore's, non-profits frequently, and ironically, justified their aggressive billing practices by invoking their status as charity institutions. They had to pursue every possible dollar to cover the costs of free care, they argued.'[W]e provide a lot of charity, and do a lot of good in the community', an Ohio hospital executive told National Public Radio. In order to provide that charity, 'we have to collect payment from those who can afford to pay us.'[58]

The non-charitable behaviors of non-profit hospitals brought further attention to the question of tax exemption. In the most well-known example, tax officials in Champaign, Illinois revoked the tax-exempt status of Provena Hospital in 2003 for failing to provide sufficient charity care. Provena was a Catholic hospital, but its $800,000 annual expenditure on 'charitable activities' was less than its $1.1 million savings in local property taxes. Even though neither federal nor Illinois law specified how much charity care or community benefit non-profits were required to provide to maintain their status, the state Supreme Court agreed that Provena no longer qualified as a charity. The Illinois Hospital Association, the state lobbying group for the hospitals, objected to the decision on the grounds that 'Imposing new tax burdens on a hospital could force it to reduce services and increase health care costs.'[59]

The growing attention to hospitals' behavior from activists, media, and state governments was not welcomed, but could no longer be ignored. What one reporter called the 'uninsured billing / charity-care

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tsunami' (meaning the flood of bad publicity for hospitals) was leading to a moment of reckoning. 'There is no question', the industry journal *Modern Healthcare* admitted in 2004, 'that a lack of clarity of mission and poor reporting by many in the industry invited this deluge of scrutiny…Some hospitals and systems really do act like for-profits, and they threaten to damage the many providers with a patient-first mentality.'[60] More unwelcome publicity arrived in the form of a series of class action lawsuits brought by high-profile anti-tobacco attorney Richard Scruggs against twelve hospital systems across the country. The suits alleged that the hospitals 'failed to conduct [themselves] as the charitable entit[ies they] purport to be', that they provided insufficient care to the poor and uninsured, and that they 'charged unreasonable and excessive rates for medical care' and engaged in 'aggressive, abusive and humiliating collections practices.' The *Wall Street Journal* noted that 'The suits are coming at a difficult juncture for the hospital industry, whose practices toward the uninsured are under scrutiny.'[61]

Scruggs's class action lawsuits failed; judges ruled that only the government, not private individuals in court actions, could enforce the tax code against hospitals.[62] Still, the industry had been put on the defensive. If hospitals did not take steps to show they were deserving of their tax exemptions, *Modern Healthcare* warned, government would step in.[63]

This prediction came true in 2006 when a Congressional subcommittee began investigating non-profit hospital practices, and the *New York Times* reported that Congress 'will set standards for the industry if it does not do so itself.'[64] Iowa Senator Charles Grassley, a longtime critic of the hospital industry, was angered that hospitals 'continu[ed] to act uncharitably'; not only did they fail to provide significant charity care, but they also paid excessively high salaries to executives, and used their profits to move out of poor areas and build new hospitals in wealthier suburbs. Grassley wanted to impose minimum requirements

for uncompensated care, and to fine hospitals that did not comply.[65] He would soon have an opportunity to bring his proposals to fruition, as Congress enacted, and Barack Obama signed into law, the most sweeping changes to the health system since Medicare and Medicaid.

The Affordable Care Act and the Fate of Charity Care

In 2010, Congress passed the Patient Protection and Affordable Care Act, the most far-reaching health reform since Medicare. The legislation, which became known as the Affordable Care Act (ACA) or Obamacare, represented a retreat from the goal of universal coverage that health reformers had sought for decades. Instead, the ACA attempted to expand health coverage incrementally, by expanding Medicaid and creating a system of subsidised private insurance plans.[66] Since the Supreme Court in 2012 made Medicaid expansion voluntary on the part of the states, the ACA ended up covering even fewer people than expected. Although Obamacare has extended health protection to around 20 million people, over 25 million Americans remained uninsured at the end of 2018.[67] The need for 'indigent care' is far from over.

The drafters of the ACA assumed that charity care by hospitals needed to continue, but that it would be balanced out by new benefits to hospitals. They argued that hospitals that treated large numbers of uninsured people would receive a vast increase in reimbursements from the coverage expansions. In exchange for the projected billions of dollars in new patient revenues (and to help fund the new system), the ACA would implement cuts to Medicare reimbursements and subsidies, and require greater safety and quality accountability from hospitals. As one medical journal put it, the ACA 'both giveth to and taketh away from hospitals.'[68]

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This was also true in the case of charity care. The ACA, especially through the Medicaid expansion, explicitly intended to reduce the volume of uncompensated care hospitals were expected to carry. But non-profit hospitals also faced stronger reporting requirements to maintain their charitable tax status. The ACA requires hospitals to file new reports with the IRS enumerating 'how much money-losing care they dispense—and how they calculate that number. They also have to list and value what they've done gratis to better their communities.'[69] Other provisions reflected Sen. Grassley's and patient advocates' earlier criticisms of non-profit hospital practices by banning non-profit hospitals from taking 'extreme collections actions' and charging higher rates to uninsured patients.[70]

Rather than heralding a new era in hospital accountability, the ACA charity care rules are more a case of things remaining the same. They set requirements for reporting, but not a requirement for actual amounts of charity care required. Hospitals can still define charity care as they wish, reporting a wide variety of activities as 'uncompensated care.' And they can even opt out of free care completely by paying a $50,000 fine—a tiny portion of hospital revenues. At least one hospital has in fact lost its tax exempt status since implementation of the ACA, but the new charity care mandates are, according to a trade newsletter, 'perhaps too vague to be effective.'[71]

It's not surprising that the Affordable Care Act reflects the contradictory and ambivalent roles of hospitals in the U.S. health system. Its attempt to reinforce hospitals' commitment to uncompensated care seemingly contradicts the ACA's overall goal of reducing the need for uncompensated care altogether. Following the Act's implementation in 2004, the amount of uncompensated care provided by hospitals did indeed decline, from a peak of $46.4 billion in 2013to $42.8 billion in 2014, and to $35.7 billion in 2015.[72] In states that did expand Medicaid, hospitals experienced significant reduc-

tions in charity care. At Seattle's Harborview Medical Center, for example, the proportion of uninsured patients fell from 12% in 2013 to an 'unprecedented' low of 2% in 2014.[73]

But as the Affordable Care Act faced both judicial challenge and repeated attempts at repeal by a Republican-majority Congress, it became clear that the need for uncompensated care would continue and perhaps even rise. The greatest blow to the ACA's success has been the Supreme Court 2012 ruling in *NFIB v. Sebelius* that upheld the Act but struck down its requirement that all states expand their Medicaid programmes for the poor. As of January 2019, 14 conservative-run states have refused the federal government's offer of billions of dollars in Medicaid subsidies to cover low-income working people. Only those states that accepted Medicaid expansion have seen a significant drop in the demand for charity care.

In addition, many of the newly-insured under the ACA have purchased the lowest-cost subsidised plans, which include extremely high cost-sharing in the form of deductibles and co-payments. By 2016, it was becoming evident that increasing numbers of patients with high-deductible policies were leading to more unpaid debts to hospitals.[74] Finally, there continues to be millions of uninsured people. These shortfalls in coverage have led hospital organisations to ask for increased funding for uncompensated care. The trade journal *Modern Healthcare* called for 'the next Congress [to] reconsider the assumption in the ACA that uncompensated care for the poor and uninsured would begin to fade away. As long as exchange enrollment lags and many states refuse to expand Medicaid, the nation's safety net hospitals will need—and deserve—additional support.'[75]

In seeking more taxpayer funding even as they continue to behave like private businesses, hospitals are continuing a strategy that is over a century old. American hospitals, with their powerful lobbying organizations, have proven adept at having their cake and eating it

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too—maximizing their profits while depending on significant subsidies from government. Despite its intentions, the Affordable Care Act has not disrupted the United States's reliance on heavily subsidised private voluntarism to compensate for the nation's refusal to adopt universal, comprehensive coverage. Like Medicare before it, the ACA preserved and reinforced the hospital's dual role as both charity and profit centre, rather than a public service available on equal terms to all.

1. Centers for Medicare and Medicaid Services, 'National Health Expenditures 2017 Highlights', https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf; Kaiser Health News, 'Government now pays for nearly 50% of health care spending', KHN Morning Briefing, 21 February 2019, https://khn.org/morning-breakout/government-now-pays-for-nearly-50-percent-of-health-care-spending-an-increase-driven-by-baby-boomers-shifting-into-medicare/; Kaiser Family Foundation, 'Key Facts about the Uninsured Population', 7 December 2018, https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/; David Belk MD, 'True Cost of Health-care' Hospital Financial Analysis, http://truecostofhealthcare.org/aha-records/.

2. Rosemary Stevens, In Sickness and in Wealth: American Hospitals in the Twentieth Century (New York: Basic Books, 1989).

3. Martin Gorsky, John Mohan, and Martin Powell, 'The financial health of voluntary hospitals in interwar Britain', Economic History Review Vol. 55, 3, August (2002), 533-57 (quote on 533).

4. On nineteenth-century hospitals, see Charles Rosenberg, The Care of Strangers: The Rise of America's Hospital System (New York: Basic, 1987); Guenter B. Risse, Mending Bodies, Saving Souls: A History of Hospitals (New York: Oxford University Press, 1999).

5. Rosemary Stevens, ''A Poor Sort of Memory': Voluntary Hospitals and Government Before the Great Depression', Milbank Memorial Fund Quarterly Health and Society, Vol., 60, No. 4, 1982, 551-584.

6. On hospital segregation, see, e.g., Vanessa Northington Gamble, Making a Place for Ourselves: The Black Hospital Movement, 1920-1945 (New York: Oxford, 1995); Samuel Kelton Roberts, Infectious Fear: Politics, Disease, and the Health Effects of Segregation (Chapel Hill: UNC Press, 2009).

7. Ronald Numbers, Almost Persuaded: American Physicians and Compulsory Health Insurance, 1912-1920 (Baltimore: Johns Hopkins, 1978); Beatrix Hoffman, The Wages of Sickness: The Politics of Health Insurance in Progressive America (Chapel Hill: UNC Press, 2001).

8. Beatrix Hoffman, Health Care for Some: Rights and Rationing in the United States since 1930 (Chicago: University of Chicago Press), 68.

9. On the Jim Crow hospital system, see David Barton Smith, Health Care Divided: Race and Healing a Nation (Ann Arbor: University of Michigan Press, 1999); Karen Kruse Thomas, Deluxe Jim Crow: Civil Rights and American Health Policy (Athens: University of Georgia Press, 2011).

10. Robert Cunningham III and Robert M. Cunningham, Jr., The Blues: A History of the Blue Cross Blue Shield System (DeKalb: Northern Illinois University Press, 1997).

11. On labour's role in the rise of the private insurance system, see Christy Ford Chapin, Ensuring America's Health: The Public Creation of the Corporate Health Care System (New York: Cambridge University Press,

10.5920/PoliticalEconomy.06

2015); Jennifer Klein, For All These Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State (Princeton: Princeton University Press, 2003).

12. After the failure of national health insurance in 1950, reformers pushed for insurance to cover the elderly only, which became known as Medicare. Existing programmes providing federal subsidies for the very poor were consolidated and attached to the 1965 Medicare bill under the new name 'Medicaid.' See, e.g., Alan B. Cohen, David C. Colby, Keith A. Wailoo, and Julian E. Zelizer, eds., Medicare and Medicaid at 50: America's Entitlement Programs in the Age of Affordable Care (New York: Oxford, 2015).

13. Centers for Medicare and Medicaid Services, National Health Expenditure Accounts https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html.

14. American Medical Association Communications Division, 'Ronald Reagan Speaks Out Against Socialized Medicine', audio recording, 1962.

15. Rosemary Stevens, The Public-Private Health Care State (New Brunswick, N.J.: Transaction Press, 2007), 311, 319.

16. Sandy Lutz and E. Preston Gee, The For-Profit Healthcare Revolution: The Growing Impact of Investor-Owned Health Systems (Chicago, Ill: Irwin Professional, 1995), 9-11.

17. Arnold S. Relman, M.D., 'The New Medical Industrial Complex', New England Journal of Medicine, 303 (23 October 1980), 963-970.

18. The for-profit health industry's lobbying groups include the Federation of American Hospitals and America's Health Insurance Plans. For a discussion of their influence on the Affordable Care Act, for example, see John F. McDonough, Inside National Health Reform (Berkeley: University of California Press, 2011).

19. In this way, non-profit hospitals mimicked their insurance industry counterpart, Blue Cross Blue Shield, which in the 1970s had begun to adopt commercial insurance practices in order to remain competitive. By 1994, the Blue Cross Blue Shield Association began allowing its plans to convert to for-profit. Cunningham and Cunningham, The Blues; Deborah Stone, 'The Struggle for the Soul of Health Insurance', Journal of Health Politics, Policy, and Law (1993) 18 (2), 287-317.

20. Bradford H. Gray, The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals (Cambridge, Mass.: Harvard University Press, 1991), 67. As much as non-profits were forced into a competitive posture by for-profit growth, the ideological environment of the 1980s (Reaganism, the cultural glorification of ruthless business practices) may also have played a role; further research is needed to weigh the material and ideological motivations of hospital leadership during this time.

21. Clare McCausland, An Element of Love: A History of the Children's Memorial Hos-

pital of Chicago, Illinois (Chicago: The Hospital, 1981), 192.

22. Elisabeth Rosenthal, An American Sickness: How Healthcare Became Big Business and How You Can Take It Back (New York: Penguin, 2017), 24-28.

23. Ge Bai and Gerard F. Anderson, 'A More Detailed Understanding of Factors Associated With Hospital Profitability', Health Affairs, Vol. 35, No. 5, 889-97.

24. American Hospital Association, Fast Facts on U.S. Hospitals, 2019 https://www.aha.org/statistics/fast-facts-us-hospitals.

25. 'History of Pennsylvania Hospital', http://www.uphs.upenn.edu/paharc/timeline/1751/. The undeserving and undesirable were the purview of government hospitals and asylums; Stevens, In Sickness and in Wealth, 27.

26. On the increased reliance on paying patients, see David Rosner, A Once Charitable Enterprise: Hospitals and Health Care in Brooklyn and New York, 1885-1915 (New York: Cambridge University Press, 1982).

27. Stevens, "A Poor Sort of Memory', 555-58; Stevens, In Sickness and in Wealth, 41. See also Internal Revenue Service, 'The Concept of Charity' (1980), https://www.irs.gov/pub/irs-tege/eotopicb80.pdf.

28. Congressional Research Service, '503(c)(3) Hospitals and the Community Benefit Standard', https://www.everycrsreport.com/reports/RL34605.html. In 2011 the tax benefit to non-profit hospitals as was estimated to be $24.6 billion.

29. 'Hospitals and Taxes', Health Law Newsletter, Issue No. 4, August 1971, 1.

30. See for example Smith, Health Care Divided. Simkins was upheld (but not decided) by the U.S. Supreme Court.

31. Jill Quadagno, One Nation, Uninsured (New York: Oxford University Press, 2006); David Barton Smith, The Power to Heal: Civil Rights, Medicare, and the Struggle to Transform America's Health Care System (Nashville: Vanderbilt University Press, 2016).

32. On Medicaid, see Jamila Michener, Fragmented Democracy: Medicaid, Federalism, and Unequal Politics (New York: Cambridge University Press, 2018) and the classic, Robert Stevens and Rosemary Stevens, Welfare Medicine in America: A Case Study of Medicaid (New York: Free Press, 1974).

33. Cook v. Ochsner Foundation Hospital, 319 F. Supp. 603 (E.D. Louisiana 1970); Beatrix Hoffman, 'Don't Scream Alone: The Health Care Activism of Poor Americans in the 1970s', in B. Hoffman, Nancy Tomes, Rachel Grob, and Mark Schlesinger, eds., Patients as Policy Actors (New Brunswick: Rutgers University Press, 2011).

34. Marilyn G. Rose, 'Federal Regulation of Services to the Poor under the Hill-Burton Act: Realities and Pitfalls', Northwestern Law Review Vol. 70, No. 1 (1975): 168-201; 'Hill-Burton', Health Law Newsletter, Issue No. 13, May 1972, 1.

35. 'Turning Point for Public Hospitals', Health/PAC Bulletin, Vol. 51, April 1973, 3.

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36. On the role of 'poverty lawyers', see Martha F. Davis, Brutal Need: Lawyers and the Welfare Rights Movement, 1960-1973 (New Haven: Yale University Press, 1993); on the U.S. welfare rights movement generally, see, e.g., Annelise Orleck, Storming Caesar's Palace: How Black Women Fought Their Own War on Poverty (New York: Penguin, 2005).

37. 'Hospitals and Taxes', Health Law Newsletter, Issue No. 4, August 1971, 1.

38. Simon v. Eastern Kentucky Welfare Rights Organization (1976), https://www.law.cornell.edu/supremecourt/text/426/26.

39. Press release n.d. ca 1979, Leadership Council on Civil Rights II, Box 41, Folder 10, Manuscript Division, Library of Congress; Richard H. Mapp of National Urban League statement to Federal Hospital Council, Oct. 20, 1972. LCCR I: 129.

40. 'South's hospitals fail to meet free care rules, council says', Hospitals, March 1, 1975, Vol. 49, 118-119. The report was by the Southern Regional Council, a civil rights group.

41. Alan Seltzer and Armin Freifeld to Hill-Burton Advocates, 14 June 1979, LCCRII, Box 41, Folder 6, Library of Congress; 'Ups and Downs of Hill-Burton', Health Law Newsletter, No. 106, February 1980; 'Trainings Pay Off, Bring Increased Advocacy', NHeLP Health Advocate, No. 111, August 1980.

42. 'Tougher Hill-Burton Regs Demanded in California', NHeLP Health Advocate, No. 124, Sept. 1981, 4.

43. For a more detailed examination of how the complexity of the US health care system has fragmented social movement efforts for reform, see Beatrix Hoffman, 'Health Care Reform and Social Movements in the United States', American Journal of Public Health, 93, 1 (January 2003): 75–85.

44. Sally Guttmacher, 'Poor People, Poor Care', Health/PAC Bulletin Vol. 15, No., 4, July-August 1984, 15.

45. Beatrix Hoffman, 'Emergency Rooms: The Reluctant Safety Net', in Rosemary A. Stevens, Charles E. Rosenberg, and Lawton R. Burns, eds., History and Health Policy in the United States: Putting the Past Back In (New Brunswick: Rutgers University Press, 2006).

46.'Humana-izing Health Care', Health/PAC Bulletin Vol 16 No. 2, March-April 1985, 6. Health Maintenance Organizations, officially recognised by Congress in 1973, are insurance plans that allow members to use only a limited network of doctors and hospitals in order to reduce costs. On the early history of HMOs, see Klein, For All These Rights; on their later development, see, e.g., Bradford H. Gray, 'The Rise and Decline of the HMO: A Chapter in US Health-Policy History', in Stevens et. al. History and Health Policy in the United States.

47. 'Dynamic firm is major force, but its power worries some', Louisville Courier-Journal, 5 May 1985; 'Trial marriage with U of L has resulted in both spats and successes', Courier-Journal, 9 May 1985; 'Hospital finances now sound, but fund for poor is assailed', unidentified clipping; Jones salary, Modern Healthcare, 10 May 1985; all clippings in Papers of John R. Mannix, Box 170, File 4

'Humana', American Hospital Association Resource Center.

48. Martin Gottlieb and Kurt Eichenwald, 'A hospital chain's brass knuckles, and the backlash', New York Times, 11 May 1997.

49. Lisa M. Krieger, 'San Jose, Calif., Groups Protest Hospital Consolidation Plans', San Jose Mercury News, 30 April 30, 1999 (Newspaper Source database).

50. Karl Stark, 'Philadelphia Consumers Group Protests Proposed Sale of Allegheny Hospitals', The Philadelphia Inquirer, 5 May 1998; Andrea Ahles, 'Advocacy Group Protests Sale of Philadelphia Hospitals to For-Profit Company', The Philadelphia Inquirer, 20 August 1998 (Newspaper Source). On the Allegheny bankruptcy, see Lawton R. Burns and Alexandra P. Burns, 'Policy Implications of Hospital System Failures: The Allegheny Bankruptcy', in Stevens et. al. History and Health Policy in the United States.

51. In 2011, 15 states had charity care requirements for hospital tax exemption and/or expansion. In Atlanta between 2006-09, some for-profit hospitals provided more charity care than the city's non-profit Piedmont Hospital, which spent less than 3% of its gross income on uncompensated care. https://www.ajc.com/news/local/charity-care-hospital-regulations-scrutinized/KmeCPOUalGN5pAYS4iCyeO/

52. On the Columbia/HCA scandal, see Kurt Eichenwald, 'HCA to pay $95 million in fraud case', New York Times, 15 December 2005. Rick Scott, later Governor of Florida and now U.S. Senator, was head of Columbia/HCA during much of the scandal. On HealthSouth, see David McCann, 'Two CEOs Tell a Tale of Fraud at HealthSouth', CFO, 27 March 2017, http://www.cfo.com/fraud/2017/03/two-cfos-tell-tale-fraud-healthsouth/.

53. American Hospital Association, 'Fast Facts on U.S. Hospitals', 2019 https://www.aha.org/statistics/fast-facts-us-hospitals.

54. Dan Diamond, 'A tarnished hospital tries to win back trust', Politico, 31 December 2017, https://www.politico.com/story/2017/12/31/yale-new-haven-hospital-community-trust-261660.

55. Connecticut Center for a New Economy, 'Uncharitable Care: Yale-New Haven Hospital's Charity Care and Collections Practices'.

56. Diamond, 'A tarnished hospital'.

57. Linda Fantin, 'Salt Lake City residents say hospitals have harassed them over unpaid bills', Salt Lake Tribune, 1 October 2005.

58. Jenny Gold, 'Nonprofit hospitals faulted for stinginess with charity care', All Things Considered, 27 April 2012, https://www.npr.org/sections/health-shots/2012/04/27/151537743/nonprofit-hospitals-faulted-for-stinginess-with-charity-care. Hospitals and insurance companies often defend their high costs as the result of cost shifting and cross-subsidization required by a fragmented health system, but this can be more of a rhetorical strategy than an economic reality. See e.g., Austin B. Frakt, 'How much do hospitals cost shift? A review of the evidence', Milbank Quarterly, 89, 1 (March 2011): 90–130.

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59. Lorene Yue and Mike Colias, 'Illinois Supreme Court upholds ruling against Provena in tax-exempt case', Crain's Chicago Business, 18 March 2010.

60. Todd Sloane op ed, Modern Healthcare, 5 July 2004, Vol. 34 Issue 27, 17.

61. Order by Joan Gottschall, District Judge, Watts v. Advocate Health Care Network, U.S. District Court, N.D. Illinois, Eastern Division, 30 March 2005, https://www.casemine.com/judgement/us/5914754cadd7b049343adff6. 'Lawsuits Challenge Charity Hospitals on Care for Uninsured', Wall Street Journal, 17 June 2004: B.1.

62. Gottschall order. See also Robert Pear, 'Nonprofit hospitals face scrutiny over practices', New York Times, 19 March 2006, 18.

63. Sloane op ed, Modern Healthcare.

64. Pear, 'Nonprofit hospitals face scrutiny'.

65. John Carreyou and Barbara Martinez, 'Grassley targets nonprofit hospitals on charity care', Wall Street Journal, 18 December 2008, A5.

66. On the politics shaping the Affordable Care Act, see McDonough, Inside National Health Reform.

67. Kaiser Family Foundation, 'Key Facts about the Uninsured', December 2018, https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/

68. Andrew M. Ryan and Alvin I. Mushlin, 'The Affordable Care Act's Payment Reforms and the Future of Hospitals', Annals of Internal Medicine 160, 10 (2014), 729-730.

69. Rosenthal, An American Sickness, 50. The new IRS form is Schedule H, Form 990.

70. Beckers' Hospital Review, https://www.beckershospitalreview.com/finance/health-reforms-new-charity-care-requirements-for-hospitals-achieving-compliance-to-avoid-penalities.html

71. https://www.beckershospitalreview.com/finance/irs-revokes-hospital-s-tax-exempt-status-for-failure-to-comply-with-aca-rule.html; Jacqueline DiChiara, 'The Affordable Care Act's Effect on Hospital Charity Care', Revcycle Intelligence, 10 February 2016 https://revcycleintelligence.com/news/the-affordable-care-acts-effect-on-hospital-charity-care.

72. Tara Bannow, 'Hospital profits, uncompensated care climb', Modern Healthcare, 8 Jan. 2018, Vol. 48 Issue 2.

73. Phil Galewitz, 'An Obamacare winner: safety-net hospitals', USA Today, 24 May 2014.'The share of uninsured patients was cut roughly in half this year at two other major safety net hospitals—Denver Health in Colorado and the University of Arkansas for Medical Sciences Hospital (UAMS) in Little Rock.'

74. Scott Gottlieb, 'ObamaCare may be growing the number of unpaid medical bills', Forbes, 19 February 2016.

75. Merrill Goozner, 'An unfair DSH formula for safety net hospitals', Modern Healthcare, 11 July 2016, Vol. 46 Issue 27.