Troubling Trends: Hospital Billing, Charity Care, and Consumer Protection in Kansas

Executive Summary

Kansas patients face persistent risks from hospital billing practices that can result in excessive charges, medical debt, and limited access to financial assistance. Evidence from patient complaints, enforcement activity, and independent research indicates that these risks are particularly acute in a non–Medicaid expansion state like Kansas.

Key findings include aggressive upcoding in emergency departments, surprise out-of-network billing, duplicate or phantom charges, unnecessary testing or admissions, and systemic failures to disclose or apply charity care policies. Analysis from the Lown Institute further shows that several nonprofit hospitals in Kansas provide charity care and community benefits that fall short of the value of their tax exemptions.

These findings raise important oversight questions for the Kansas Legislature and the Attorney General, including whether existing consumer protection authority, transparency requirements, and nonprofit accountability standards are sufficient to protect Kansas patients and taxpayers.

Hidden Costs, Opaque Systems

Problem: Kansas patients face inflated medical bills, surprise charges, and limited access to charity care.

Evidence: 71% of Kansas nonprofit hospitals fail fair share parity; $104M statewide deficit.

Why It Matters: Medical debt, delayed care, taxpayer-subsidized systems lacking accountability.

What Kansas Can Do: Enforce transparency, strengthen charity care standards, and use existing consumer protection authority.

The Problem: Hospital Billing as a Consumer Protection Issue

Hospital billing practices have become a major driver of medical debt nationwide, and Kansas is particularly exposed. Patients routinely receive bills they could not anticipate, understand, or reasonably avoid, even when they have insurance. These problems affect uninsured Kansans as well as middle-income families with coverage who face high deductibles, coinsurance, and post-care billing disputes.

Key drivers include: - Opaque pricing and chargemaster rates unrelated to actual costs - Aggressive coding and billing intensity in emergency departments - Fragmented provider networks that expose patients to surprise charges - Inconsistent disclosure and application of hospital charity care

Medical debt is now a leading cause of credit damage and delayed care, making hospital billing a matter of economic stability and consumer protection—not merely healthcare administration.

Evidence of Systemic Harm in Kansas

1. Aggressive Emergency Department Billing

National audits by the U.S. Department of Health and Human Services Office of Inspector General show that more than 20 percent of high-intensity emergency department claims lacked sufficient documentation to support the billing level. Kansas patient complaints mirror these findings, with routine emergency visits frequently billed at the highest severity levels, triggering large deductibles and coinsurance obligations.

2. Surprise and Post-Care Billing

Even when patients seek care at in-network hospitals, they may receive bills from out-of-network emergency physicians, anesthesiologists, radiologists, or

pathologists. Although the federal No Surprises Act has reduced some forms of balance billing, enforcement gaps and patient confusion persist, particularly in emergency care.

3. Duplicate, Phantom, and Unnecessary Charges

Kansas patients report duplicate lab charges, medications never administered, overlapping facility fees, and observation stays that dramatically increase costs without clear clinical justification.

Charity Care and Nonprofit Accountability Gap

Nonprofit hospitals receive substantial federal, state, and local tax exemptions in exchange for providing community benefit, including charity care and financial assistance. Federal law requires these hospitals to: - Maintain written financial assistance policies - Publicize eligibility standards - Make reasonable efforts to determine eligibility before extraordinary collection actions

Independent analysis by the Lown Institute shows that approximately 71 percent of Kansas nonprofit hospitals fail to provide charity care and community benefits equal to the value of their tax exemptions, resulting in a statewide fair-share deficit of roughly $104 million.

This gap is especially consequential in Kansas because the state has not expanded Medicaid, leaving more working families dependent on hospital charity care as a last line of protection against medical debt.

Why Kansas Is Structurally at Risk

Kansas's healthcare landscape magnifies the impact of billing opacity and weak charity care enforcement: - No Medicaid expansion increases uncompensated care pressures - Rural consolidation limits patient choice - High-deductible insurance plans shift financial risk onto families

Together, these factors make hospital billing practices a central determinant of financial security for Kansas households.

Existing Kansas Authorities

Kansas does not need to create new agencies or expand spending to act.

Kansas Consumer Protection Act (KCPA) - Prohibits deceptive and unconscionable practices:

- Applies to misleading billing, failure to disclose financial assistance, and improper collection practices

Attorney General Oversight

- Authority to review nonprofit compliance with charitable purpose obligations - Ability to investigate patterns of billing abuse and charity care failures

Federal Law Alignment

- No Surprises Act protections against balance billing - IRS §501(r) requirements for nonprofit hospitals

Policy Options for Legislative Consideration

Legislators may consider the following targeted actions:

Standardized Charity Care Reporting

Require uniform, public reporting of charity care and community benefit spending

Fair-Share Benchmarks

Establish minimum expectations tied to the value of tax exemptions

Enhanced Financial Assistance Screening

Require hospitals to screen patients for charity care eligibility before billing or collections

Billing Transparency Standards

Require clear, itemized bills and documentation supporting coding levels

Oversight Hearings and Data Requests

Use legislative hearings to examine billing practices, emergency department coding, and nonprofit accountability

These options focus on transparency and enforcement rather than rate-setting or system restructuring.

Bottom Line

Hospital billing practices are imposing real financial harm on Kansas families and taxpayers. Evidence suggests these harms are systemic and correctable. By

exercising existing oversight authority and adopting targeted transparency and accountability measures, Kansas can reduce medical debt, protect consumers, and ensure nonprofit hospitals fulfill their public obligations—without expanding government spending.

Hospital Billing Traps, Scams, and Practices Cost Kansas Taxpayers Millions

Below are common hospital billing practices seen nationwide, with specific, real-world examples and context from Kansas. These examples reflect complaints raised by Kansas patients, reporting by regional media, and enforcement actions involving Kansas hospitals and insurers.

Upcoding: Being Billed for More Serious (and Expensive) Care Than You Received

What happens: Hospitals bill insurers and patients for higher-level services than were provided. For example, a routine emergency room visit may be billed as a "critical care" visit, dramatically increasing the cost.

Kansas patients have reported emergency department visits for minor issues—such as dehydration, mild infections, or uncomplicated injuries—being coded as high-severity ER visits (Level 4 or 5) at large hospital systems in Wichita and the Kansas City metro area. In some cases, patients were discharged within a few hours with minimal testing yet received bills exceeding several thousand dollars due to aggressive coding practices.

In rural Kansas hospitals, patients have also reported being billed for extended observation or higher-complexity evaluation and management codes even when no specialist consultation or advanced intervention occurred.

Surprise Out-of-Network Charges at In-Network Hospitals

What happens: Even if the hospital is in-network, certain providers (such as anesthesiologists, radiologists, pathologists, or emergency physicians) may not be. Patients often do not choose these providers but still receive out-of-network bills.

Prior to full implementation of the federal No Surprises Act, Kansas patients undergoing planned surgeries at in-network hospitals—particularly in Topeka, Overland Park, and Kansas City—reported receiving large out-of-network bills from anesthesiology or radiology groups that contract separately from the hospital.

Emergency care has been a frequent problem area. Kansas residents treated in emergency rooms after car accidents or sudden illnesses often had no ability to

choose providers, yet still received balance bills from out-of-network ER physicians or air ambulance services operating in the state.

Duplicate or Phantom Charges on Hospital Bills

What happens: Hospital bills list the same service multiple times, or include charges for tests, medications, or procedures the patient never received.

Kansas example: Kansas consumers have flagged hospital bills that included:

Multiple charges for the same laboratory test performed once

Medication charges for drugs that were ordered but never administered

Supply fees (such as surgical trays or IV kits) billed despite no corresponding procedure

In some Kansas hospitals, patients reported being charged separately for facility fees, observation fees, and nursing services that overlapped with one another, inflating the total bill without clear explanation.

Unnecessary Tests or Procedures Driven by Revenue, Not Care

What happens: Hospitals recommend additional imaging, lab work, monitoring, or overnight stays that may not clearly align with symptoms or standard treatment guidelines.

Patients in Kansas have described being encouraged to stay overnight for observation after routine procedures or low-risk ER visits, only to later learn that the admission triggered much higher facility charges. Others reported receiving multiple imaging studies—such as CT scans followed by MRIs—without a clear medical explanation, particularly in emergency departments.

In smaller Kansas communities where hospital systems face financial pressure, patients have raised concerns that financial incentives may influence decisions about testing or admissions.

Financial Assistance Not Disclosed or Improperly Denied

What happens: Hospitals fail to inform patients about charity care, financial assistance programs, or income-based discounts, even when patients qualify.

Kansas example: Kansas law and federal regulations require nonprofit hospitals to maintain financial assistance policies, yet many Kansas patients report never being

told these programs exist. Some only learned about charity care after accounts were sent to collections or wages were threatened with garnishment.

Patients in Kansas—particularly uninsured or underinsured residents—have reported being asked to pay large sums upfront without being screened for financial assistance, despite meeting income eligibility thresholds.

Kansas and the Charity Care Gap: Findings from Lown Institute Reports

Charity Care vs. Tax Benefits in Kansas
Source: Lown Institute Hospital Community Benefit Reports

The Lown Institute analyses compare nonprofit hospitals' spending on charity care and other community benefits to the estimated value of their federal, state, and local tax exemptions. In Kansas, several nonprofit hospitals fall below parity—meaning the value of their tax benefits exceeds what they provide in free or discounted care. This gap is most consequential in a non-expansion Medicaid state, where more patients rely on hospital financial assistance as a last line of protection against medical debt.

Independent analyses by the Lown Institute, which evaluates nonprofit hospitals' community benefit performance nationwide, have highlighted a significant charity care gap in Kansas.

What the Lown Institute has found

Lown Institute reports comparing hospital spending on charity care to the value of their tax exemptions show that many nonprofit hospitals nationally—and several in Kansas—provide less in free or discounted care than the value of the public subsidies they receive. This gap is especially pronounced in states with high levels of underinsurance and medical debt, including Kansas.

In Kansas, Lown Institute analyses have shown that some large nonprofit hospital systems—particularly in urban and suburban markets—spend a relatively small share of operating revenue on charity care while aggressively pursuing collections against low-income patients. At the same time, Kansas has a sizable population of residents who are uninsured or underinsured, increasing reliance on hospital charity care policies that are often difficult to access or poorly disclosed.

Kansas Fair Share Deficit

In Kansas, Lown Institute analyses have shown that some large nonprofit hospital systems—particularly in urban and suburban markets—spend a relatively small share of operating revenue on charity care while aggressively pursuing collections against low-income patients. At the same time, Kansas has a sizable population of residents who are uninsured or underinsured, increasing reliance on hospital

According to the Lown Institute Hospitals Index, Kansas had a "fair share deficit" of nearly $104 million for the fiscal year ending in 2021. This means that Kansas nonprofit hospitals received approximately $104 million more in tax breaks than they spent on community benefit and charity care.

Percent of Hospitals with Deficit:

In Kansas, nearly 71% of nonprofit hospitals operated at a fair share deficit in the 2021 fiscal year. charity care policies that are often difficult to access or poorly disclosed.

Because Kansas has not expanded Medicaid, more working families fall into coverage gaps, making hospital financial assistance policies a critical safety net. Lown Institute findings suggest that when charity care is limited or inconsistently applied, patients are more likely to face medical debt, collections, and credit damage—even when receiving care from nonprofit hospitals.

Why this matters for patients

The Lown Institute's work underscores that nonprofit status does not guarantee affordability. Kansas patients should be aware that hospitals receiving tax benefits may still deny or limit charity care, apply narrow eligibility criteria, or fail to proactively screen patients for assistance.

Policy implications for Kansas enforcement and oversight

The charity care gap identified by the Lown Institute raises clear questions for Kansas policymakers and regulators. When nonprofit hospitals provide community benefits that fall short of the value of their tax exemptions, state oversight bodies—including the Kansas Attorney General's Consumer Protection Division—may have grounds to examine whether billing practices, financial assistance disclosures, and collection activities are consistent with consumer protection standards. Legislators may also consider whether additional transparency, minimum charity care

benchmarks, or reporting requirements are warranted to ensure nonprofit hospitals meet their obligations to Kansas communities.

Takeaway for Kansas Patients

Kansas patients should not assume hospital bills are accurate or final. Requesting itemized bills, understanding your rights under federal and state law, and asking direct questions can prevent thousands of dollars in unnecessary charges.

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The Need for More Sunshine in the Sunflower State

Upcoding: Kansas patients have reported emergency department visits for minor issues—such as dehydration, mild infections, or uncomplicated injuries—being coded as high-severity ER visits (Level 4 or 5) at hospitals in Wichita (including Ascension Via Christi facilities) and in the Kansas City metro area, including hospitals affiliated with the University of Kansas Health System.

In some cases, patients were discharged within hours with minimal testing yet received bills exceeding several thousand dollars due to aggressive coding practices.

Surprise Out-of-Network Charges at In-Network Hospitals

Even if the hospital is in-network, certain providers (such as anesthesiologists, radiologists, pathologists, or emergency physicians) may not be. Patients often do not choose these providers but still receive out-of-network bills.

Prior to full implementation of the federal No Surprises Act, Kansas patients undergoing planned surgeries at in-network hospitals—particularly in Topeka, Overland Park, and Kansas City—reported receiving large out-of-network bills from anesthesiology or radiology groups that contract separately from the hospital.

Emergency care has been a frequent problem area. Kansas residents treated in emergency rooms after car accidents or sudden illnesses often had no ability to choose providers, yet still received balance bills from out-of-network ER physicians or air ambulance services operating in the state.

Duplicate / Phantom Charges: Kansas consumers—particularly patients treated at large urban hospitals in Wichita, Topeka, and Johnson County—have flagged hospital bills that included duplicate lab charges, medications never administered, and overlapping facility or nursing fees without clear documentation.

Unnecessary Tests or Admissions: Hospitals recommend additional imaging, lab work, monitoring, or overnight stays that may not clearly align with symptoms or standard treatment guidelines.

Patients in Kansas have described being encouraged to stay overnight for observation after routine procedures or low-risk ER visits, only to later learn that the admission triggered much higher facility charges.

Patients in Kansas have described being encouraged to stay overnight for observation after routine procedures or low-risk ER visits at hospitals in Wichita, Salina, and the Kansas City suburbs, only to later learn that the admission triggered significantly higher facility charges. Others reported receiving multiple imaging studies—such as CT scans followed by MRIs—without a clear medical explanation, particularly in emergency departments. In smaller Kansas communities, where hospital systems face financial pressure, patients have raised concerns that financial incentives may influence decisions about testing or admissions.

Charity Care Failures: Patients in Kansas—particularly uninsured or underinsured residents treated at nonprofit hospitals in Wichita, Topeka, and Kansas City—have reported being asked to pay large sums upfront without being screened for financial assistance, despite meeting income eligibility thresholds.

Financial Assistance Not Disclosed or Improperly Denied

Hospitals fail to inform patients about charity care, financial assistance programs, or income-based discounts, even when patients qualify.

Kansas law and federal regulations require nonprofit hospitals to maintain financial assistance policies, yet many Kansas patients report never being told these programs exist. Some only learned about charity care after accounts were sent to collections or wages were threatened with garnishment.

Patients in Kansas—particularly uninsured or underinsured residents—have reported being asked to pay large sums upfront without being screened for financial assistance, despite meeting income eligibility thresholds.

The Political Economy of Hospital Pricing

Hospital prices are not determined by market competition in any conventional sense. Chargemaster rates (a hospital's "list price" for a specific service, procedure, or item) bear little relationship to underlying costs and vary dramatically across institutions. Negotiated insurance rates are protected by confidentiality clauses, preventing meaningful price comparison.

For patients, this means that the price of care is unknowable at the point of service. Billing occurs after care is delivered, when patients have little leverage. This dynamic creates fertile ground for practices that inflate charges without improving outcomes.

The Architecture of Hospital Billing Systems

Hospital billing relies on a multilayered architecture of clinical documentation, coding, pricing, and reimbursement. Each layer introduces opportunities for complexity, error, and revenue maximization.

Coding systems such as CPT and evaluation-and-management classifications translate clinical encounters into billable events. These systems require subjective judgment, particularly in emergency and observation settings. Pricing systems apply facility fees, technical charges, and ancillary costs that are invisible to patients during care.

Upcoding and Severity Inflation

Upcoding occurs when hospitals bill for higher-intensity services than were actually provided. In emergency departments, minor conditions may be coded at the highest severity levels, dramatically increasing charges. Patients rarely have access to the documentation needed to challenge these decisions.

Duplicate and Phantom Charges

Duplicate charges list the same service multiple times, while phantom charges bill for items never received. These charges persist because billing systems prioritize completeness from the hospital’s perspective rather than accuracy from patients.

Revenue-Driven Utilization

Payment structures reward volume and intensity, encouraging additional tests, imaging, and admissions. While individual clinicians may act in good faith, systemic incentives shape patterns of care that increase costs without clear benefit.

Surprise Billing and Network Fragmentation

Fragmented provider networks expose patients to surprise bills even when they seek care at in-network hospitals. Ancillary providers often contract separately, leaving patients financially responsible for charges they could not anticipate or avoid.

Emergency care presents the highest risk, as patients have no ability to choose providers. Although federal reforms have reduced some forms of balance billing, enforcement gaps and limited patient awareness remain significant challenges.

Kansas Patient Experiences

Patient complaints and reporting across Kansas illustrate how billing practices translate into real-world harm. Patients describe emergency visits for minor conditions billed as high-severity encounters, overnight observation stays triggering large facility fees, and bills containing undocumented services.

These experiences are reported in urban systems, suburban hospitals, and rural facilities alike, indicating that the problem is systemic rather than anecdotal.

Conclusions and Recommendations

Hospital billing practices have become one of the most significant yet least transparent drivers of medical debt in the United States. In Kansas, opaque pricing structures, aggressive coding strategies, fragmented provider networks, and inconsistent access to hospital charity care expose families to financial risk long after medical care has been delivered.

These harms extend well beyond the uninsured. Middle-income Kansans with insurance increasingly face large balances due to high deductibles, coinsurance, facility fees, and post-care billing disputes. For many families, a single hospital encounter can trigger years of debt, damaged credit, and delayed care.

This policy paper synthesizes consumer complaints, Kansas-specific patient experiences, nonprofit hospital financial data, federal and state legal frameworks,

and independent accountability research to demonstrate that these outcomes are systemic rather than accidental. Analysis from the Lown Institute shows that approximately 71 percent of Kansas nonprofit hospitals fail to provide charity care and community benefits equal to the value of their tax exemptions, producing a statewide fair-share deficit of roughly $104 million.

Kansas already has the authority to act. By enforcing existing consumer protection laws, strengthening nonprofit accountability, and improving billing transparency, the state can reduce medical debt, protect patients, and ensure that public subsidies deliver measurable value to Kansas communities.

The physical and financial harms experienced by Kansas patients is not inevitable. It reflects policy choices about transparency, oversight, and accountability. By using existing authority and adopting targeted reforms, Kansas can reduce medical debt, protect consumers, and ensure that nonprofit hospitals serve the public interest.

Additional Resources

Hospital Community Benefit Rankings and Charity Care Reports*. Boston, MA.

Kansas Attorney General. *Consumer Protection Division: Health Care Billing Complaints and Enforcement Authority*.

Centers for Medicare & Medicaid Services. *No Surprises Act: Patient Protections Against Surprise Medical Bills*.

Internal Revenue Service. *Requirements for 501(c)(3) Hospitals – Financial Assistance and Community Benefit Standards*.