



UNHEALTHY PURSUITS:

How the Sick and Vulnerable are Harmed by
Abusive Medical Debt Collection Tactics



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EXECUTIVE SUMMARY

When patients without insurance get sick, the end result is often medical debt. Nearly half of uninsured consumers, as well as many underinsured consumers, have outstanding medical bills. One irony is that this debt is often based on “sticker prices” that are double or triple what insurance companies or Medicare/Medicaid pay.

Where there is debt, there is debt collection. This report documents the array of heavy-handed collection tactics employed all over this nation in the name of health care providers, many of which are nonprofit institutions that receive tax breaks and other money to further their charitable missions. This report provides real life examples from states all over the country.

Some of the tactics examined in this report include:

- Failing to offer charity care to those who qualify for it, thus creating debts that should never exist in the first place.
- Suing patients and their spouses over medical bills. Patients said to owe money are being relentlessly pursued by health care providers for amounts that are obviously well beyond any ability to pay -- or any ability to pay without impoverishing the patient's family. Spouses of incapacitated individuals are also being pursued, an especially problematic practice for older Americans who can be financially destroyed by a spouse's prolonged terminal illness.
- Selling high cost credit to indebted patients. Providers are acting as de facto loan brokers by referring uninsured consumers to credit card companies, finance companies and other high-cost creditors and advising these consumers to take out expensive credit to pay for medical bills.
- Using the credit reporting system as a collection tool against indebted patients. Medical debt may be responsible for the ruined credit records of millions of consumers.

- Seeking wage garnishment. Care providers and their debt collectors have been seeking to garnish up to 25% of the wages of those said to owe them money, often with scant regard to any real ability to pay -- a practice that has been devastating to lower-income families' ability to meet everyday needs.
- Obtaining liens on patients' homes. Health care providers have attempted to get paid by encumbering what is often a working-class family's only significant asset.

This report also offers a legal analysis of some of these tactics. In some cases, the collection methods used by providers or the agencies they hire may violate the law or be legally challengeable.

Finally, this report contains advice for both consumers and for health care providers seeking to avoid engaging in abusive practices. It offers a list of suggestions for legal reforms to protect patients with medical debt, including:

- Enacting medical debtor protection laws that prohibit hospitals from suing poor patients eligible for charity care, require them to inform patients about the availability of charity care, prohibit them from charging uninsured patients more than the actual cost of services, and protect poor patients from debt collection activity.
- Protecting the spouses of patients from impoverishment by medical debt.
- Holding hospitals accountable for charity care.

INTRODUCTION: REMEMBERING WHAT'S REAL

When considering the issues to be discussed in this report we feel compelled to remind people of two clear facts that somehow seem to elude those responsible for these abusive practices. The first is that no one asks to get sick. The second is that medical debt is most assuredly NOT like any other kind of debt. This isn't just some impulsive or unnecessary shopaholic's purchase – and the extent of reckless spending in this country is exaggerated in any event. You can't very well comparison shop during a medical crisis either (“Hey, there's a special on heart attacks at Mass. General today – let's go there!”).

The amount of medical debt burdening consumers and especially low-income consumers is enormous. More than 45 million Americans – over 15% of the population – lack health insurance.¹ When consumers are uninsured or lack adequate insurance, medical debt looms as an omnipresent potential calamity. A survey of nearly 7,000 uninsured patients by The Access Project found that that 46% of them had outstanding medical debts.² A later study reported that medical debtors average almost \$9,000 worth of medical bills.³ That makes for potentially over 20 million medical debtors who owe in the ballpark of \$180 billion in medical debt.

The uninsured are far from alone. According to a report from the Commonwealth Fund, families that HAVE health insurance -- defined as those where all members of the family have coverage -- comprise nearly two-thirds (62%) of families with medical debt problems.⁴ A study by Harvard Medical and Harvard Law Schools

¹ Carmen DeNavas-Walt, Bernadette D. Proctor, and Cheryl Hill Lee, *U.S. Census Bureau, Current Population Reports, P60-229, Income, Poverty, and Health Insurance Coverage in the United States: 2004.*

² Dennis Andrulis, Lisa Duchon, Carol Pryor, and Nanette Goodman, The Access Project, *Paying for Health Care When You're Uninsured* (Jan. 2003) available at http://www.accessproject.org/paying_for_healthcare_when_youre_uninsured.pdf; See also Robert Seifert, The Access Project, *Home Sick: How Medical Debt Undermines Housing Security* (Nov. 2005) available at http://www.accessproject.org/adobe/embargoed_home_sick.pdf.

³ The Access Project, *The Consequences of Medical Debt: Evidence from Three Communities* (Feb. 2003), http://www.accessproject.org/downloads/med_consequences.pdf.

⁴ Michelle Doty, Commonwealth Fund, *Seeing Red: Americans Driven Into Debt by Medical Bills* (August 2005), available at http://www.cmwf.org/usr_doc/837_Doty_seeing_red_medical_debt.pdf.

found that 75% of bankruptcy filers who reported medical debt had health insurance when they got sick.⁵

You'd be hard-pressed to argue that most or even a large portion of these tens of millions of Americans are deadbeats or derelicts. The medically indebted are really just one major symptom of the fact that this nation's health care system is badly broken.

This report has two goals:

(1) To shine a light on abusive medical debt collection practices nationwide so that consumers, their advocates and the news media can be better informed and moved to action. We hope that this information will at least curb these practices among medical care providers and those paid to collect their debts. We also hope this information will spark challenges or efforts to eliminate these practices in places where they continue. Finally, we hope it will lead to reform of a health care system that is wrecking lives and economic prospects as it spins beyond control for so many Americans.

(2) This report also seeks to analyze tactics described in this report under current law, in order to expose legal violations and point to suggested reforms.

⁵ David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, *Illness and Injury as Contributors to Bankruptcy*, Health Affairs – Web Exclusive, February 2, 2005, available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.63v1>.

I. WHY IS THERE SO MUCH MEDICAL DEBT?

The first answer to the question above is perhaps the saddest: *Many of those now suffering under crushing medical debt burdens should never have been considered debtors in the first place.*

Why? Because they were grossly over-charged for their medical services from the start. They should not owe this money. But they do owe it because two mind-bogglingly harsh and unfair practices pervade the medical care marketplace:

- The first is that the uninsured are often forced to pay grossly inflated “sticker” prices for their care – prices that are several times what health insurers pay for the exact same service. So, your emergency room visit for a broken leg may have cost your insurer \$3,000, while my out-of-pocket cost for the same service in the same emergency room on the same day was \$11,275, since I’m uninsured and no one bargained the price down for me in advance. You’ll see numerous real-life examples of this practice -- which we call “discriminatory pricing” -- in this report or the reports cited here.

Keep in mind that the uninsured are disproportionately lower-income people to boot, so we have a situation where those who are better-off generally pay a lot less for care than those who can least afford to pay more.

- The second unfair practice is that many patients who qualify for so-called “charity care” in the hospital or medical practice where they’re being treated – again the poorest -- are never informed of that fact, and thus billed for services they should never have had to pay for. There is great dispute over whether this misinformation comes about mostly by accident or design – there undoubtedly are cases representing both to be found somewhere in the country. We’ll leave it to the readers of this report to judge which explanation is the more prevalent.

It's important to note here that so-called "charity care" isn't something many hospitals are extending solely out of the goodness of their hearts. The fact is they usually have an obligation to extend this care, often because they're subsidized by government through the granting of non-profit status, property and other tax breaks, and government funding. In addition, many hospitals receive "Disproportionate Share" payments from the Medicaid and Medicare programs for serving low-income, vulnerable populations, which amount to over \$20 billion per year.⁶ They also receive private donations (for which donors can claim tax write-offs) to support their charitable activities. So their obligation to provide charity care is often explicit because hospitals are getting very significant financial benefits in return.

Even medical debt that's not eligible for charity care reveals large cracks in the health care system's foundations. More people are getting into more debt because more of them simply lack health insurance -- its rising cost is making it prohibitive for many families to buy their own even as fewer employers are providing it.⁷ There's also more medical debt because more families lack comprehensive insurance, meaning lots of care just isn't covered, and because more of those who have insurance are forced to pay more out-of-pocket for hospitalization, office visits, prescription drugs and other care.⁸

Medical debt is also undermining more families' financial security right now because it's paired with a host of outside factors affecting a wide swath of Americans. These include increasing family debt burdens caused by very high costs for other necessities like housing and education, plus increasing job insecurity, income volatility, and downward pressure on real incomes. These factors taken together are more commonly referred to as "The Middle-Class Squeeze."

⁶ Barbara Wynn, Teresa A. Coughlin, Serhiy Bondarenko, and Brian K. Bruen, RAND, *Analysis of the Joint Distribution of Disproportionate Share Hospital Payments* (Sept. 2002), available at <http://aspe.hhs.gov/health/reports/02/DSH/report.pdf>.

⁷ Sara R. Collins, Cathy Schoen, Michelle M. Doty, and Alyssa L. Holmgren, Commonwealth Fund, *Job-Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace* (March 2004), available at http://www.cmwf.org/usr_doc/collins_jobbased_718.pdf.

⁸ Cathy Schoen, Michelle M. Doty, Sara R. Collins and Alyssa L. Holmgren, *Insured but Not Protected: How Many Adults are Underinsured?* Health Affairs-Web Exclusive, June 2005.

II. A ROGUE’S GALLERY OF ABUSIVE PRACTICES: THREE OF THE WORST

We start by reporting that the following is a collection of examples we were able to gather about medical debt collection abuses and not a comprehensive, nationwide survey of the prevalence of these problems. Limited resources prevented us from undertaking extensive investigative work in this area. In addition to informing readers of the scope of this report, we state this to appeal to the news media to pursue these stories further. We commend the reporters who have already done groundbreaking work in this area, and hope that more can do so in their own communities. We also express our deep gratitude to the numerous community organizations, advocates and organizers that have labored for years to bring attention to this problem. They’re a good resource for journalists as well.

Though we were only able to document these practices through prior reporting and our own research that’s relatively close to hand, we’re highly confident based on what we’ve found that such practices are far more pervasive than even the widespread examples cited here.

That said, let’s start by listing the major abusive medical debt collection practices we’ll discuss in this report. As you’ll see, each of the individual case stories as well as the reports from local and state community groups contain examples of several of these practices. Given this duplication, it would have been difficult to segregate the documentation of each practice into its own individual section. The practices spotlighted in this report include:

A. FAILING TO OFFER CHARITY CARE to those who qualify for it, thus creating debts that should never exist in the first place and are subject to the abusive practices below.

B. PATIENTS AND THEIR SPOUSES SUED: Patients said to owe money are being relentlessly pursued by health care providers for amounts that are obviously well beyond any ability to pay -- or any ability to pay without impoverishing the patient's family. Spouses of incapacitated individuals are also being pursued under community property laws or archaic legal doctrines, an especially problematic practice for older Americans who can be financially ruined by a spouse's prolonged terminal illness.

C. CARE PROVIDERS AS DE FACTO LOAN BROKERS: Health care providers act as de facto loan brokers by referring uninsured consumers to credit card companies, finance companies and other high-cost creditors, advising these consumers to take out expensive credit to pay for medical bills. There's a conflict of interest in these arrangements, as it gives the provider clear reason to thrust the indebted patient into a situation that eases the provider's problem (getting payment) while creating problems for the debtors (unsustainable debt and its many negative offshoots that you'll see in this report).

A. Charity Care, Without the Charity

The failure to inform sick people of their eligibility for charity care creates loads of medical debt that should never exist, a double tragedy when the unwarranted debt in turn destroys a family's finances which is an exceptionally stressful, destructive and all-too-frequent outcome.

According to studies by **The Access Project**, 70 to 80% of patients with medical debt were never offered any financial assistance by their medical providers.⁹ A New York Times report discussing one of these studies also added **reporter Jonathan Cohn's**

⁹ Robert Seifert, The Access Project, *Home Sick: How Medical Debt Undermines Housing Security* (Nov. 2005) available at http://www.accessproject.org/adobe/embargoed_home_sick.pdf; (78% of patients not offered financial assistance); Dennis Andrulis, Lisa Duchon, Carol Pryor, and Nanette Goodman, The Access Project, *Paying for Health Care When You're Uninsured* (Jan. 2003), available at http://www.accessproject.org/paying_for_healthcare_when_youre_uninsured.pdf; (70% of needy emergency room patients said staff never offered to find out if financial assistance was available).

observation that: “among the patients I interviewed, even those who had been informed about charity care said the information was incomplete or delivered in a haphazard way.”¹⁰

These tragedies are further triggered and compounded by discriminatory pricing that over-charges uninsured patients. Then, when patients really can't pay, hospitals and other health care providers make a self-interested mockery of the problem by claiming the full inflated charge in their annual accounting of charity care disbursed, which exaggerates their benefit to the community, or by grandly “discounting” the inflated bill so that it appears they're giving a “break” to the beleaguered patient. But granting a 50% discount on a bill that's 300% of what an insured patient would have been charged amounts to exactly zero largesse, or no “break” at all.

Here are some charity care abuses reported around the country:

MINNESOTA

A recent compliance review by the office of **Minnesota Attorney General Mike Hatch**¹¹ found that one of that state's biggest health care providers, **Fairview Health Services**, frequently fails to offer qualifying patients charity care. Backed by affidavits from some 40 representative patients, the review notes that “Fairview has failed to adequately promote or implement its limited charity care policies” and that Fairview executives “have not fulfilled their fiduciary responsibility of ensuring that the organization acts in a manner consistent with its non-profit mission.”

“The indifference Fairview displays to these patients is particularly troubling,” the compliance review continues, “when juxtaposed against the golf trips, ski trips, country club memberships, luxury cars, lavish compensation and other perks extended to

¹⁰ Jonathan Cohn, *Uncharitable? Non-profit hospitals, with tax exemptions for serving the poor, are quietly charging indigent patients – and even suing over unpaid bills. How did an arrangement to serve the needy become so unhealthy?* New York Times Magazine, December 19, 2004.

Fairview executives.” One cancer patient who says she was never informed of any charity care or financial assistance options appealed to the Attorney General’s office after being hounded by Fairview’s debt collection agency, saying: “Short of killing myself, I don’t know what else to do.”

In testimony this past April before the **U.S. Senate Finance Committee, Attorney General Hatch** detailed extensive laundry lists of lavish perks and compensation uncovered in compliance reviews of two other large, non-profit Minnesota health care providers, **Allina Health Systems** and **HealthPartners**.¹² The Allina case was especially egregious, including among many other items an expensive retreat to Monterey, California, where executives and their spouses traveled in limousines and spent thousands of company dollars on meals at exclusive restaurants.

Allina told Hatch’s office that trip was “designed to teach executives how to run a health care system with a ‘moral center.’”

Later in his testimony, and without naming specific care providers, Hatch told the Senate that “many non-profit hospitals deliver charity care at paltry levels, far less than the need of their patients or their revenue, assets or fundraising would allow.” He said many hospitals mislabel other expenditures or even the difference between discounted government reimbursement rates and “sticker” prices for care as charity care, then tout their supposed level of charity when soliciting tax-deductible donations.

“A hospital that does this,” Hatch said, “while at the same time billing the uninsured a phony retail price, not providing fair levels of charity care, and hounding patients through unfair debt collection practices, engages in the fraudulent solicitation of charitable donations.”

¹¹ Minnesota Attorney General’s Office, *Compliance Review of Fairview Health Services* (Jan. 31, 2005), available at <http://www.ag.state.mn.us/consumer/PDF/CharityCare.PDF>.

¹² Senate Finance Committee Hearing, Statement of Minnesota Attorney General Mike Hatch (April 5, 2005), at <http://finance.senate.gov/hearings/testimony/2005test/mhtest040505.pdf>.

CALIFORNIA

Last summer California's **Health Consumer Alliance**, a partnership of 10 state health care advocacy groups, issued "Sick and in Debt: Improper Practices that Cause Medical Debt for Low-Income Californians." Among the report's findings are that some of the state's health care providers "fail to screen uninsured consumers" for charity care and other free- or low-cost care programs, and that some county hospitals and their contractors also fail to screen patients' eligibility for programs for the medically indigent.

The result? "Patients who are least able to afford their care end up with medical debt."

NEW YORK

The Legal Aid Society of New York, in two studies,¹³ extensively documents how patients in New York City's many hospitals routinely fail to receive the charity care to which they're entitled even as they're often charged inflated "sticker" prices for their care. Some of the studies' findings are:

- That the state does not hold hospitals accountable for how they disburse much of the \$847 million allocated for its Bad Debt and Charity Care ("BDCC") fund.
- That *none* of 22 hospitals surveyed in the first study had any process for uninsured and underinsured patients to apply for and access BDCC funds. Nor did any of these hospitals post public notices advising patients of the availability of this care.

¹³ Legal Aid Society of New York, *State Secret: How Government Fails to Ensure that Uninsured and Underinsured Patients Have Access to State Charity Funds* (2003), available at <http://www.legal-aid.org/Uploads/BDCCReport.pdf>; Legal Aid Society of New York, *State Secret 2005: How Government Statutes and Hospitals' Voluntary Efforts Fail to Protect Uninsured and Underinsured Patients* (Jan. 2005), available at <http://www.legal-aid.org/Uploads/statesecret05.pdf>.

- That there's no protection for these patients when hospitals charge maximum rates for services, or fail to offer inpatient sliding-fee programs or realistic payment plans.
- That state law doesn't require hospitals to advise patients about financial assistance programs, fails to regulate the often-high charges levied on low-income uninsured and underinsured patients, and fails to regulate often-aggressive hospital debt collection practices.

CONNECTICUT

At Connecticut's non-profit **Yale-New Haven Hospital** (YNNH) and a sister institution, a joint investigation by a labor union and public-policy group uncovered continuing problems with treatment of the uninsured and underinsured. In the report "**A Debt Past Due: The need for more charity care reform at Yale-New Haven Health,**"¹⁴ investigators found that "YNNH administers its free care program so inefficiently as to rouse speculation that the program is designed to reject on technicalities and to discourage as many eligible applicants as possible." They also found that the system's free care application requirements discriminate against immigrants, that it provides less free and uncompensated care than many other hospitals in the state, and that it continues to employ an array of aggressive collection tactics against patients who should qualify for free care.

"These revelations are even more disconcerting in light of the Hospital's written policy of denying care to uninsured and underinsured patients with outstanding debts," states the report.

¹⁴ The report was produced by the Hospital Debt Justice Project, which describes itself as "a joint initiative of the Connecticut Center for a New Economy and the New England Health Care Employees Union, District 1199/SEIU." The SEIU is the Service Employees International Union.

ILLINOIS

Extensive charity care problems and other medical debt collection abuses have also been reported in two parts of the Illinois, the Chicago area and the downstate twin cities of Champaign-Urbana. There'll be more about Champaign-Urbana later in this report.

In the report “Insult to Injury: Hospital Debt and Aggressive Collections Practices by Advocate Hospitals,” the **Hospital Accountability Project of the Service Employees International Union** takes to task Advocate Hospital & Health Care Corporation, metropolitan Chicago’s second-largest private employer with 10 hospitals and more than 200 health care sites. Among the findings:

- “Rather than extending charity care, Advocate has sued families and individuals who cannot make payments, have no wages to garnish and no property to seize. Even when Advocate fails to recover any portion of the bill, the lawsuits can destroy whatever credit the indigent family possesses.” (We’ll return to the topic of medical debt’s impact on family credit ratings later in this report.)
- Repeated instances where patients were never told they might be eligible for charity care, or were denied care even though non-Advocate providers had extended it to them and often for the same illness.
- Very harsh debt collection tactics including rude and abusive collection techniques, predatory payment agreements and the use wage garnishments and property liens – all of which will be further discussed later in this report.

The Hospital Accountability Project’s Jack Hanson told NCLC in June that “one of the major difficulties we have encountered in our work is the refusal of hospitals to commit publicly to real, systemic reform of their charity care policies and collections practices, rather than just responding piecemeal to the cases that have attracted media attention.”

Three Stories from the Hospital Accountability Project’s “Insult to Injury”

ROSE SHAFFER

Without health insurance, the road to bankruptcy can hit middle-class professionals as well as the poor. Rose Shaffer, a registered nurse, now works two jobs in order to make ends meet. She serves as Director of Nursing at a long-term care facility in the South Lawndale community on Chicago’s West Side, and also works a part-time nursing position.

Her full-time job provides her with insurance through a PPO plan. It was a different story in 2000, when Shaffer worked at a home health agency that did not provide health coverage and was so poorly managed that several of her paychecks had bounced. Shaffer suffered a major heart attack in October of 2000. Paramedics rushed her to Advocate South Suburban Hospital, where she was kept for two nights and then transferred to Advocate Christ Hospital, where she stayed one night. They charged her almost \$18,000, or about \$6,000 per day. (If Shaffer had been insured under a typical group policy, the insurance company would have been asked to pay approximately \$8,500).

At South Suburban, the social worker asked her about her insurance and told Shaffer she would mail her application forms for help paying her bills. Shaffer never received any such charity care forms. When she called the hospital, nobody knew anything—she kept getting transferred, and eventually would get cut off and have to start over.

Shaffer waited for the charity care application. Then she was sued. Later, Advocate got the court to issue a warrant for her arrest for failure to appear.

She has been to court twice, once to get the arrest warrant vacated, and once in late October, 2002, when she was accompanied by a lawyer.

“I never appeared before a judge. We went into the hall with the hospital’s lawyer. My lawyer tried to get him to work out a payment plan, but Advocate’s lawyer said he wasn’t authorized to do that. My heart attack and the bills threw my whole life out of kilter—my house is in foreclosure, my debts have climbed.”

Shaffer was told that there was nothing that could be done for her at court, that they would start to garnish \$350 from each paycheck. Her doctor told her to avoid stress, but the lawsuit and debt were taking a toll. “The hospital saved my life and now they’re trying to take it,” she says.

Rose recently filed for Chapter 13 bankruptcy. Asked if she would return to South Suburban Hospital, Rose said, “Hell no! Not even if I had another heart attack.”

(Note: Ms. Shaffer is a cousin of U.S. Senator Barack Obama, who says in the report: “My cousin Rose Shaffer was a victim of Advocate’s aggressive collection practices. She was forced into bankruptcy over her \$18,000 bill. “Insult to Injury” exposes our failure to protect society’s most vulnerable citizens. People should not be treated like criminals or harassed simply because they were sick and did not have adequate insurance. I am committed to working diligently to protect consumers from this type of activity.”)

SHENELL WILSON

"I grew up in the Lutheran Church, and my aunt Merla still attends Bethany Lutheran Church," said Shenell Wilson, a young single mother (NOTE: The Advocate health care system is affiliated in part with the Evangelical Lutheran Church of America). At the time Shenell was admitted to Advocate Trinity Hospital because of a miscarriage she was working at a laundromat and didn't have health insurance.

Shenell was in the hospital for one day. She was not told that Advocate offered charity care and wound up with a bill of \$5,468. Afterward, Ms. Wilson recalls that they sent letters and made phone calls asking for payment.

"I tried to make payment arrangements but they said I took too long and they wanted half the money. I couldn't afford it." Advocate secured a judgment against Shenell and began garnishing \$25 from her already low weekly take home pay of \$255. "They sent letters to my boss. He didn't want to cooperate with them but they threatened to sue him too."

Several months later the laundromat closed down. Shenell is now looking for work. She'd like to be a housekeeper or dietary aide at Trinity Hospital since it's so close to her house and she doesn't have a car.

"I try my hardest not to get sick. I don't want to go to the doctor anymore. I can't afford it. I'm looking for work. But when I do find a new job, sooner or later Advocate will start taking money out of my check again."

At the first court date, the Advocate lawyer approached Hardiman with a deal. Under Illinois law, a legal garnishment of her wages would come to approximately \$26.25 per week, or \$105 per month. Advocate's lawyer met with Bertha, who did not have a lawyer, and "negotiated" an agreement that has her paying \$200/ month, **almost twice the amount legally allowed by garnishment.**

"I'm paying all this money I can't afford. I'll never go back to Bethany again. Cook County has the best doctors, and they don't sue you," said Bertha.

Regardless of the legality of what transpired in the payment arrangement Bethany reached with Hardiman, the disconnect grows between Advocate's professed values and its behavior. "The mission of Advocate Health Care," says some of the non-profit's corporate literature, "is to serve the health needs of individuals, families, and communities through a holistic philosophy rooted in our fundamental understanding of human beings as created in the image of God."

BERTHA HARDIMAN

Bertha Hardiman is a laundry worker for the Aramark Corporation. One day she fainted at work and was rushed to Advocate Bethany Hospital in an ambulance. Once there, Hardiman was told that she just had gas in her stomach and chest. The doctor put her on an IV and ran some tests.

She was released and stayed home from work for a couple of days. Some days later Bertha passed out at home, and again was taken to Bethany Hospital. The third time this happened, Hardiman decided to go to Cook County Hospital. She stayed a week at County, where they diagnosed the problem as gallstones and performed surgery to have them removed. Since then Hardiman has been feeling much better.

Hardiman didn't have trouble with her bill from Cook County Hospital—it was settled between County and the insurance plan she received from work.

But Advocate Bethany Hospital was a completely different story. The insurance company kicked in only \$2,000 toward Bertha's bill and refused to pay any more. That left Bertha to come up with the rest: \$6,192.

Hardiman only makes \$8.60 an hour at Aramark and couldn't come up with more than \$6,000 for Bethany. So Advocate sued her. Hardiman had nobody to represent her in court against Advocate's collection attorney. In a handwritten note in the court file, she had written, "No, I don't think I should pay for the amount they suing me for because I'm not able to pay for it. My insurance should.... They suppose to pay (sic) 80% of my hospital bill but they did not pay 80% of my bill."

The Legal View: Uncharitable is Unfair

A few attorneys and advocates have attempted to challenge the uncharitable behavior of hospitals and their discriminatory pricing practices. Legal services attorney Alan Alop, a pioneer in representing patients dunned for medical bills, challenged the discriminatory pricing policies of Resurrection Medical Center in Chicago using the Illinois Consumer Fraud Act. Alop's lawsuit argued that charging uninsured patients several times more than government and private insurers was an unfair business practice. Alop cleared a major legal hurdle in January 2005 when the trial court held he had a viable legal theory to proceed.¹⁵

In Connecticut, YNHH has been sued numerous times over its failure to inform eligible patients of the availability of charity care. Connecticut courts have found that patients could challenge YNHH's behavior under that state's Unfair Trade Practices Act.¹⁶

A coalition of consumer attorneys, led by famed Mississippi plaintiff's attorney Richard F. Scruggs, have filed lawsuits against a number of hospital systems and the American Hospital Association over aggressive debt collection techniques and the failure to provide charity care despite their nonprofit status.¹⁷ While the lawsuits have met with mixed success in federal court, they were re-filed in state court under state consumer protection laws, which apparently has been the better strategy.¹⁸

One Scruggs-related lawsuit led to a tentative settlement with giant regional health care provider, **North Mississippi Medical Center**. According to the Washington Post, the agreement called for North Mississippi "to provide free care for patients earning less than 200 percent of the poverty level and low-priced care for those with incomes up

¹⁵ *Servedio v. Our Lady of the Resurrection Medical Center*, No. 04 L 3381 (Cir. Ct. Cook County Jan. 6, 2005).

¹⁶ *Ahmad v. Yale New Haven Hospital*, 2004 WL 2361781 (Conn. Super. Sept. 29, 2004); *Yale New Haven Medical Center v. Mitchell*, 683 A.2d 1362 (Conn. Super. 1995) (correcting opinion at 662 A.2d 178); *Yale New Haven Hospital v. Gargiulo*, 1999 WL 989422 (Conn. Super. Oct. 18, 1999).

¹⁷ Information about these class action lawsuits is available at www.nfplitigation.com.

to 400 percent of poverty.”¹⁹ The hospital also agreed to issue refunds to patients meeting those criteria who’d been treated over the three previous years. The deal fell apart, however, when the hospital said news of it began attracting indigent patients who would have otherwise gone elsewhere for their treatment.

The unraveling of the North Mississippi settlement points out the problem with simply reforming medical debt collection practices on a case-by-case basis. Hospitals may fear they will become a “magnet” for uninsured patients if they offer discounts or explicitly tell patients about free care. Addressing the problem of medical debt collection will require more than the kindness of hospitals - it will require legislation or regulatory change to ensure an “even playing field” prohibiting all hospitals from engaging in abusive practices and requiring them to publicize their charity care and collection policies.

B. “The Criminalization of Illness”: Suing the Indebted and Their Spouses

Very few tactics seem more heartless than to sue a sick, uninsured patient to collect on a medical bill (and for amounts that are far above what insurers pay due to discriminatory pricing). Yet suing patients, and their spouses, is a common collection tactic for providers. A review by the **Champaign County Health Care Consumers** of small claims court records found that during a six month period, health care providers filed 7 lawsuits a week against their patients.²⁰ Journalist and author Barbara Ehrenreich calls the burden of brass-knuckle medical debt collection tactics “the criminalization of illness.”

¹⁸ Press Release, Nonprofit Hospital Litigation Status, Statement From Dick Scruggs (October 11, 2005).

¹⁹ Ceci Connolly, *Tax-Exempt Hospitals’ Practices Challenged, 46 Lawsuits Allege That Uninsured Pay the Most*, Washington Post, January 29, 2005.

²⁰ Champaign County Health Care Consumers, *How Medical Debt Affects Champaign County Consumers* (July 11, 2002), available at http://www.prairienet.org/cchcc/Medical_Debt/med-dp2.htm.

Hospital officials and experts testifying before Congress in June, 2004²¹ claimed that debt collection efforts against uninsured consumers generate little revenue. Given that reality, the fact that such efforts persist with a high level of vigor raises a simple question: Why? Here are two opinions.

“Their goal is to discourage these uninsured patients from returning,” **Mississippi attorney Richard Scruggs** told the Washington Post.²² Scruggs, who’s suing hospitals nationwide over their billing and debt collection practices, isn’t alone in his opinion.

“They are sending a message to the community,” Minnesota Attorney General Mike Hatch told the Minneapolis Star-Tribune. “The best way to prevent these (uninsured) people from coming back is to pound them. Those people are too afraid to come back in.”

The lawsuit and threats of legal action have emerged among the weapons of choice for pursuing medical debtors.

NEW JERSEY

How far will health care providers carry this tactic? Let’s start with one powerful recent example from New Jersey. What follows are the opening words from “Crushed by Medical Bills,” a lengthy report by Lindy Washburn that ran June 12th of this year in the Record newspaper of Hackensack. This appalling and powerful story can be read in its entirety in Appendix A of this report. Here are its opening paragraphs:

“The sheriff’s constable delivered the lawsuit to the neat brick home in Cliffside Park on Valentine’s Day. It was a bouquet of heartache from Hackensack University Medical Center.

²¹Subcommittee on Oversight and Investigations, House Energy & Commerce Committee, *A Review of Hospital Billing and Collection Practices* (June 24, 2004).

²² Ceci Connolly, *Tax-Exempt Hospitals’ Practices Challenged, 46 Lawsuits Allege That Uninsured Pay the Most*, Washington Post, January 29, 2005.

"‘GUIDO OSSO,’ it read. ‘You are hereby summoned in a Civil Action of the Superior Court of New Jersey.’

“The reason: Failure to pay a hospital bill of \$160,170.35.

“The wanted man sat at home, slumped in his wheelchair. His head rested on a television tray and his bottom on an incontinence pad. Since a devastating series of strokes in 1999, the 66-year-old Osso hadn't known what day it was, much less the details of his worsening financial situation.

“He'd been a butcher all his working life, cutting steaks and roasts at the Grand Union and A&P. He was a member of his union's health plan. When he felt sick that October morning as he woke up to take his 14-year-old son to school, his family thought only of his health.

“Little did they know that his illness could end up costing them everything. Guido Osso didn't have enough health coverage. It ran out 21 days into his 38-day stay at Hackensack.

“From that moment on, everything done for Guido was on Guido's dime.

“He was charged the hospital's highest rates - its so-called sticker prices - rather than the heavily discounted fees insurers pay. That meant he was billed nearly twice as much as his health plan would have paid for the same care.

“And when he no longer qualified for the insurance discount, the hospital was no longer satisfied with his plan's payment for those first 21 days. He was billed tens of thousands of dollars more for that care, too.

“It was all completely legal. The Osso family's predicament was business as usual for the hospital's billing department.

“‘We look to recover our charges one way or another,’ said Harold Hogstrom, Hackensack's chief financial officer. If a patient is underinsured, ‘we can't be expected to write the rest of it off.’

“Guido Osso's story is a cautionary tale. It shows how inadequate insurance, rising medical costs and aggressive hospital collections all contribute to America's worsening health-care crisis. For millions of Americans, financial disaster is just one hospital stay away.”

The Record's reporting recounts how bills from the illness devastated Osso's family, its finances, and its dreams in a variety of ways – and remember this was a family that had health insurance coverage at the time Guido Osso fell ill. As of the date of that story, the hospital was still pursuing the Osso family in court.

One might wonder, after reading such a tale, whether it merely represents an extreme or outrageous example. Consumer advocates, after all, battle a constant litany of “spin control” from industries caught red-handed committing abuses who claim that “it's just a few bad apples” and not representative of a supposedly more benign whole.

Unfortunately, Guido Osso has plenty of company.

MASSACHUSETTS

In Springfield, Massachusetts, **Baystate Medical Center** stopped suing patients and placing liens on their homes early this year after being placed under state review for its aggressive collection methods. Hospital executives also told **The Boston Globe** that they will no longer tack interest onto patients' unpaid bills.

A Globe review of court records found that Baystate's collection firm had taken nearly 300 patients to court in the previous 15 months and placed liens on the homes of at least 46 patients. The firm "was charging patients up to 12 percent annual interest, creating situations in which patients could never climb out of debt because the charges accrued faster than they could afford to pay them off," the Globe reported.²³

How prevalent are these tactics in Massachusetts? According to a February 2004 survey on medical debt in the state from **The Access Project**,²⁴ "almost two-thirds of respondents with debt said they had been contacted by a collection agency, while 16 percent were sued in small claims court because of the debt." While these results were limited to the clients at the two community health centers that were surveyed, they are consistent with many other studies.

The study also found that lots of Massachusetts residents are laboring under the burden of medical debt -- this in a state which historically has had a relatively extensive social safety net and which even now boasts a state-funded Uncompensated Care Pool to partially reimburse hospitals' charity care costs. The Access Project study found that "medical debt is a serious problem for many people," with 41% of the 342 survey respondents reporting such debt and a surprising 29% of respondents who were continually insured over the past year also carrying debt.

Even more disturbing, the report found that "almost six in ten respondents (59%) said their medical debt caused them to delay getting needed health care. Most of these respondents said they delayed care because they were uncomfortable about their bills (73%), but 30% said they were asked to pay cash upfront, and 14 percent said they were denied care altogether."

²³ Liz Kowalczyk , *Hospital Softens Collection Tactics*, Boston Globe, January 27, 2005.

²⁴ Carol Pryor and Deborah Gurewich, *The Access Project, Getting Care But Paying the Price: How Medical Debt Leaves Many in Massachusetts Facing Tough Choices* (Feb. 2004), available at <http://www.accessproject.org/downloads/MAreport.pdf>.

CONNECTICUT

In neighboring Connecticut the problems at Yale-New Haven Hospital extend to suing indebted patients.²⁵ One of the findings by the Hospital Debt Justice Project:

YNHH still files collections lawsuits against patients who qualify for its free care program, uses liens (on patient's homes), and uses....an aggressive law firm the Hospital claims to have fired. YNHH filed a total of at least 152 new collection lawsuits in the first 10 months of 2004 (331 including Bridgeport Hospital). The Hospital is still demanding patients pay court costs and is charging the maximum interest allowable by law.

YNHH is also engaging in a new practice of suing the vast majority of patients in distant courts outside of the city of New Haven, which may enable the Hospital to more easily obtain court judgments by default (because more patients don't show up at distant court venues) and avoid fulfilling its legal obligations to cease collections against patients eligible for free care. 'I called [YNHH] for help to pay the bill,' said one impoverished patient from New Haven who was sued for a \$3,800 emergency room bill, 'and the woman told me that they would send me a form. The only mail I received was an order from a court in Meriden.' (Meriden is 20 miles away.)

CHICAGO

The New York Times Magazine's "Uncharitable?" story gives several accounts of lawsuits aimed at medically-indebted patients by Chicago-area hospitals, including:

²⁵ Hospital Debt Justice Project, *Broken Promises: A Debt Past Due at Yale-New Haven Hospital* (May 2005), available at <http://www.ctneweconomy.org/Publications/Debt.pdf>.

-- A suit aimed at a widow, Margaret Loncar, whose husband had refused to be taken to **Advocate Christ Medical Center's** emergency room on the day he died, a refusal his wife believes was triggered by the family's \$40,000 outstanding debt to the hospital. Loncar told the Times she had been refused reduced-cost or charity care there in the past despite having little money. She said she learned of the suit when she learned that the hospital had won a judgment allowing it to garnishee her wages, taking the legal maximum of about \$100 from her \$680 bi-weekly gross pay. The garnishments, which she eventually recovered in court, had by that time triggered a second financial crisis that forced the family from their mobile home.

-- Robin Lee Kemp told the Times she had one brief conversation about financial assistance at **Resurrection Westlake Hospital**, while heavily medicated, when she received emergency room care there in 2000. She says the next thing she heard from the hospital was a summons for an unpaid bill of nearly \$9,000. She offered partial payment plus monthly installments at that point but was told it was too late, and ended up filing for bankruptcy. Kemp and the hospital disagree over how much information she received from the hospital, and provided to it, during that incident.

-- Marijon Binder says she submitted a charity-care application to **Resurrection Medical Center** after an August 2001 emergency room visit, but an \$11,395 bill nevertheless arrived in her mailbox shortly thereafter. The hospital says it never received the application or responses to half a dozen notices it sent. Binder, a former nun who chose the hospital because of its Catholic mission, says she tried to rectify the matter after receiving the notice and was told not to worry, but then a police officer showed up on her doorstep, summons in hand. She says she made several direct appeals to the hospital but it would not relent until, months later, a judge took her side in court. "To this day," the Times account says, "Resurrection argues that its records show Binder to have been the irresponsible party." The story then adds: "From 2000 to 2003, Resurrection pursued cases against at least

77 other people who qualified for indigent status... Today, Resurrection still uses the standard method for paying its collection attorneys – offering them a percentage of the money they collect. Under this scheme, if the attorney discovers that a defendant was wrongly denied charity care and refers the patient back to Resurrection’s financial assistance office, that attorney would get no compensation.”

These practices aren’t just limited to a few Chicago-area hospitals, according to the **Hospital Accountability Project of the Service Employees International Union**. The Project’s October 2003 “Insult to Injury” report notes that, based on a review of 2001 Cook County court records, “the 59 acute-care hospitals in Cook County filed 5,493 lawsuits in 2001 against people with unpaid hospital bills,” with an average amount of \$5,552 sought in each case.

The report says that the **Advocate Health Care** system, with a sixth of the region’s market share, is responsible for almost a quarter of the suits filed and more than 38% of the dollar amount sought.

Things haven’t changed much since 2001 either, says **the Project’s Jack Hanson**. “One of the major difficulties we have encountered in our work,” he wrote in June, “is the refusal of hospitals to commit publicly to real, systemic reform of their charity care policies and collections practices, rather than just responding piecemeal to the cases that have attracted media attention.”

Hanson says he is continuing to encounter lawsuits filed by hospitals (including hospitals with charitable missions), as well as wage garnishment, spouses being sued for bills incurred by their deceased partners, and “many” liens being placed on homes of those said to owe medical debt.

CHAMPAIGN-URBANA

One would think a place that's garnered national headlines for its health care providers' medical debt collection tactics and charity care problems might see an across-the-board tempering of those tactics, but that doesn't appear to be the case in the twin university cities of **Champaign-Urbana, Illinois**.

Longtime Champaign-Urbana advocate for health care consumers Claudia Lennhoff says the region's two big hospitals, under threat or actual loss of their property tax-exempt status, have improved, but that other providers like local clinics have continued or even escalated harsh tactics until "a greater number of people are still affected" than ever before.

The two hospitals found themselves on the front page of the Wall Street Journal in a 2003 story about their use of "body attachments," the actual arrest and incarceration of medical debtors. That practice has stopped, Lennhoff says, but "we're seeing a lot of wage garnishments and also going after spouses for medical debts."

Lennhoff says the for-profit Carle Clinic Association, attached to non-profit Carle Hospital, and Champaign's Christie Clinic both have flagged the accounts of those deemed to owe the clinic money and now refuse to grant medical appointments to those people unless they first talk to the clinics' accounts-payable department. Worse, Lennhoff says they are also refusing to grant appointments to uninsured people and those covered by Medicaid, meaning that "about 30 percent of the people in this county can't see a doctor."

The tactic of denying people appointments might not be such a big deal in a major city, but Lennhoff says the Carle Clinic is the practice base for 60% of greater Champaign-Urbana's doctors. The two clinics combined are base to more than 90% of the county's doctors. She also notes that many people who have insurance have run into medical debt woes, not just those seeking uncompensated care, and she says both clinics

have also been known to abruptly change payment conditions for debtors already using payment plans.

And it's frighteningly easy to get into debt trouble with these clinics. Lennhoff says that the clinic's portion can easily constitute half the cost of a hospitalization bill.

"They don't have to play by any rules," she says. "It's unfair to work out a payment agreement, have people honor it, and then six months later tell them that they have to do things differently."

Lennhoff says she's received no answer when she asked why this practice occurs. "They don't answer because they don't have to," she says, "and someone should make them answer."

The two clinics also continue imposing harsh terms like 10-month payment plans on those who owe them money (requiring full payment of the debt in 10 monthly installments), and pushing people into using credit cards to retire their medical debt.

It seems to work, at least for the medical providers. "People are paying," says Lennhoff. "My complaint is that they try to pay but this is involuntary debt that people with relatively small balances like \$300 to \$600 are being strong-armed, and that even payers with a good track record are being squeezed."

Lennhoff, who heads the non-profit **Champaign County Health Care Consumers**, says the group looked at lawsuits filed against medical debtors by Carle Hospital and found that half of them were against people living in the county's poorest neighborhoods.

She says that until recent improvements, "hospitals had to be dragged kicking and screaming into telling folks about charity care, and when a person called the first thing they'd suggest is a payment arrangement."

In April, the **Champaign-Urbana News Gazette** reported that the county's Board of Review recommended that the state deny property tax-exempt status to five Carle Foundation Hospital properties.

"In a 14-page brief," said a story by **reporter Mike Monson**, "the county board of review said that 0.5 percent of Carle's revenues go toward providing charity care and that the hospital charges the low-income uninsured its highest list prices.

"Carle Foundation also files 'a large number of lawsuits' against patients who are unable to pay their medical bills and does not publicize its charity care program well, the brief said."

NCLC obtained a copy of the Board of Review's brief, which contains this observation in its conclusion, a reference to the for-profit Carle Clinic: "There is a glaring juxtaposition of a 'charitable' hospital allowing doctors complete access and use of their 'exempt' facilities to pursue private gain while this same 'charitable' hospital continues an unfair policy of overpricing and suing the uninsured. This juxtaposition cannot be ignored, and it violates one's sense of fairness. It is our view that no hospital that permits this fundamental unfairness to exist can be considered 'charitable' or tax-exempt."

MINNESOTA

Minnesota Attorney General Mike Hatch told the U.S. Senate's Finance Committee that, in his state, "some non-profit hospitals hire debt collectors to sue impoverished patients, to garnish their meager bank accounts, hound them with harassing calls or even threaten them with arrest... We have discovered debt collection lawyers who lie about serving summonses (and) who sue patients because hospitals bill insurers over a year late and are therefore barred from collecting from the insurers."

Winning by Default

Advocates for medical debtors say that lawsuits are a highly-effective way for health care providers to pursue patients because, for various reasons, they are often won by default (in the absence of the defendant) and therefore are quick and easy victories. For example, YNHH won by default in 70% of the medical collections lawsuits it filed. Only 9% of patients sued by YNHH were able to obtain legal help to defend themselves.²⁶

Another important aspect of the many default judgments is that providers don't have to defend or even reveal their pricing structures and collection practices – revelations they might be reluctant to make before a jury because it would display so many of the embarrassing aspects of how hospitals price services for the poorest patients.

This kind of pressure on supposedly-indebted patients also has very real health consequences, consequences that too often go unnoticed. Medical debtors often shun or are denied additional needed treatment, and those postponements often mean more expensive and less effective care later on as conditions that should have been nipped in the bud worsen. This cycle of indebtedness also creates extremely serious family stress, the kind that prompted one target of a Chicago hospital's debt collectors to say: "They are like bulldogs backing you into a corner. They're cutthroat."

Dunning Widows and Spouses: The Unnecessary Doctrine of Necessaries and Community Property Laws

It's bad enough that medical debt ruins the lives of patients, but providers ruin entire families by aggressively pursuing spouses. The stories of Elia Osso and Margaret Loncar discussed earlier are only two of the many examples of this tactic. Spouses of medical debtors, themselves often elderly and stressed by the burdens of caring for their

²⁶ Connecticut Center for a New Economy, *Uncharitable Care: Yale-New Haven Hospital's Charity Care and Collection Practices* (Jan. 2003), available at <http://www.ctneweconomy.org/Publications/UC.pdf>.

sick loved one, find themselves the target of collection calls and lawsuits. As with Margaret Loncar, the patient may have even passed away, leaving their elderly surviving spouse harassed and impoverished by the pile of medical bills remaining. Imagine spending what are supposed to be your golden years of retirement in constant fear and stress like Elia Osso.

You might ask – what gives the hospitals the right to go after someone who didn't incur the debt? In some states, it's community property laws that say what's John's belongs to Jane – both the property and the bills. While that may make sense for property and for some debts, it creates an unbearable hardship when it comes to medical debt. In non-community property states, it's an archaic legal theory called the “doctrine of necessities.” This doctrine originated in the 19th Century, when married women were not able to own property. In order to enable wives to buy “necessaries” from merchants on credit, the law imposed liability on husbands for their wives' bills for necessities, including medical bills, but not vice versa. Some states have abolished this doctrine or ruled it unconstitutional, but many other states have rewritten it to impose liability on a wife for her husband's expenses. Medical providers are one of the main groups that use the doctrine of necessities to pursue spouses for the debts incurred solely by the debtor.

C. Any Way You Can: How Care Providers Push Debtors Into Deep Water by Acting as De Facto Loan Brokers

A growing debt collection tactic by health care providers is to urge patients to borrow money to pay medical bills. Medical bills are a big source of credit card debt. A recent survey by **Demos** and the **Center for Responsible Lending** found that medical bills contributed to the credit card debt for 29% of low and middle income borrowers.²⁷

For providers, the advantages of convincing those owing them money to pay it by taking out a loan or credit line are obvious: they usually get their money right away,

²⁷ Demos and Center for Responsible Lending, *The Plastic Safety Net* (Oct 2005), available at http://www.demos.org/pubs/PSN_low.pdf.

while in many cases simultaneously offloading any burden for pursuing payments to third parties. In addition, there is evidence that patients feel more pressured to pay off a credit card bill than a medical debt. One purveyor of a medical credit card claimed that its borrowers have paid about 80% of their bills, more than twice the industry average.²⁸

The advantages (if any) for patients aren't so clear. Before we get into that, let's first raise a few questions about the whole notion of health care providers steering patients toward these payment plans:

- Was the patient eligible for charity care and adequately informed of that eligibility, and is the patient being charged a fair price for services rendered along the lines of what other patients' insurers would pay?
- Is the care provider receiving a commission or other form of kickback from the lender, and if so does that constitute a conflict-of-interests?
- Are non-profit care providers violating rules governing their status even if they don't receive some form of kickback?

A cursory examination of this form of medical debt collection uncovered several examples from around the country:

ALABAMA

Several months ago **Attorney P. Michael Yancey** of the **McCallum & Methvin law firm** in Birmingham, Alabama, sent NCLC a disturbing example of one way that steering medical debtors toward consumer finance "solutions" can go awry. Here's a portion of his account, with the names of the clients on whose behalf he sued omitted to protect their privacy.

"My clients, (Mr. and Mrs. X), are an elderly couple who purchased hearing aids for (Mr. X) in June 2002. The purchase was made at Doctors Hearing Center ("DHC")

²⁸ Daniel Costello, *Hospital Bills – But With Interest*, Los Angeles Times (December 12, 2005).

and the cash sale price for the hearing aids was \$2,136.24. DHC encouraged (Mr. and Mrs. X) to participate in a payment plan for the hearing aids because (Mr. X's) insurance claim would take some time to process and the payment plan would allow (Mr. X) the convenience of receiving the hearing aids immediately. (Mr. and Mrs. X's) insurance was to pay \$1,600 and (Mr. and Mrs. X) were to pay the balance of \$536.24.

“The payment plan was offered through “Elite Physician Services” (“Elite”) who ‘partnered’ with MBNA²⁹ for the financing. Elite processed the application over the telephone, MBNA made the credit decision and agreed to extend credit for the hearing aid purchase. (Mr. and Mrs. X) understood that this process was being done only for the purpose of providing DHC with immediate payment for the hearing aids. Once the insurance claim was processed, (Mr. and Mrs. X) would pay their \$536.24 portion of the bill and the transaction would be complete.

“Unknown to (Mr. and Mrs. X) was the fact that Elite and MBNA were arranging credit in the form of a \$15,000 line of credit (obviously, an open-end transaction). After (Mr. and Mrs. X) paid their \$536.24 to MBNA, the bills kept coming, interest kept accruing and the open-end nature of the transaction spiraled out of control. (Mr. and Mrs. X) disputed the accounting, the matter went to collections, more disputes were lodged, collection efforts continued over the objections, and eventually the lawsuit was filed.

“In response to discovery requests, Elite revealed that its employee took (Mr. and Mrs. X's) application over the telephone, received approval from MBNA and informed (Mr. and Mrs. X) of the approval. Also, MBNA funded the deal by sending \$2,136.24 to Elite. Elite then sent \$1,922.62 to DHC for payment of the hearing aids. Elite's contract with MBNA, as well as the contract with DHC calls for Elite to retain 10% of every deal. This fact was not disclosed to (Mr. and Mrs. X) and is not disclosed on any forms used in Elite transactions.”

²⁹ MBNA is one of the largest nationwide credit card issuers.

At the end of August, 2005 Attorney Yancey said MBNA had tentatively agreed to a settlement of Mr. and Mrs. X's lawsuit in this matter, but that the matter is still pending with MBNA's co-defendant Elite Physician Services.

THE CAROLINAS

The **Carolinas HealthCare System** serving both North and South Carolina offers the following ways of financing medical debt on its website, which at least mentions the possibility of charity care:

“Long-Term Payment Arrangements: Some patients are unable to pay balances in full and need extended time to pay for services. Carolinas HealthCare System has a business partner who offers long-term financing options to assist in these situations. They establish affordable payment arrangements without a credit check and without a lengthy application. All patients qualify by agreeing to accept the terms of this payment program. Please contact Customer Service at 704-512-7000 to establish a payment arrangement. Sending a partial payment does not establish a formal payment plan.

“Financial Counseling: Carolinas HealthCare System has several ways to assist patients who do not have insurance or cannot pay their deductible or co-payment at the time of service. We offer a healthcare credit card through a business partner, which allows monthly payments on account balances. For patients who are financially unable to pay, Financial Counselors are on staff to assist with eligibility for Medicaid, Mecklenburg County Indigent Funds (Mecklenburg County Residents only) and our Uninsured/Charity Care program. Patients are required to provide financial information to qualify for these programs in accordance with the current federal poverty guidelines.”

A July 2003 report in **The Charlotte Observer** about one of the system's hospitals, Carolinas Medical Center, says that hospital and others "have turned to a small Charlotte company, AccessOne" to handle their unpaid bills. According to the report: "Essentially, AccessOne takes over some of the hospital's bill collections. When a patient signs up, the company pays off his or her bill, minus a 6 percent administrative fee. Then AccessOne works out a payment plan with the patient.

"The company charges interest, the prime interest rate plus 4.5 percent. 'The average credit card charges 14 percent,' said Dr. Rusty Salton of Charlotte, the company's president.

"What about hardship cases," the newspaper continues, "where a low-income family owes a much larger amount?"

To keep payments down, the company puts a portion of the bill on a zero percent-interest promissory note, asking the patient to initially pay only on a small part of the total. So a family may face a \$100,000 bill, but still be asked to pay only \$39 a month.

But AccessOne also charges late fees and an 18 percent default interest rate if the patient falls 60 days behind. 'If there's no consequences to a bill, it tends not to get paid,' Salton said.

The report also contains this anecdote:

"Not everyone is a fan. This year, Judy Bettendorf balked when CHS told her she could settle the family's several thousand dollar account by getting an AccessOne card for 'a nominal' 8.9 percent interest rate.

'I told them 8.9 percent didn't sound too nominal to me,' said the Charlotte woman, who paid with her Visa Gold card, which gives her a lower rate.

“Other hospitals don't charge interest, she noted. For example, Charlotte's Presbyterian Hospital offers a payment plan that gives patients nine months without interest.

“What does she think of the 20 percent discount CHS offers to sign up with AccessOne? The discount didn't apply to the Bettendorfs, who have insurance but still face hefty bills over and above what their insurer pays.”

ILLINOIS

In Chicago, SEIU's previously-mentioned “Insult to Injury” report states that **Advocate Illinois Masonic Hospital** offers three ‘choices’ for uninsured patients and others coping with substantial medical bills.

“Plan A calls for the patient paying the entire bill at once, for which a 10% discount is offered. (This discount is much less than the 50% to 70% discounts offered major insurers). With hospital bills running in the thousands and tens of thousands of dollars, this is not a practical or realistic option for most middle class Americans, let alone the indigent.

“Of course, Advocate lets patients know that they accept Visa, MasterCard, Discover, and American Express, which would leave them with large credit card debt at exorbitant interest rates.

“Payment Plan B calls for paying off the entire bill over three months in three monthly installments. Plan C calls for taking a loan directly from Advocate, most recently quoted at 13.5% interest, which is above most current credit card rates. After a bill is delinquent 60 days, Advocate starts collection procedures, sometimes using law firms and sending accounts to collection agencies.

“Many people in the interview sample claimed they never received a bill, but became aware of the gravity of their situation when a sheriff’s officer served them with a court summons. Prior to collections proceedings, there appears to be little or no effort made to help people qualify for Medicaid or free care. Many debtors made efforts to work out payment plans based on their ability to pay, but all were put into collections and eventually sued in Cook County Circuit court. Of 150 people interviewed, only two recall being told about the availability of charity care.”

The 12.9% Solution: An Unhealthy Debt Cure for the Patient

(NOTE: The practices of Provena Covenant Medical Center have become more consumer-friendly, after substantial public pressure including the loss of the hospital's property tax-exempt status, since this case arose. But this story nevertheless stands as an example of the severe toll this kind of de-facto loan brokering by hospitals, still common in many places, exacts on patients who owe them money. In fact, clinics and other medical care providers in this same city continue with such practices, according to sources there who spoke with NCLC.)

Getting sick for a couple of days shoved Laura Helm's life off the tracks of stability for a couple of *years*, and she's still not fully recovered that stability. A loan arrangement suggested to her by the hospital she owed money to made a bad situation significantly worse.

It started four Octobers ago, when Helm visited her doctor's office in Urbana, Illinois, thinking she had bronchitis.

Helm says the visit turned into something more. "They became alarmed because my vital signs were disproportionate. They determined I might be having a heart attack so I was sent to the Provena emergency room," she says, referring to giant Provena Covenant Medical Center, one of two big providers that cover almost the entire health care market in the twin cities of Champaign-Urbana.

Helm, who's 50 and single, had no insurance but thought she'd be released the following day. Her lack of insurance tells a story in and of itself.

"I just couldn't afford it," says the \$16,000-a-year hotel worker. "I had had Blue Cross/Blue Shield but it was a very nominal policy, minimum care. Then the rates went up again and I just decided the heck with it and dropped it, and shortly after that I was in the hospital. But I don't believe even if I'd had Blue Cross/Blue Shield it would have covered most of my hospital expenses."

Wait a minute, she's asked. A critic might say that you work full time and are responsible for yourself -- isn't it up to you to find some way to afford insurance?

She answers instantly and with a conviction bordering on vehemence. "I couldn't! I could not afford it! It was a little over \$200 every two months, but again just minimal coverage and I could not afford it!"

Laura Helm was hardly living the high life when she was interviewed in the spring of 2004 (an update on what's happened to her since then in a moment). Her 30-year-old mobile home was in poor repair, her car needed fixing, and she said she indulges in few luxuries save occasional travel with friends from a club she belongs to.

When her hospital stay extended beyond a day – a disruption she blames largely on the failure of a doctor to show up and authorize her discharge -- she ended up with several thousand dollars in bills from Provena. She also had separate bills from clinic doctors for her care during this incident.

"Yes I got a bill and Provena had a program called Covenant Cares (to provide free care for those who otherwise can't afford it) but I knew when the lady came to speak with me in the hospital that I made too much to qualify for it, so she said that's alright and when you get out we'll arrange a payment plan. So I waited and waited and never heard from them. Then they sent an application and I wanted to dispute one test and being in the hospital an extra day when the doctor never arrived to take care of me and a couple of other minor things, and that's when they stopped returning phone calls."

Without being asked, Helm began sending Provena \$100 a month "to show good faith," and her bill was adjusted down to about \$3,000-4,000 (Ms. Helm doesn't remember the exact figure) in response to some of her complaints. But the hospital wanted more than she was paying, and that's where the real trouble started.

"Since I had no insurance they said 'Well, you can finance your bill through our bank

that we do business with. We'll set it up for you. We'll take care of it just fill out the paperwork and pay it off through the bank.”

The offer from Capstone Bank of Kankakee, Illinois, was for a three-year loan at 12.9% interest. Helm says the hospital offered no realistic alternatives.

“They didn’t talk about any other options for paying off the bill unless I wanted to pay it in one lump. Their first and only option was either to pay in cash or take out a loan, or credit card options.”

But Helm had had credit card problems in the past and was working hard to restore her credit rating, so “the last thing I wanted to do was put over \$3,000 on my charge account again and be paying that interest. I think (the loan’s) interest rate was pretty high, 12.9 percent for crying out loud! But I don’t imagine my credit would have gotten me a much better loan and at that point I just wanted to get this bill paid off.”

The payments of about \$200 a month really put the squeeze on, even with Helm taking on some extra work to help pay the bill. “I mean, I missed quite a lot of work with this incident,” she says. “I missed at least a week of work and probably longer. And my other bills were piling up too. I had not only the Covenant bill but one from a doctor who treated me, one for the echocardiogram he did, all the lab bills were extra and the doctors that oversee the lab got \$75-100 a pop. Doctors I’d never heard of before. And I got a hundred-dollar antibiotic prescription to fill.”

The new bills were taking a toll when we spoke.

“I’d love to be able to do some much-needed home repair,” she said, “and I’d love to be able to do more car repair. That can’t be done because I know I had this obligation. I’d also like to have a little more time off, but I know I’ve got this and other responsibilities always looking at me.”

Claudia Lennhoff, the Champaign County Health Care Consumers advocate who represented Helm, says that even though things have changed at Provena Covenant now this deal should never have been so onerous in the first place.

“What the hospital could have done better is first of all respond to the billing dispute and do what it’s legally obligated to do (such as responding within 30 days to written objections or suspending payment demands), and on the other hand actually work with her to set up a reasonable payment plan she could live with and not just send her these loan papers first thing.

“It’s outrageously coercive, I think it’s outrageously coercive. That action basically says ‘look, you need to find a way to pay off all of this in this way.’ So I think they could have worked with her on payment arrangements that are reasonable to her, and I don’t think hospitals should even be in the business of offering loans – I think there’s no way around the coercive nature of that.”

The whole affair with her faith-based health care provider (from Provena’s website in September 2005: “Provena Health, a Catholic health system, builds communities of healing and hope by compassionately responding to human need in the spirit of Jesus Christ.”) taught Laura Helm some lessons that were literally quite dangerous to her own health.

“Well, I fainted at home a few months ago,” she said when we interviewed her, “and woke up with a bloody, broken nose and no idea why I’d fainted. My nose is still not healed right and I couldn’t afford to go to an emergency room to get it checked since I had no insurance. I was just flabbergasted and had to go to work later that day because I couldn’t afford to take off work, so here I am at work with a broken nose and dizzy and just trying to get through the day.”

Her nose was still hurting and untreated months later when we spoke, but an even more serious problem had reared its head.

“Right now I’m facing a situation where I have a suspicious spot on my right breast, but thank God for the local Breast and Cervical Cancer Society. I found they’ll pay to have this checked out.

“But I know I’m walking on a tightrope. It gets scary when something tragic happens but

you just have to have faith that something positive will come out of it and everything will be alright somehow, some way.”

Helm is asked what she makes of a situation where someone can work full time but still can't afford to get sick.

“Well, I wish our country would find some kind of national health care for people,” she says. “There are people with situations far worse than mine who can't get insurance either, who are making the kind of money I make but they're feeding kids and living far worse than I am.”

(POSTSCRIPT: We checked in with Laura Helm in September 2005, 16 months after the interview above, and here's how her situation had played out:

- *Her breast cancer scare turned out to be no major concern and did not cost her any additional money.*
- *Her broken nose “finally healed,” on its own and without medical intervention, but Helm says it was “very sore for a very long time.”*
- *New medical debt problems arose as a result of a car accident in mid-2004 that sent her to emergency room treatment. There's been some dispute over how much her auto insurance would pay for that treatment but the upshot is that a lien was placed on Laura Helm's aging mobile home due to medical bills. She says she still suffers pain from that accident but is reluctant to seek medical treatment for it, while at the same time the auto insurance company has denied responsibility for covering the price of some accident-related medical tests called for by her primary care physician. She has therefore not had those tests. And the need to replace her car after the accident has added another unexpected financial burden.*
- *Helm expects to retire her original medical debt loan with Capstone Bank “within a year” but says her finances remain “pretty grim – I'm living paycheck to paycheck and working as many hours as I can.*

“I don't ever see being out of debt,” she says. “That's just not part of my world. It seems that there's always something that comes along. It's very stressful.”)

Elsewhere around the country

Other examples of loan products aimed at medical debtors include:

-- In the D.C. suburbs of Northern Virginia, the seven-hospital, non-profit **Inova Health System** offers some of its indebted patients the MediCredit payment plan. An Inova MediCredit application supplied to NCLC by The Access Project states that the plan's interest rate will not exceed 12% a year.

-- **Citibank** offers consumers the Citi Health Card, touted on Citi's website as “a smart, affordable way to pay for various health care procedures. And you can share the benefits with your entire family - even your pet.”

-- The **Via Christi Regional Medical Center in Wichita, Kansas**, offers patients the Via Christi MedCharge credit card.

-- **Kaiser Permanente** is signing up its members for a Kaiser credit card to pay for medical expenses. The card has an initial 9.9% APR teaser rate, which then jumps to a high variable rate -- currently 24.24% APR -- after 12 months. Kaiser offers the card in Hawaii and Colorado, and plans to roll it out nationwide.

Risks to Debtors

At least one bankruptcy and medical debt expert has strong reservations about the impact of this lending on debtors. In testimony before the U.S. Congress, **University of North Carolina law professor Melissa B. Jacoby** -- also a former senior staff attorney for the National Bankruptcy Review Commission -- offered several caveats, which we'll quote here directly from her Congressional testimony:

“These products [medical-specific credit aimed at indebted patients] have received little systematic attention at this point and they raise a host of issues. According to a quote in the American Medical News, the director of the American Medical Association Institute for Ethics worries that these products may result in ‘further commercialization of the patient-physician relationship,’ and that [credit] cards targeted toward those with poor credit histories ‘are in essence endorsing the idea that impoverished patients who have the worst credit history should sign up for another credit card, which by the way will pay [medical providers] off first.’

“For purposes of this hearing, however, it suffices to say that these products do not seem to address the needs of uninsured hospital patients. A \$40,000 credit card bill is not much better than a \$40,000 hospital bill, and may be worse. Some medical credit products offer interest-free installments for limited periods, but the interest rates jump to 20% or higher thereafter. Even at a lower interest rate, the patient may face a perpetual oppressive obligation. To the extent lenders and providers encourage medical-specific home equity products, it is worth noting that undiscounted hospital bills rolled into home mortgage loans raise the stakes further; home equity loans for

large medical bills reduce retirement security through the loss of equity, and may lead to home loss altogether.”³⁰

So, it seems safe to conclude that medical providers are going a long way toward solving their own problems with these types of deals while likely exacerbating the problems of those who purportedly owe them the money.

Risky Home Loans

As Professor Jacoby notes, sending patients to interest-charging lenders also puts them at risk of seductive pitches to have that loan “flipped” into a home equity loan. A Harvard Medical/Law study of bankruptcy filers found that 15% of homeowners who had taken out a second or third mortgage did so as a result of medical debt. An earlier study by Federal Reserve economists found that 10% of home equity lines of credit were used to pay medical debt.³¹

Converting medical debt into a home-secured loan is a losing proposition for most patients. It strips them of the equity in their home, which is the primary source of wealth for most Americans. It puts the patient (and her family) at direct and immediate risk of losing their shelter over medical bills. A lender can foreclose on a home fairly easily for nonpayment of a mortgage, in some states without having to go to court. In contrast, a medical creditor or collector must obtain a court judgment, and in many states there is a legal protection called a “homestead exemption” that will prevent foreclosure.

Also, medical debts often will end up tarnishing the patient’s credit report (a typical scenario discussed below). A study by The Access Project found that medical

³⁰ United States House of Representatives Committee on Energy and Commerce, Subcommittee on Oversight & Investigations hearing, *A Review of Hospital Billing and Collection Practices* (June 24, 2004).

³¹ Glenn B. Canner, Thomas A. Durkin, and Charles A. Luckett, *Recent Developments in Home Equity Lending*, Federal Reserve Bulletin (Federal Reserve, Washington DC, Apr. 1998).

debt creates housing problems for over a quarter of debtors, one of the most common housing problems being the inability to qualify for a mortgage.³²

For those who do manage to obtain a mortgage, if the medical debt has shown up on their credit record, the patient is likely to end up with a subprime or predatory mortgage. The Harvard Medical/Law study discussed above revealed in follow-up interviews that 14% of homeowners with subprime mortgages cited a medical reason for taking out the loan.

-- Mrs. Y is an example of homeowner who ended up with a predatory mortgage to pay off medical debts. Mrs. Y lived in a modest home in upstate New York, which she co-owned with her adult daughter. A few years ago, her daughter married a man who convinced the daughter to borrow \$25,000 to pay off various debts, including medical bills from 4 different health care providers. The daughter asked her mother to sign on to the loan, which was secured by a mortgage on the house. Previously, Mrs. Y and her daughter had owned the home free and clear.

Mrs. Y and her daughter were charged over \$3,000 in fees for this \$25,000 loan, which had an APR of 13.23% (at a time when the average rate on a mortgage was a little over 7%) and required monthly payments of \$261. Unable to keep up with the payments due to their limited and fixed incomes, the predatory lender foreclosed on Mrs. Y's home. Mrs. Y and her daughter filed for bankruptcy in order to stop the foreclosure. Meanwhile, the husband of the daughter left the household and the marriage.³³

³² Robert Seifert, The Access Project, *Home Sick: How Medical Debt Undermines Housing Security* (Nov. 2005), available at http://www.accessproject.org/adobe/embargoed_home_sick.pdf.

³³ From court documents provided to National Consumer Law Center.

Legal implications

Hospitals that act as de facto loan brokers should be concerned with more than just bad publicity. Several states have laws that regulate loan brokers, requiring they be licensed by state banking departments and capping the loan rates that can be charged. For example, Massachusetts requires small loan brokers to obtain a license from the state Division of Banks and prohibits them from brokering loans that charge over 23% annual interest (which some credit card issuers have been know to charge).³⁴ Pennsylvania requires brokers of loans under \$25,000 to be licensed and caps rates at 24% per year.³⁵ Even without the rate caps, a number of states require licensing of loan brokers, which presumably many providers have not obtained.³⁶

For-profit hospitals have even more to be concerned about. They may be violating state credit services organizations laws that govern for-profit loan brokers. In addition to requiring registration, these laws often impose a 3 day cooling off period and mandatory disclosures for loan brokers.³⁷

³⁴ Mass. Gen. Law c. 140, § 96.

³⁵ 7 Pa. Cons. Stat. Ann. § 6201 *et seq.* (requiring brokers of loans of \$25,000 or less to obtain a license and prohibiting them from brokering loans the interest on which exceeds 24% per year). *See also* Ga. Code Ann. § 7-3-1 *et seq.* (requiring brokers of loans of \$3,000.00 or less to obtain a license and capping interest rates); R.I. Stat. Ann. § 19-14.1-1 (requiring loan brokers to obtain a license and capping interest rates); Tex. Fin. Code Ann. § 342.051 (requiring persons who engage in the business of negotiating loans to obtain a license and capping interest on those loans as specified under § 342.201).

³⁶ Ala. Code § 5-19-1 *et seq.* (requiring brokers of loans of \$2,000 or less to obtain a license); Ariz. Rev. Stat. § 6-601 *et seq.* (requiring loan brokers to obtain a license); Iowa Code Ann. § 535C.1 *et seq.* (prohibiting loan brokers from collecting advance fees and requiring written loan brokerage agreements); Neb. Rev. Stat. § 45-189 *et seq.* (requiring loan brokers to file disclosure and brokerage agreements with the state and to pay a filing fee to the state; prohibiting loan brokers from collecting advance fees; and requiring brokers to provide borrowers with disclosures and written agreements); NJ Stat. Ann. § 17:11C-1 *et seq.* (requiring loan brokers to obtain a license); N.D. Cent. Code § 13-04.1-02 (requiring loans brokers to obtain a license).

³⁷ See National Consumer Law Center, Fair Credit Reporting, Ch. 15 (5th ed. 2002 and Supp.).

III. Rogue's Gallery #2: A Brief Look at Other Abusive Medical Debt Collection Practices

There's so much overlap among these abuses that you've already seen some of what's listed below in the first "Rogue's Gallery" section of this report. So without going into great detail, here are some other significant abuses in the world of medical debt collection:

CREDIT REPORTING A medical bill itself may cause harm because it is often reported to credit bureaus, especially if it is sent to a collection agency.

WAGE GARNISHMENT Care providers and their debt collectors have been seeking to garnish up to 25% of the wages of those said to owe them money, often with scant regard to any real ability to pay -- a practice that has been devastating to lower-income families' ability to meet everyday needs.

IMPOSITION OF HOME LIENS The use of home liens by medical creditors is well-documented and has been exceptionally widespread in several locales; it again poses problems of encumbering what is often a working-class family's only significant asset.

Let's look at these more closely.

A. CREDIT IMPACTS

Unpaid medical bills will often end up as a black mark on a consumer's credit report, especially if they are sent to a collection agency. Collection agencies almost always automatically send a negative report to credit bureaus, which will also cause a consumer's credit score to plummet.

The collective scope and impact on medical debt on the credit histories of uninsured patients is enormous and cannot be understated. One stunning statistic from Federal Reserve researchers is that *over half* of collection agency accounts and nearly *one-fifth* of lawsuits that show up as black marks on credit reports are for medical debts. The Commonwealth Fund has found that about one-third of those without health insurance had been contacted by a collection agency over a medical bill - with 46 million uninsured Americans, that would translate to potentially 15 million patients with bad credit records from medical debt.³⁸

A recent study from The Access Project shows damage to a credit report is a frequent occurrence for patients with medical debts. Of those surveyed who knew the answer, three out of five medical debtors reported that their medical debts had shown up their credit reports. Some of these black marks were for small dollar amounts - 16% of the medical debts showing up on credit reports were for under \$500.³⁹

This problem isn't limited to the uninsured either. Sometimes a patient will get caught in a dispute an insurer and a provider, during which the provider will send the bill to a collection agency.⁴⁰

The threat of ruined credit also becomes a club in the medical debt collector's arsenal. Uninsured consumers are often compelled to pay medical debt, and even questionable debt, because of the impact of non-payment on their credit histories. Consumers will often pay a medical debt that is disputable (for example, because the medical bill is one which an insurer should have paid) in order to protect their credit histories.

³⁸ Michelle Doty, Commonwealth Fund, *Seeing Red: Americans Driven Into Debt by Medical Bills* (August 2005); Lisa Duchon, et al., The Commonwealth Fund, *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk* (Dec. 2001).

³⁹ Robert Seifert, Access Project, *Home Sick: How Medical Debt Undermines Housing Security* (Nov. 2005).

⁴⁰ Jennifer Steinhauer, *Will Doctors Make Your Credit Sick?*, New York Times, February 4, 2001.

"Medical bill collection activity hurts patients' credit rating whether or not the activity produces payment for the hospital," said University of North Carolina professor Melissa Jacoby in recent Congressional testimony, adding:

“When a collection agency action, lawsuit, judgment, and lien all are listed on a patient’s credit report, the adverse effects of one default not only multiply, but linger In addition, the Fair Credit Reporting Act permits credit reports to be used for a variety of other purposes, such as employment-related inquiries. Thus, one expensive trip to a hospital, followed by zealous collection and reporting, can bring about a host of unexpected negative effects.

“A bad credit report and score can mean denial of more than just credit, such as a mortgage, car loan or credit cards. Bad credit can result in being denied a job, since employers often use credit reports. Insurance companies in many states can raise a debtor’s premiums or even refuse coverage over a bad credit score. Landlords, utilities, and other folks who hold the key to some of life’s necessities will use bad credit to deny or charge more for these necessities.”

Hospitals that steer patients to outside lenders also do a disservice to their patients’ credit records. In discussing medical-related financial products such as loans for medical debts and medical-debt credit cards, Jacoby told the Congress: “in addition to all of the previously discussed effects of medical debt, the mere existence of a trade account can affect the patient’s credit score, particularly if the liability is large or if the patient recently opened other accounts. In addition, the lender is likely to regularly report any lateness in repayment, further affecting the patient’s credit rating. Given these risks, medical-specific credit products are not likely to offer the solution to the problems being discussed today.”

Some real-life examples of these credit impacts:

In one 2004 case from **Maine**, *Bickford v. Onslow Memorial Hospital Foundation*,⁴¹ the plaintiff alleged intentional infliction of emotional distress as well as tortious interference with economic advantage over a hospital's wrongfully reporting to a credit bureau that the plaintiff owed money for services to his ex-wife's daughter, to whom the plaintiff had no legal relationship.

In **California**, the Health Consumer Alliance's "Sick and in Debt" report had two findings with frightening implications for consumers' credit ratings: that "Some health care providers wrongly bill insured consumers [in order] to pressure their health plans to pay a medical bill or to collect more than the insurance would pay," and that "some health care providers pressure non-responsible relatives to accept liability for medical bills," an echo of the Maine case.

Chicago hospital patient Betty Jones, a 10-year military veteran on full disability whose medical costs are supposed to be fully covered by the government, was nevertheless sued by one hospital, had a lien slapped on her house, and the effects on her credit rating were profound.

"I was left homeless for three months and was turned down for two good jobs because this unpaid bill showed up on my credit report," she said in the previously-mentioned "Insult to Injury" report.

The Veterans' Administration eventually took care of that problem, but then the very same hospital sued Ms. Jones again over a second bill.

"Insult to Injury" makes these points among its recommendations:

"Bad credit reports can persist well beyond when the original debt is paid off or dismissed. Hospitals must take the final step of writing and contacting credit bureaus to clear former patients after their medical debts have been paid or written off."

⁴¹ 2004 WL1925415 (Maine August 31, 2004).

B. WAGE GARNISHMENT

After a health care provider gets a judgment against a patient, usually by default, the provider will try to collect the judgment. A common tactic is to garnish the patient's wages. There may well be no more eloquent testimony to just how thoroughly broken the American health care system is than this real-life scenario:

1 – The patient is an employee of the hospital to which he/she owes money for medical services.

2 -- The patient becomes indebted because the hospital (of all places!) either does not provide adequate health insurance to cover a medical event, or provides it only at a cost the employee feels he/she cannot afford, in either case leaving the modestly-paid employee with a large out-of-pocket debt.

3 -- The employee then becomes the subject of a collections action by his/her own employer.

4 -- The collections action results in the hospital's garnishing a portion of the employee's paycheck, with the hospital simultaneously paying itself while indirectly saving on wage costs. This creates a situation reminiscent of sharecropping or perhaps the notorious "company stores" of an earlier America, where employees never quite earned enough to pay back what they owed their employers who also ran the store.

In our brief survey we found cases involving garnishment of hospital employees' pay in two cities, New Haven and Chicago. Of course hospital employees are just a small minority of the victims of wage garnishment.

In **Minnesota**, the Minneapolis Star-Tribune newspaper reported on the garnishment of half of an 82-year-old woman's Social Security check one month. By the

way, garnishing Social Security benefits is illegal under federal law. Another man had \$7,700 garnished directly from his checking account. Similar stories in that state are plentiful.

St. Paul Attorney Peter Barry told the newspaper that, in Minnesota, “debt collectors take advantage of (a) procedural loophole of not having to file their lawsuits in order to save themselves money and take advantage of unsuspecting consumer debtors,” adding, “On numerous occasions I’ve seen instances where financial institutions such as banks or credit unions simply automatically release garnished funds without a court order. This is illegal, and it deprives consumers of their right to file an answer in the case and object to the garnishment of their funds.”

In **New York City**, investigators for the **Legal Aid Society of New York** found that 27 of the city’s 31 non-profit hospitals use wage garnishments as a collection tactic, and that 24 of those hospitals use bank account attachments to collect their purported debts.

Wage garnishments were also reported to be an often-used tactic in the debt-collection arsenal of health care providers in Champaign-Urbana Illinois.

C. HOME LIENS

The use of home liens against medical debtors has already been documented in this report in New Jersey, Massachusetts, Connecticut and Illinois. Yale New Haven Hospital, one of the worst offenders, have placed liens on an estimated **7.5%** of the owner-occupied homes in New Haven during a nine year period.⁴²

⁴² Connecticut Center for a New Economy, *Yale, Don’t Lien on Me* (September 2003), available at <http://www.hospitaldebtjustice.org/dontlien.pdf>.

D. AND FINALLY...

We'd like to note here three other abuses that are outgrowths of the debt collection practices described in this report.

- DENIAL OF FURTHER CARE, sometimes as a matter of written policy, to those said to owe money and even to debtors suffering from serious medical conditions who have few alternatives in their locales to the provider denying them help.
- COSMETIC REFORM of abusive practices exposed to the public, usually after promises of much more substantial change.
- HOUNDING OF SUPPOSED DEBTORS BY DEBT COLLECTORS: Pursuit by debt collectors is a common fact of life for patients with medical debt. Studies by the Commonwealth Fund⁴³ and The Access Project⁴⁴ have found that about one-third of the uninsured and one-half of medical debtors report that they have been contacted by collection agencies.

The rampant abuse of consumers by the debt-collection industry has been the subject of close scrutiny by National Consumer Law Center advocates in the past.⁴⁵ Our scrutiny hardly stands alone. The debt-collection industry has topped the Federal Trade Commission's list of the most complained-about industries for many years running now.

So it's no surprise that abuse at the hands of debt collectors is a more-than-passing phenomenon for medical debtors as well. Indeed, health care collection

⁴³ Michelle Doty, Commonwealth Fund, *Seeing Red: Americans Driven Into Debt by Medical Bills* (August 2005), available at http://www.cmwf.org/usr_doc/837_Doty_seeing_red_medical_debt.pdf.

⁴⁴ Robert Seifert, Access Project, *Home Sick: How Medical Debt Undermines Housing Security* (Nov. 2005), available at http://www.accessproject.org/adobe/embargoed_home_sick.pdf.

⁴⁵ See Steve Tripoli, National Consumer Law Center, *National Consumer Law Center Calls on Media to Expose Debt Collection Industry's Widespread Illegal Practices*, February 2003, at www.consumerlaw.org/initiatives/debt_collection/press_release.shtml.

occupies its own niche within the collections industry. Many of the abuses outlined in this report are a direct outgrowth of abusive debt collection activity.

IV. WHAT SHOULD HEALTH CARE PROVIDERS DO?

Treat Patients Fairly

We want to make clear that we believe hospitals should get paid for their services. They should be expected to give some care away as well. Many hospitals are non-profit, charitable institutions and they should be helping low- and moderate-income patients to pay their bills as much as they can. Most importantly, they should be expected to collect from the uninsured and underinsured - who are among the poorest of their patients - no more than they collect from government programs or HMOs.

The fact that hospitals acknowledge that their existing collection efforts generate little revenue leads to the idea that making things a little more reasonable on both the billing and collections end might benefit everyone. We recommend that hospitals:

- Establish clear policies on charity care and inform all patients of the availability of not only charity care, but Medicaid eligibility and any other programs to which they may apply.
- Establish clear discounting policies based on income and make them well known. Many hospitals, such as the Partners System in Massachusetts, have done this in response to the publicity this issue has received over the past couple of years. Discounting policies should require low-and moderate-income patients to pay no more than Medicaid, Medicare or private insurers.
- Offer reasonable payment plans pegged to income. This would probably result in better returns on collection efforts as well. Health care advocates have been told often that many patients want and fully intend to pay their bills until they see what they actually owe. A more realistic payment schedule would likely mean more revenue.

Many of the problems documented in this report are the result of inadequate systems in hospitals. A large majority of the billing activity at most hospitals is an automated process, and not very flexible or accommodating to people of limited means with special circumstances. While a hospital may have a policy of considering special circumstances, it too often takes a “squeaky wheel” – a patient or advocate who happens to know about a hospital’s policy or takes the initiative to negotiate – to access that process.

Supervise Bill Collectors

Once a bill goes to a collection agency, often after about four months of billing, the hospital may know a lot less about what goes on. When informed of abuses, the response of some hospitals has been “we didn’t know that was going on.”⁴⁶ That kind of ignorance about debt collectors acting in the hospital’s name is unacceptable. Even the American Hospital Association’s Guidelines recommend better oversight of outside collection agencies.⁴⁷

- Hospitals must give very clear guidelines to medical collection agencies. These guidelines should include:
 - Prohibitions against seeking arrest warrants for body attachments of medical debtors.

⁴⁶ See, e.g. Jonathan Cohn, *Uncharitable?*, New York Times Magazine, December 19, 2004, at 51 (quoting former head of Medicare stating “90 percent of the hospital CEO’s in the U.S. had no idea what the collection offices were doing.”); Minnesota Attorney General’s Office, *Compliance Review of Fairview Health Services* (Jan. 31, 2005), available at <http://www.ag.state.mn.us/consumer/PDF/CharityCare.PDF> (finding that non-profit hospital had no internal controls over its debt collection activities); Lucette Lagnado, *Cold Case Files: Dunned for Old Bills, Poor Find Some Hospitals Never Forget*, Wall Street Journal, June 8, 2004, at A1 (hospital officials pleading ignorance of abusive bank account seizures).

⁴⁷ Board of Trustees of the American Hospital Association, *Hospital Billing and Collection Practices – Statement of Principles and Guidelines* (December 2003).

- Prohibitions against placing liens on the homes of patients, or at least patients who are low- or middle-income.
- Hospitals should monitor their collection agencies to make sure the agencies are following the provider’s guidelines and not engaging in debt collection abuse.
- Hospitals should not send medical bills to collection agencies:
 - Until they’ve made a good faith attempt to negotiate with the patient.
 - Until at least 180 days have passed.
 - If there is an ongoing dispute between the patient and insurer over coverage.
- Hospitals should also refrain from pursuing the spouses of patients, or at least spouses who are elderly or low to middle income.

V. REFORM SUGGESTIONS

State legislatures can and should be part of the solution in protecting patients from being squeezed by medical bills and harsh collection tactics. Some of the options to protect medical debtors include:

A. Enact medical debtor protection laws

A good place to start is Connecticut , which has a law that:

- Prohibits a hospital that receives “free bed funds,” i.e., charity care funds, from suing a medical debtor unless it determines that the debtor is not eligible for the free bed funds.

- Requires hospitals to include information about free bed funds and other free care programs in all bills and collection notices.
- Prohibits hospitals from collecting from low-income, uninsured patients more than the actual cost of services, which prevents them from engaging in discriminatory pricing.
- If a hospital has information that a patient qualifies for free beds funds, the Uninsured Patient Discount, or any other program that could reduce a medical debt, the hospital's debt collectors must cease collection, even if there is a judgment against the debtor, until a determination is made regarding eligibility for these programs.
- Provides an increased homestead exemption for hospital debts; limits the amount of pre- and post-judgment interest; and prohibits wage garnishment, bank account executions, and lien foreclosures if a medical debtor is complying with a court-ordered installment payment plan.

B. Protect spouses of patients

States should legislatively override common law necessities doctrines or repeal them if they are statutory. Community property states should enact protections for spouses of medical debtors, at least those who are elderly or low to middle income

C. Hold Hospitals Accountable for Charity Care

States should require hospitals to document and report on how they fulfill their charitable care obligations. While the obligation to provide charity care is no longer explicit in most cases, there is an implicit understanding that the nonprofit status of hospitals means they owe some "community benefit" of which charity care is often a part. Only a handful of states (Massachusetts, Texas, California) require any accounting of this.

VI. ADVICE FOR CONSUMERS

If you have unmanageable medical bills, here are some suggestions:

A. Getting Help To Pay The Bills

Insurance. Before anything else, are you absolutely certain you've exhausted all possibilities that you may be covered by some sort of insurance? Are there any current or former employers who have insurance you may be covered under? If you are divorced or separated, might you still be covered under your former spouse's policy? Do you have credit disability insurance on your mortgage or car loan that might apply? If your medical care was due to an automobile accident, are you covered under someone's insurance policy?

Medicaid. Check to see if you qualify for Medicaid. In most states, Medicaid will provide coverage retroactive to the third month prior to the date of application.

And of course...**Make sure to apply for Charity or Free Care!!** (If you have been sued for a medical bill, make sure the hospital's lawyer gets a copy of your application).

There may be other charity programs to help you with medical bills, such as churches and social service organizations.

B. Strategies to Deal with Medical Debt

Negotiate! Use the fact that the hospitals engages in discriminatory pricing. Find out what that hospital pays to Medicaid, Medicare or private insurers, then ask for the same price. Make sure that you can afford to pay under the terms of any agreement, and

get it in writing. Negotiating an unaffordable payment plan or a reduced amount that you cannot pay will only make matters worse if you default on an agreement.

Check for errors and mistakes. Medical bills are notorious for double-billing, overcharging, and mistakes.

- Make sure to get an itemized bill, not just the short summary you may receive from the hospital.
- Double check that the number of days you were charged for on your bill reflects the actual number of days you spent in the hospital.
- Compare bill against your medical records to check for any inconsistencies. Challenge any procedure that you were billed for if it is not reflected in your medical records.
- Inquire about any charge that appears more than once, especially during the same day - duplicate billing is a common error.
- Data entry is another common occurrence. Were you charged for 200 face masks rather than two?
- Look for any charges that seem vague or excessive charges, such as \$75.00 for a laxative, \$30.00 for a "thermal therapy kit" (plastic bag of ice cubes), or \$10 for a "urinal" (plastic cup). One common practice is charging for a full day's worth of intravenous solutions on the day of admission, even though you were admitted late in the day and only received a half day's worth.
- Challenge any charges that were due to the hospital's own negligence. For example, did you have to stay an extra day because of an error in scheduling a test? Was your hospital stay extended because of an infection that occurred while you were being treated?

There are companies that can help you review or "audit" a medical bill. One example is www.billadvocates.com.

Use any available appeals processes. For example, you are entitled to an appeals process if you are covered by Medicare. Many states also have a

managed care ombuds office to resolve disputes over HMO coverage. In addition, many HMOs have their own internal patient appeals processes.

C. Whether and When to Pay Medical Bills

It's important to consider medical bills in the context of your overall financial picture. Create a budget, and see if you can afford to pay the bills even in installments. Sometimes you may not be able to pay medical bills and all your other bills. In that case, it's important to know which bills to pay first, as well as the consequences of not paying some bills immediately.

It's also important that you don't stop paying other higher priority bills, such as mortgages/rent or car loans, in order to pay medical bills. Medical bills are unsecured debt, and as such usually should not take priority over secured debt (i.e., debt for which you have pledged a piece of property like your home or car) or essential expenses such as food and utilities. You don't want to lose your home, have your family go hungry, or lose your car because you paid a medical bill instead of those creditors.⁴⁸ Of course, there are exceptions to this advice, especially if you are in an area without a lot of healthcare providers and are concerned about obtaining future care from the provider.

You should never move medical bills up in priority because of debt collection harassment. Creditors who engage in harassment often do so because they have no better way of getting their money than to pressure a client into paying.

NEVER turn unsecured debt into secured debt by, for example, taking out a second mortgage to pay for medical bills. You do not want to risk losing your home if you cannot keep up with mortgage payments. A medical creditor or collector can only sue you at best to collect, and there are protections in many states for your home even if you lose a lawsuit. A mortgage lender can take your home much more easily, in some

states without going to court. Also, if you have medical bills showing up on your credit report, you may end up with a high cost or predatory mortgage with hidden fees that will add hundreds or thousands of dollars to the cost of the loan.

You should not move up a medical debt in priority even if you are sued. First, you may have defenses to the lawsuit, such as discriminatory pricing and errors in your bill. Second, the consequences even if you lose the lawsuit may be not as severe as failing to pay your mortgage or car loan. This is particularly true if you are judgment proof, i.e., you have no property or income that the collectors can reach. Federal and state protections may protect you and your property from being taken.

- If you own your home, check to see whether the equity in it is protected by a “state homestead exemption” act.
- Federal law prohibits garnishment of Social Security, SSI and veteran’s benefits, and protects the first \$154.50 of take-home pay from garnishment.
- Some assets, such as used household goods, are rarely seized by creditors because they’re simply not worth it.

Note that being judgment-proof is not necessarily a permanent state. If your financial situation improves, collectors can pursue non-exempt property, assets, or income.

Bankruptcy can be an important alternative to address overwhelming medical debt. A full discussion of bankruptcy is beyond the scope of this report. Information about bankruptcy, including the effect of the new bankruptcy law, is available in the National Consumer Law Center’s brochure “Answers to Common Bankruptcy Questions,” available at www.consumerlaw.org (Click “Action Agenda”, then “Bankruptcy,” and scroll down to “Consumer Information”).

⁴⁸ Unfortunately, many patients have faced housing problems or even lost their housing due to medical bills. See Robert Seifert, Access Project, *Home Sick: How Medical Debt Undermines Housing Security*

D. Other Resources

For more advice on dealing with medical debt, see

Champaign County Health Care Consumers, *Medical Debt Pamphlet*, July 2002.

Connecticut Center for a New Economy, *Know Your Rights About Hospital Debt – A Handbook For Connecticut Hospital Patients*, available at www.hospitaldebtjustice.org/rights.html.

National Consumer Law Center, *In Sickness and In Debt: Using Consumer Law to Help Elders Facing Overwhelming Medical Bills*, 2001.

Volunteer Lawyers Project of the Boston Bar Association, *An Advocates' Guide to Helping Consumers Address Medical Debt*, forthcoming 2006.

(Nov. 2005), available at http://www.accessproject.org/adobe/embargoed_home_sick.pdf.

APPENDIX A: Guido Osso's story

Crushed by medical bills

Sunday, June 12, 2005

By **LINDY WASHBURN**
STAFF WRITER
THE RECORD (HACKENSACK, N.J.)

The sheriff's constable delivered the lawsuit to the neat brick home in Cliffside Park on Valentine's Day. It was a bouquet of heartache from Hackensack University Medical Center.

"GUIDO OSSO," it read. "You are hereby summoned in a Civil Action of the Superior Court of New Jersey."

The reason: Failure to pay a hospital bill of \$160,170.35.

The wanted man sat at home, slumped in his wheelchair. His head rested on a television tray and his bottom on an incontinence pad. Since a devastating series of strokes in 1999, the 66-year-old Osso hadn't known what day it was, much less the details of his worsening financial situation.

He'd been a butcher all his working life, cutting steaks and roasts at the Grand Union and A&P. He was a member of his union's health plan. When he felt sick that October morning as he woke up to take his 14-year-old son to school, his family thought only of his health.

Little did they know that his illness could end up costing them everything.

Guido Osso didn't have enough health coverage. It ran out 21 days into his 38-day stay at Hackensack.

From that moment on, everything done for Guido was on Guido's dime.

He was charged the hospital's highest rates - its so-called sticker prices - rather than the heavily discounted fees insurers pay. That meant he was billed nearly twice as much as his health plan would have paid for the same care.

And when he no longer qualified for the insurance discount, the hospital was no longer satisfied with his plan's payment for those first 21 days. He was billed tens of thousands of dollars more for that care, too.

It was all completely legal. The Osso family's predicament was business as usual for the hospital's billing department.



DANIELLE P. RICHARDS / THE RECORD

▲ Stroke victim Guido Osso at his Cliffside Park home. He owes Hackensack University medical Center \$160,000. The hospital has sued to get the money.

"We look to recover our charges one way or another," said Harold Hogstrom, Hackensack's chief financial officer. If a patient is underinsured, "we can't be expected to write the rest of it off."

Guido Osso's story is a cautionary tale. It shows how inadequate insurance, rising medical costs and aggressive hospital collections all contribute to America's worsening health-care crisis. For millions of Americans, financial disaster is just one hospital stay away.

Across the nation, a growing number of Americans have less coverage than they need. Many have less than they think they have. As insurance costs soar, employers are trimming benefits, raising deductibles and sometimes dropping health coverage altogether. The result: Medical bills now cause nearly half of all bankruptcies, according to a recent study - and most of the victims are middle class and insured at the time of their illness.

Elia Osso, Guido's wife, feared her family would become one of those statistics. Every flat surface of her home was covered with medical bills, every day filled with worry.

For five years before the lawsuit arrived, Elia had cared for her husband - fed, bathed and shaved him, brushed his teeth, cooked his food, pivoted him from bed to wheelchair and wheelchair to bed. No holidays, no respite and no thanks from Guido, whose mind is elsewhere, permanently.

She was at once fiercely protective - and powerless.

"They call my Guido a criminal?" Elia asked, furious and frightened, a few days after the papers arrived. "They want to put me in jail?" She switched to Italian, a torrent of words her daughter partially translated as, "They are cold, heartless hypocrites."

"I am in jail already," she said, finally, her chest heaving.

A CRUSHING BURDEN

Elia Osso went to school in Italy, but only through fifth grade. She could barely read the lawsuit, much less understand it.

She was overweight, overworked and overwrought. Her brown eyes overflowed with tears. Until she broke her elbow in March and Guido was moved temporarily to a nursing home, her nights were interrupted whenever her husband called for water or needed help to the bathroom.

At 53, she felt like an old woman.

Before Guido got sick, the Ossos were living the immigrant dream. They worked hard to pay off their mortgage and put two of their three children through college.

But Elia had to quit her factory job to care for her husband, and now she and her son are without health insurance. She drew down their savings to buy Guido's medicines and adapt their house for his wheelchair. For a while, she tried to keep the collection agency at bay with \$100 a month, she said.

Last December, her two daughters, Sabrina and Susan, met with Hackensack's patient accounts department to offer as much as they could - everything except the house. Their offer totaled \$32,000, they said.

The hospital said no. Nothing less than \$80,000 would do. "He has assets," said Anne Goodwill Pritchett, vice president of patient accounts.

Now, Hackensack University Medical Center - the hospital whose charity galas have raised \$1.3 million in a single star-studded evening - was taking the Ossos to court. Elia feared they would take her home.

"My parents don't have some Swiss bank account," said Sabrina, a computer support analyst. "They never lived luxuriously. It was just basic stuff. ... What will we do for my mother if we have to sell the house? That is the last, last, last thing they own."

THE COVERAGE RUNS OUT

Guido Osso's story began in Calabria, Italy. He emigrated in 1949 as a boy of 11. His father found work as an ice man in New York City, and Guido went to school. He eventually enrolled at Hunter College, but quit to work.

He was a serious man. He worked as many hours as he could get - nights, weekends, holidays - to support his family.

In 1972, he bought the house in Cliffside Park. With a rental apartment on the first floor, and room for a growing family in a spacious upstairs apartment, it was a solid investment. It's now assessed at \$338,000.

Like most Americans with a job, Guido didn't have much choice when it came to his health coverage. It was simple: take what was offered.

He was a member of Local 464A of the Food and Commercial Workers International Union, which counts more than 18,000 food-industry employees in New Jersey and New York.

The union is proud of its benefits. The plan includes "doctor and hospital visits, major medical coverage, medical center services," according to its Web site. The coverage comes with union membership and there is no deductible. A health center at the union's headquarters in Little Falls provides free medical care for members.

"In this day, you'd be hard-pressed to find a plan as generous," said George R. Murphy, an attorney for the local's welfare funds.

But, as the Ossos would discover, Local 464A's Health and Welfare Plan had serious shortcomings.

The plan limited its coverage to 31 days of hospital care per illness each year, plus \$100,000 more over the course of Guido's lifetime for additional hospital days or other medical expenses.

The Ossos would soon learn that a major illness can quickly eat through that kind of coverage. Guido was in the hospital for 48 days: 38 at Hackensack and 10 before that at Palisades General Hospital in North Bergen.

His health plan also failed to cap the amount Guido would be required to pay for medical care. Most insurance plans set maximum out-of-pocket expenses, after which the insurer pays everything. But Local 464A's plan simply stopped when its limit was reached, leaving Guido liable for everything that followed.

"That's almost like no insurance," Hogstrom, the Hackensack CFO, said of Guido's health plan. Most plans cover at least six to 10 months in the hospital, he said.

Murphy defended the union's benefits as "outstanding," especially compared with what he called the meager benefits provided by many in the grocery industry. When 45 million Americans have no health insurance at all, to disparage the plan would be "truly outrageous," the Washington-based attorney wrote The Record.

Despite written permission and a request from the Osso family, Local 464A's officers - John T. Niccolai, its president, and Kathleen F. Pridmore, its director of medical benefits - declined to speak about Guido Osso's case.

"We just have a policy not to put our business on the street," Murphy said.

But a state labor leader expressed sympathy for Guido. "I've got a heavy heart, because he's a union man," said Charles Wowkanech, president of the New Jersey State AFL-CIO, which includes Local 464A. "But we're all in the same boat."

Unions are caught in a vise when it comes to benefits these days, he said. The costs of health benefits in New Jersey are among the highest in the nation.

"When you're competing against the likes of Wal-Mart, which is paying \$6 or \$7 an hour, exploiting immigrants and offering no health-care plan, the good players are being forced to come down to a level like this," Wowkanech said.

Most people are like the Ossos - they don't know until it's too late where the holes in their coverage are. Elia had never read the booklet describing the union health plan, and her husband probably had just glanced through it, she said.

Elia didn't think about costs when she had her husband transferred to Hackensack from Palisades General Hospital. The ambulance had taken Guido to the closest hospital, but after 10 days he was getting worse. Elia thought he would do better at Hackensack.

"I trusted them," she said.

Hackensack is a top-ranked institution whose size and reputation have grown the past 15 years. From childbirth to heart surgery, stem-cell transplants to trauma care, the hospital has a distinguished record. It is full or nearly so on most days, when many hospitals around the state are half-empty and losing money.

When Guido was admitted, the hospital asked him to sign paperwork accepting responsibility for any unpaid bills. But nobody told him that from Day 22 on, it was all coming out of his pocket.

There he lay in his room on the fourth floor, swallowing his pills and drinking his Ensure, with machines monitoring his heart rate and oxygen level, as his bill climbed by thousands of dollars a day.

115 PAGES OF TROUBLE

The meter just kept running.

Each day, Guido was charged the full sticker price - \$3,348 - for room rent.

And like an a la carte restaurant menu, every service he received resulted in an additional charge.

The oxygen flowing through a tube in his nose: \$541 a day.

The device that measured his blood-oxygen level: \$286 daily.

Feeding bags: \$31 for a day's supply.

The 8-ounce cans of nutritional drinks he was fed instead of solid food were a dollar each. The speech therapist who assessed his hearing and stroke-addled speech added \$170 each time she visited. The professional who spent 30 minutes walking with him in the hallway: \$62 more.

Guido's bill for his 38-day stay in late 1999 stretches to 115 pages.

It is full of unexplained corrections, long numeric codes and arcane abbreviations. The list of charges for a single day includes 67 items.

An analysis of the bills - with assistance from a pharmacist and the Health Care Payers Coalition of New Jersey, a non-profit alliance of business, union and trade-association benefit plans - revealed that:

- Guido was charged 2¼ to 10 times what Medicare would have paid for services ranging from chest X-rays to the telemetry that monitored his heart rate. The federal government sets Medicare rates to reflect actual average hospital costs, and they are used as a benchmark by insurance companies when setting their own payments.
- He was charged two to seven times the average wholesale price for medication. A simple aspirin, which costs a hospital less than a penny, was 14 cents. A drug for the treatment of anemia was marked up 500 percent, to \$606 per dose.

The total charges were \$232,689.83.

Had Guido been discharged on his 21st day, when his health plan was still covering his care, the hospital would have accepted the plan's check for \$46,865 as payment in full. Even for the 17 additional days of his stay, Guido would have owed only \$50,000 had he been allowed the same discounts as his health plan.

But it didn't work that way. The insurer's discount applies only if the insurer pays for the entire stay, Hogstrom said.

When the hospital took away the discount, it billed Guido Osso "sticker price" for each and every item of his entire stay - it even expected him to pay tens of thousands more out of his own pocket for care his plan already paid for.

His final bill - minus his plan's payment, an "adjustment" of \$41,676.86, and \$70 for his telephone - totaled \$144,077.97.

In early 2000, the sick man went back to the hospital. His stays at Palisades General, Hackensack, and the Kessler Institute for Rehabilitation exhausted the \$100,000 lifetime maximum his health plan provided for additional medical costs, according to a letter from the plan's director of medical benefits. When he finally left Hackensack the second time, he had racked up a bill for \$16,192.38.

That's how Guido Osso came to owe \$160,270.35 to Hackensack University Medical Center. The hospital's lawsuit inexplicably subtracted \$100 from the bill, but demanded attorney's fees and interest.

Hospital officials said the size of Guido's bill is unusually high because his plan covered so little of his stay. But there was nothing unusual in the way it was calculated.

"Patients are responsible for whatever their insurance company doesn't pay," Hogstrom said. "That's as simple as I can make it. It's the way all billing works."

NO DISCOUNTS FOR SOME

It is a bizarre paradox of American health care that the very people who can least afford to pay are charged the most by hospitals. Every patient receives a "sticker price" bill, but nearly everyone gets a hefty discount.

Everyone except the uninsured and under-insured.

At Hackensack, 6 percent to 8 percent of patients are expected to pay sticker price, hospital officials said. As individuals, these patients lack the bargaining clout of a large insurer. Few of these patients fight their bills - they simply can't understand them. The lingo of costs and charges is like a foreign language, and those with the biggest bills are usually the sickest.

Congress was so concerned about these inflated prices, and the aggressive way hospitals try to collect on debts, it held three hearings on the issue.

The victims are "being charged two to four times what people with health insurance coverage pay for hospital services," Dr. Gerard Anderson, director of the Johns Hopkins Center for Hospital Finance and Management, said at a House committee hearing last June.

"They are the ones charged an arm and a leg in order to get one or the other fixed," said Rep. Joe Barton, the Texas Republican and committee chairman.

Dozens of class-action lawsuits in New Jersey and around the country are questioning whether these billing practices are at odds with the tax-exempt status that hospitals receive as charitable institutions.

Under fire, the nation's second largest hospital group - the California-based Tenet Healthcare Corp. - has begun offering the uninsured discounts that match those given to managed-care companies.

Meanwhile, a lawsuit in federal court against New Jersey's nine-hospital Saint Barnabas Health Care System claims the inflated charges "discriminate against the very uninsured patients who are supposed to benefit most."

New Jersey hospitals have the highest "sticker price" mark-ups in the nation - their charges, on average, are four times higher than costs, according to an analysis of 2002 data by the Institute for Health and Socio-Economic Policy, affiliated with the California nurse's union.

At Hackensack, the sticker price is three to 3½ times costs.

But the revenue Hackensack receives doesn't come close to what it charges, because of the heavy discounts to insurers. Hackensack took in just 28 cents for every dollar it charged in 2002, about average for hospitals in New Jersey, according to the state Health Department.

Even so, the non-profit hospital doesn't lose money. It cleared \$34 million after expenses in 2003. Its parent corporation owns several profitable subsidiaries. The medical center's president earns upwards of \$1.2 million a year.

Hospitals get away with high charges "because no one knows the true cost of hospital services," said David Knowlton, a former state deputy health commissioner and founder of the Health Care Payers Coalition.

Sean Hopkins, senior vice president for health economics at the New Jersey Hospital Association, said the high charges are "the end result of a broken payment system." This is what you get, he said, when Medicare and Medicaid pay below break-even rates, and managed-care companies delay and deny payments. Hospitals have to make it up somewhere.

Health care is a business - and Hogstrom has a business to run.

Unpaid bills are growing as employers scale back, raise deductibles or drop health coverage, Hogstrom said. He's seen patients come in with health plans that cover just five days in the hospital.

"The uninsured and the under-insured just become a bigger and bigger problem every year," he said.

Hackensack tallied \$68 million in bad debts last year, Hogstrom said. "Most of it is little stuff," he said. At the same time, he said the hospital provided \$121 million - calculated at sticker price - worth of free care to the indigent and received only \$8 million back from the state for such charity care.

"We're a medical center," he said. "We fix what's wrong with you, then we talk to you about paying the bill. That's what we have to do."

AN AVALANCHE OF BILLS

Guido Osso was a complete invalid when Elia brought him home just before Christmas in 1999.

"The saliva was drooling down," she remembered. "His mouth was crooked. He was shaking."

Numerous strokes had damaged Guido's brain, impairing his vision, speech, movement, and bladder and bowel control.

"I was lost," Elia said.

The bills soon started arriving from Hackensack University Medical Center. After four months, a collection agency was sending them. By May 2002, Hackensack had turned the Osso account over to a second collection agency, Community Collections Inc. of Union.

Two statements arrived at Guido's house each month.

"It's that time," they said cheerfully, "when we would like to remind you of the status of your account."

Hospital collections is a burgeoning business. Each year, collection agencies interested in medical debts contact more than one in 10 American families, according to a survey by the Kaiser Family Foundation. The debts are rising so quickly, The Commonwealth Fund warned last year that "medical bills and lingering medical debt are undermining the financial security of American families."

The Ossos and the hospital disagree on some things. Elia says she sent the collection agency a check for \$100 a month - a total of \$1,300 - before the constable came knocking. The hospital says she was offered a \$70-a-month payment plan and didn't keep up, and that their collection agency was told at one point that Guido had died.

Hospital officials offered in January to drop the bill to \$80,000, even though they said the Ossos didn't qualify for a discount. They said they knew the family had the resources to pay. The Ossos said they didn't.

So the hospital went to court.

The collections attorneys who work for Hackensack University Medical Center file dozens of legal actions each week against former patients over debts that have ranged from \$458 to Guido's \$160,000. When the judge slams his gavel and judgment is rendered, the only escape is death or bankruptcy. Bank accounts, salaries, valuables like jewelry or a sports car, the proceeds from home sales - the law allows the hospital to go after all of these to get its money.

In the last five years, four major North Jersey hospitals have won judgments against more than 1,700 people who owe money.

Hackensack won 517 cases from January 2000 to April 1 of this year, according to court records. The medical center was an interested party in 14 foreclosures.

The Valley Hospital in Ridgewood won 688 judgments, Holy Name Hospital in Teaneck 256, and Englewood Hospital and Medical Center 229, court records show.

The lawsuits filed by the hospitals usually result in a default judgment - few debtors have the money to hire a lawyer. A judgment allows the hospital to put a lien on the debtor's property. That's what the Ossos feared - a lien on the house that was to be Elia's security in old age.

Hogstrom defended Hackensack's lawsuits.

"Companies sue people who don't pay their bills all the time. If we don't do that, we won't be here next year to take care of the patients who really need it," Hogstrom said. He added, "We go very far, but we don't ever really go to the point where we're going to put people in bankruptcy or take away their house."

As an example, Hogstrom cited a couple who recently faced a hospital bill of more than half a million dollars. When the couple, in their 60s, offered to take out a reverse mortgage to pay the debt, the hospital refused because it likely would have rendered the couple homeless within six months. Hospital officials said they discounted the couple's bill, based on their financial need, and devised an affordable monthly payment plan.

Hospitals, including Hackensack, are "committed to treating patients with compassion - not only at the bedside, but at the billing office," said Hopkins, the official with the state hospital association. "It's not, nor should it be, our intention that a patient be bankrupted over a bill."

A RELENTLESS BURDEN

The note Elia found taped to her door last February said "urgent" and asked her to call the constable. "We are attempting to personally deliver important legal documents," it said. Elia was too scared to make the call. She asked Sabrina to do it.

When the lawsuit was delivered the next day, Elia feared that she was headed for financial ruin, and taking her children with her. After Elia quit her job to care for her husband, the family had no income until Guido's pension and Social Security kicked in recently. Their savings had been depleted.

Once, family had been everything to her. But standing in her kitchen a few days later, she told a visitor that her family didn't exist anymore. Her heart broke to see her once powerful husband so completely dependent, she said. Her son was still a boy when he lost the father he knew, and it made her sad.

Christmas, New Year's, Easter - holidays were no different than other days, lost beneath the burden of daily chores. "I change his diaper, I take him to the doctor. I go get medicine, clean, wash and get food - that is my life," she said.

When she first brought Guido home, Elia had to call an ambulance - and pay hundreds of dollars - each time she took him to the doctor. Finally, a physical therapist showed her how to maneuver his unwilling form up and down the 17 steps from their apartment.

Elia paid for renovations to widen their bathroom door so that Guido's wheelchair could roll in and out. She had to buy a hospital-style bed for him. Last year, she stopped renting out the ground-floor apartment - losing the rental income - so that Guido could stay there, and be taken in and out more easily.

Their son, Michael, who'd been a student at Paramus Catholic High School, had to transfer to a public school.

"We couldn't afford it anymore," Elia said.

She had hoped he would go on to a four-year college, but Michael now attends Bergen Community College, while living at home to help look after his dad.

Eighteen months after he stopped working, Guido's union health plan stopped covering Elia and Michael. Elia paid \$508 a month for insurance, but couldn't afford it for long. Guido went without health insurance for two years, until he turned 65 and qualified for Medicare.

"My worry is that my mom can incur more health bills than my father," said Sabrina, the oldest daughter. "It's all stress. She doesn't care for herself."

She was right. Elia's precarious personal and financial situation took a terrible turn this spring, when she slipped while caring for her husband and broke her right elbow. Susan heard her screams and came running. She called an ambulance.

Through her pain, Elia asked to be taken to Holy Name Hospital, where she qualified for charity care. Even so, she was required to pay a portion of the hospital's charges, as well as the surgeon's fees. The family medical bills, said Susan Osso, grew by more than \$10,000.

The relentless burden has changed Elia.

"Look at me," she said recently. "I cry like a baby. I can't breathe. I throw up. Nobody can help you."

She is so ashamed of her transformation that she asked that no photographs be taken.

The Ossos have hired attorney Anthony Marucci. After The Record interviewed hospital officials, the collection agency proposed a settlement, Marucci said last week. He said the agency required secrecy about the terms of the agreement - which includes money from both the family and the union - and would not put it in writing. Marucci has sent the collection agency a check, and hopes the settlement goes through.

For its part, the hospital said Friday that nothing had changed. It has had no recent contact with the Ossos, said Pritchett, the vice president of patient accounts.

Elia Osso hopes she never has to go to court.

But if she does, she'll bring Guido.

"She will wheel my father in from the ambulance," said Sabrina, "and say, 'Here we are. See it with your own eyes. This is what you're doing. We're not just numbers.' "

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