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TESTIMONY SUMMARY

Testimony before the House Energy & Commerce
Subcommittee on Oversight & Investigations

by Mark Rukavina, The Access Project

"A Review of Hospital Billing and Collection Practices"

June 24, 2004

Hospitals practices around pricing, billing and collections are prominent among the causes of medical debt. The existence of medical debt on a large scale, and the consequences of this debt, belies many prevalent misconceptions about the uninsured and their ability to access health care.

(1) The first misconception is that uninsured patients can get the care they need from safety-net institutions for free or at affordable prices.

(2) The second misconception is that uninsured people expect to get their care for free, or are simply unwilling to pay for it.

(3) A third misconception is that the "truly needy" are not billed or subject to aggressive collection actions because they qualify either for public programs or for hospitals' indigent care programs.

(4) A final misconception is that hospitals and other healthcare providers bear the full burden of providing care for the uninsured.

Recommendations

(1) Offer uninsured hospital patients discounts equivalent to those extended to people with insurance.

(2) Screen uninsured hospital patients and provide assistance to all patients who are eligible for public programs to ensure that they are enrolled in them.

(3) Have consistent and well publicized charity care policies for hospital patients who are not eligible for public programs and stop aggressive collection actions as an integral part of a hospital's service to their communities.

(4) Establish clear rules of accountability for funds that hospitals receive through the Medicaid DSH program and other sources to help defray the costs of uncompensated care.

(5) Build on the American Hospital Associations Guidelines and Principles for Hospital Billing and Collection Practices by establishing a Financial Assistance Initiative for Uninsured Patients.

(6) Create a system of affordable health care for all.

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Thank you for inviting me to speak before this panel on the important issue of hospital billing and collection practices with respect to uninsured patients.

My name is Mark Rukavina, and I am the executive director of The Access Project. The Access Project is a national resource center providing support to local organizations seeking to improve access to health care. The Access Project works in partnership with the Heller School for Social Policy and Management at Brandeis University in Massachusetts. In our work with local groups since 1998, we have undertaken numerous research and policy analysis projects and produced a series of reports on subjects relating to health care access barriers. Over the last four years, our work has increasingly focused on the problem of medical debt and its consequences. Through our research, and that of others, we have learned that the problem is widespread and its causes diverse. Hospitals practices around pricing, billing and collections are prominent among the causes of medical debt. The existence of medical debt on a large scale, and the consequences of this debt, belies many prevalent misconceptions about the uninsured and their ability to access health care. In my remarks, I would like to clarify some of these basic misunderstandings.

(1) The first misconception is that uninsured patients can get the care they need from safety-net institutions for free or at affordable prices.

The Access Project documented the actual experiences of the uninsured through a survey it conducted in 2000 of uninsured people who had received care in local safety-net institutions. <u>In the 24-site survey of nearly 7,000 uninsured respondents, 60 percent said they needed help</u>

paying for their medical care, and nearly half (46%) said they owed money to the facility where they received care. For those who received care in hospital emergency rooms, the percentages were even higher.

These findings are reinforced by other national research. For example, the Commonwealth Fund's recent report, *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey (March 2004)*, found that two out of five adults in 2003, and 6 out of 10 among those who lacked insurance, had problems related to medical bills or accrued medical debt.

Moreover, medical debt has a direct effect on people's ability to access health care. In our 24-site survey, among the respondents with unpaid bills, almost a quarter said the debt would deter them from seeking care at the facility in the future. In another Access Project study, we interviewed low-income consumers with medical debts in three communities. More than half said their medical debts made it harder for them to get medical care. They reported that providers discouraged them from seeking additional services by requiring cash payment upfront, flatly refusing care, or encouraging them to seek new providers.

A 2000 study done by the National Association of Public Hospitals and Health Systems found that even safety-net providers do not automatically provide free care to uninsured patients. More than 80 percent of the public hospitals surveyed had implemented cost-sharing plans and an increasing number implemented pharmacy co-payment plans.

Medical debt can erode not only individuals' access to care, but also their overall financial security and that of their family. One survey found that more than a quarter of families in which one or more members were uninsured reported having to "change their way of life significantly" to pay medical bills, a figure that rose to nearly 40 percent when all family

members were uninsured. In the recent Commonwealth Fund survey, among the uninsured respondents who had medical bill problems or medical debt, almost 4 in 10 said they were unable to pay for basic necessities such as food, heat or rent; *over half said they used all or most of their savings to pay medical bills*; and more than 2 in 10 said they had taken on large credit card debt or loans against their homes to pay medical bills.

(2) Another misconception is that uninsured people expect to get their care for free, or are simply unwilling to pay for it.

In fact, the uninsured do pay a significant portion of their bills. As the Commonwealth Fund survey indicates, many exhaust their savings, take out loans, or assume large credit card debt to pay their medical bills. A recent report by the Kaiser Commission on Medicaid and the Uninsured, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending? (2004),* estimates that people who are uninsured for an entire year pay over a third (35%) of their health care costs out-of-pocket, considerably more than the 20 percent share paid by those with insurance. According to the report, the uninsured can be expected to pay 32.6 billion dollars for their care in 2004.

Our interviews with low-income people with medical debt found that many respondents had a strong desire to pay off their debt and tried to negotiate payment plans, but found that the terms of the plans hospitals offered were difficult to maintain, given inflexible hospital collection practices and their own tenuous financial circumstances. Here are what some of our survey respondents told us.

"…they demanded I pay a certain amount bi-weekly. I couldn't afford it. They didn't want to help. I was willing to pay some money, as much as I could."

"I (said) I couldn't pay $500, that I could pay $100, but the person answered no, that it had to be $500."

Moreover, not being able to pay their medical bills in full caused many people tremendous anxiety and stress. Again, here is what some of our respondents told us.

"I am constantly worrying about my medical debt…I feel hopeless. I am a single mom and think that in the future I will not be able to better my life."

"Owing money affects every part of your life. You don't stop worrying about it anytime."

"I couldn't sleep…I just slept a few hours and it (the debt) even took my appetite away."

One factor that makes it especially difficult for uninsured people to cover the entire cost of their care is that they are often expected to pay more for the same services than other payers. Uninsured patients don't have access to the discounts negotiated by insurers or set by the government. Uninsured patients are expected to pay full charges or "the rack rate." A Wall Street Journal article in March of 2003 told the story of Rebekah Nix, a 25-year old uninsured woman in New York who was billed $14,000 – not including doctor's fees – for a two-day stay for an appendectomy. The state's Medicaid program would have paid about $5,000 for the procedure, and Medicare about $7,800.

In testimony before the House Ways and Means Committee this past March, University of Southern California Professor Glenn Melnick showed that nationally, hospitals increased their mark-ups – the amount charged over and above the cost of care – from 159% in 1993 to 211% in 2003. Average mark-ups across states ranged from 135% to 300%. Given this, it's no surprise that the uninsured can't cover these costs.

Adding insult to injury, many hospitals enforce these payments through aggressive billing and collections practices, a situation that has been documented in the press and by various community groups. Reports of hospital billing and collections practices in Connecticut, New York and Illinois led to a series of articles in the *Wall Street Journal*. The *Journal* articles, as well as articles in other newspapers across the country, have detailed cases of the devastating effects of harsh collections practices in which people were hounded by collection agencies, charged high interest, had wages garnisheed and property attached, had liens put on homes, and were even arrested as they struggled to pay their bills. For example the *Journal* documented the case of Quentin White, who had been paying Yale-New Haven Hospital for over 20 years for the debt from his late wife's medical care. The hospital charged 10 percent interest, placed a lien on the White's home, and in 1996 nearly cleaned out Mr. White's bank account. Over the years, Mr. White paid nearly $16,000 on what was originally a bill of just less than $19,000. However, his outstanding balance had ballooned to about $39,000 in 2003 because of the interest charges. In another case in Champaign, Illinois, Marlin Bushman was arrested and jailed after missing a court hearing on a $579 hospital bill. Kara Atteberry was briefly jailed because she missed two court hearings on a $1,678 hospital bill incurred for a miscarriage.

Hospitals have used other tactics to improve their collection rate. Some have arrangements with commercial banks to facilitate the initiation of loans to cover medical expenses. Others have created open-ended credit accounts that are marketed as *Trouble-Free Payment Plans* but fail to disclose interest rates or other fees at the time of application. We even know of a hospital that is issuing its own credit card to patients.

Some hospitals take drastic measures through their collection agents. Earlier this month, the Wall Street Journal reported on a practice in New York where hospital collection agencies

attach the bank accounts of patients with hospital bills going back as far as 15 years. Some hospitals had even written off some of these bills and had received partial reimbursement from a state-run bad-debt pool.

There should be no place for such high-pressure tactics used against low-income people who have the misfortune of getting sick.

Given recent attention on this issue, the financial community is beginning to scrutinize hospital billing and collection practices**.** The Health Capital Group provides an illustration. The Health Capital Group offers services to hospitals and other medical providers relating to mergers, acquisitions and investment banking, as well as an array of other related "transactional" services including sophisticated valuation services. They recently expressed concern that hospitals failing to inform certain patients who might reasonably qualify for financial assistance or 'charity care' would be exposed to class action lawsuits as well as the possibility of direct intervention from state attorneys general. They fear that this could create enormous contingent liabilities that could, in turn, significantly impair their access to capital.

As a result The Health Capital Group announced that they will cease issuing valuation opinions, validating bond ratings, rendering creditworthiness opinions, certifying debt capacity, making recommendations to bond funds or issuing compliance comfort letters and related analyses unless a hospital or hospital system demonstrates that it has written policies and procedures to inform patients of financial assistance, pricing and collection policies and publicizes these policies and procedures.

Just last week it was reported that a federal class action lawsuit was filed in federal courts in eight states against nearly one dozen non-profit hospital systems challenging whether tax exempt status should be granted to these institutions. Clearly the billing and collection practices

of hospitals that have created problems for uninsured patients are now creating problems for the entire hospital industry.

(3) A third misconception is that the "truly needy" are not billed or subject to aggressive collection actions because they qualify either for public programs or for hospitals' indigent care programs.

While most hospitals do claim to have financial assistance programs to assist people without the means to pay for their medical care, research indicates that many who might qualify for these programs never learn about them. In our 2000 survey of the uninsured, almost half (48%) of those needing help paying for care said they were never offered financial assistance, such as being informed about the facilities' own charity care programs. Among those who received care in urban or suburban hospital emergency rooms, 70 percent said they were never offered assistance. This lack of information about available financial assistance is consistent with findings from subsequent research that The Access Project and others have done, and is a wholly avoidable cause of medical debt. Again, here is a comment from one of our survey respondents:

"I would like the hospital to make the help office, the one that helps you pay the bill, more accessible to the people. Because I have a lot of bills that could have been paid, had they told me about that office sooner. Instead, my bills are now in a collector's office when I qualified for financial assistance, because they did not give me the necessary information…"

In this regard, I would like to share with you The Access Project's own experience trying to obtain hospitals' financial assistance policies. Last December, the American Hospital Association issued guidelines for its members recommending that all hospitals have written financial assistance policies that they disseminate widely in their communities. In 2003, both

Tenet and HCA healthcare systems announced with fanfare programs to help the uninsured with discounts and sliding scales. Learning about the HCA program in the third quarter of 2003, and unable to find information on their website, I contacted the company to request a copy of the policy. I received no response. I made another request a month later. Finally, in December, I was told that while the policy had been implemented, HCA didn't want to post it until they saw if it "worked as intended", probably around the beginning of the new year. In February of this year, we invited HCA, along with Tenet and other area hospitals, to meet with community leaders in Florida to provide information about their financial assistance policies. Unfortunately, both HCA and Tenet declined to attend.

Only in late April, more than six months after we first requested information, did the hospitals provide us with their policies. The Access Project is hopeful that working with these systems will be far easier in the future. However, I share this story to point out that if it takes the professional staff at a national health care resource center over half a year to find out about the hospitals' financial assistance program, one can imagine the difficulties faced by uninsured people who try to do so, especially while they are ill and vulnerable.

It is possible for hospitals to inform uninsured patients of the financial assistance programs that are available to them. However, providing information is often not enough. Hospital can and must do more than that. We recently identified a program at The Cooley Dickinson Hospital in Northampton, Massachusetts. Cooley Dickinson case managers visit each uninsured patient and review their individual health care needs. They help patients complete program applications, they refer them to a local network of physicians offering care on a sliding fee scale and assist them in applying for hospital charity care. By providing this assistance, they have enrolled hundreds of patients in Medicaid and other programs. The hospital gains needed

revenues and the patients avoid crushing debt. The hospital and the patient are both better off. The crucial point is that case managers review payment alternatives with patients at the front end of the process, not after the bills have been sent to collection. Without such help, many patients would be reluctant to go back to the hospital.

(4) A final misconception is that hospitals and other healthcare providers bear the full burden of providing care for the uninsured.

I have already discussed that the uninsured themselves in fact pay a significant portion of the costs of their care. In addition, while hospitals definitely do bear a portion of this burden, they also receive funding from a variety of sources to help defray these costs. As Secretary of Health and Human Services Tommy Thompson pointed out in a letter to the American Hospital Association, "Medicare and Medicaid have a long history of doing their part to help the uninsured that includes paying hospitals $22 billion each year through the disproportionate share hospitals provisions to help hospitals bear the cost of caring for the poor and uninsured." In addition, most states and many counties and local communities have programs that help fund care for the indigent and uninsured.

A word is warranted here about the "uncompensated care" that hospitals provide. Most hospitals report their uncompensated care as a combination of bad debt and charity care, without disaggregating the two. While both types of uncompensated care similarly affect a hospital's bottom line, their effects on patients are starkly different. "Bad debt," even after a hospital has written it off, still burdens the patient. Collection efforts by outside collection agents may continue indefinitely, and the debt may be a blot on a consumer's credit record for years; it may hinder people from buying homes, getting loans, or even affect their employment. So while from

the hospital's perspective the services are uncompensated (at least that portion of the bill a patient is unable to pay), from the patient's perspective the bad debt write-off is by no means "charitable" and should not be confused with the legitimate benefits of a hospital's charity care program.

Recommendations

The widespread problem of medical debt is clearly a symptom of much that is wrong with our fragmented health care system that leaves so many people exposed to lack of access to care and to financial ruin. While this situation cries out for systemic solutions, some steps can be taken in the interim to reduce the burdens of unaffordable health care costs on low-income uninsured people.

(1) Offer uninsured hospital patients discounts equivalent to those extended to people with insurance.

The current situation reflects the lack of clout that uninsured consumers have in the healthcare marketplace compared to all of the other players – employers, insurers, and providers. Charging the highest rates to those least able to pay is simply unfair, especially when it comes to necessary medical care.

By itself, however, this is not sufficient. From the standpoint of the low- or even middle-income consumer struggling to pay his medical bills, the salient issue is not only the prices a hospital charges but also the availability of financial assistance programs. Even with changes in hospital pricing practices – the immediate concern of the subcommittee – problems of medical debt will remain for those who require medical treatment but are unable to pay the (albeit reduced) fees for which they are responsible. For low-income people, or those with very high

bills relative to their income, even discounted prices may not prevent devastating medical debt. For a family earning slightly more than the federal poverty level, reducing a bill from $50,000 to $25,000 does not provide enough help. For people at this income level, a bill of a few thousand dollars, or even less, may simply be beyond their means to pay.

(2) Screen uninsured hospital patients and provide assistance to all patients who are eligible for public programs to ensure that they are enrolled in them.

This is a win-win situation for the hospital and the uninsured patient; it provides hospitals with some reimbursement for services rendered, and it helps prevent people from being saddled with unmanageable debt. We know of hospitals that have adopted very proactive programs to ensure that all of their uninsured patients know where to get help in applying for these programs. And they have continued to fund these programs because they have found them to be financially beneficial to the hospital as well as the patient.

(3) Have consistent and well publicized charity care policies for hospital patients who are not eligible for public programs and stop aggressive collection actions as an integral part of a hospital's service to their communities.

In this regard, we are hopeful that the recent HHS guidance on billing and collections practices, as well new guidelines from the AHA and a number of state hospital associations, will help to reduce the role hospitals play in imposing medical debt and its harsher consequences. Hospitals must take a proactive role in informing their patients of charity care and they must stop aggressive collection actions against uninsured patients. Such actions cost hospitals money and provide little financial return while ruining the credit of uninsured patients.

(4) Establish clear rules of accountability for funds that hospitals receive through the Medicaid DSH program and other sources to help defray the costs of uncompensated care.

Disproportionate Share Hospital payments provide vital funding for America's healthcare safety net. Hospital receiving DSH payments should be required to provide details on how this funding is used to support services to poor and uninsured patients.

(5) Build on the American Hospital Associations Guidelines and Principles for Hospital Billing and Collection Practices by establishing a Financial Assistance Initiative for Uninsured Patients.

We call on the AHA to create an initiative with the purpose of providing financial assistance to patients with no insurance. An essential part of this effort would be for hospitals to work in partnership with community and consumer advocacy organizations that work with, and represent, people with no health insurance. These community and consumer advocacy organizations could assure that hospitals have transparent policies that are understood and supported by their uninsured patients. Hospitals participating in this initiative would have clear, written policies governing their practice for screening uninsured patients for financial assistance, as well as for billing, charity care, and debt collection practices related to uninsured patients. The AHA should enroll hospitals in this initiative to bring clarity and decency to billing and collection practices. One basic principle could drive the initiative - Do No Harm. Hospitals must start treating their patients of limited resources with dignity, respect and justice. If hospitals are unwilling to comply, legislation might well be in order.

It is only after hospitals improve their billing and collection systems, that they should seek additional funds to support the cost of providing health care to uninsured patients.

(6) Create a system of affordable health care for all.

We recognize that hospital bills are only one component of medical debt. As health care costs rise and employers and insurers shift more of the costs on to consumers, medical debt from all sources is likely to grow. While improved hospital financial assistance programs are an important step in alleviating this problem, systemic efforts that include all types of healthcare providers and significantly expand coverage will ultimately be needed to address the underlying factors that leave many patients – both uninsured and insured - with unmanageable medical debt.

On behalf of the more than 43 million American with no health insurance, thank you for the opportunity to testify today.

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List of Attachments

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REPORTS:

- *"The Consequences of Medical Debt: Evidence from Three Communities"*, The Access Project
- *"Don't Lien on Me: Why the State's Medical Indigency Program is Unhealthy for Idahoans",* The Access Project
- *"Getting Care But Paying the Price: How Medical Debt Leaves Many in Massachusetts Facing Tough Choices"*, The Access Project
- *"Hospital Free Care: Can New Yorkers Access Hospital Services Paid for by Our Tax Dollars?"*, Public Policy and Education Fund of New York
- *"Into the Red to Stay in the Pink: The Hidden Cost of Being Uninsured"*, Health Matrix: Journal of Law-Medicine, Symposium: Barriers to Access to Health Care, The Legal Aid Society of Cincinnati and The Access Project
- *"Not There When You Need It: The Search for Free Hospital Care",* Community Catalyst, Inc.
- *"Paying for Health Care When You're Uninsured: How Much Support Does the Safety Net Offer?"*, The Access Project
- *"Sick and In Debt: Improper Practices that Cause Medical Debt for Low-Income Californians"*, the Health Consumer Alliance
- *"State Secret: How Government Fails to Ensure that Uninsured and Underinsured Patients Have Access to State Charity Funds"*, The Legal Aid Society
- *"Uncharitable Care: Yale-New Haven Hospitals Charity Care and Collections Practices"*, Connecticut Center for a New Economy
- *"Uninsured and Overcharged: How Advocate HealthCare Overcharges Chicago Hospital Patients"*, SEIU Hospital Accountability Project
- *"Unintended Consequences: How Federal Regulations and Hospital Policies Can Leave Patients in Debt"*, The Access Project and Brandeis University for The Commonwealth Fund
- *"Your Money or Your Health. Discriminatory Pricing and Aggressive Debt Collection Practices by Sutter Health"*, Health Access Foundation
- *"Your Money or Your Health. Discriminatory Pricing and Aggressive Debt Collection Practices by Sutter Health in San Francisco"*, Health Access Foundation and the Service Employees International Union (SEIU) 250