

THE CASE FOR REFORM: HOW NEW YORK STATE'S SECRET HOSPITAL CHARITY CARE POOL FUNDS FAIL TO HELP UNINSURED AND UNDERINSURED NEW YORKERS

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Christine and Ed King live in New Jersey. After the World Trade Center disaster, Ed was only able to get a part-time tech job that paid just \$350 per week (\$18,000 per year) and did not offer health insurance. When their baby, Stella, was born with a cleft palate, the Kings were able to apply for and receive New Jersey State “charity care” funds administered through the hospital. At a six-month post-natal visit, Christine’s doctors discovered a baseball-sized cancerous tumor on her ovary. Christine had a hysterectomy, again paid for by New Jersey State charity care funds. During the operation, the doctors discovered that the cancer had spread to her kidney and had metastasized. Short of a miracle, Christine was expected to die.

Christine’s doctors referred her to a national expert on her type of cancer at Our Lady of Mercy Hospital in the Bronx, which receives roughly \$6 million a year from New York State to provide charity care. Our Lady of Mercy refused to provide Christine life saving cancer treatment unless she paid \$20,000 of her projected \$80,000 bill in *advance* of her admission.

When Ed asked hospital staff for the charity care application, hospital staff claimed that, unlike New Jersey, New York State did not have a charity care program. Then Legal Aid Society attorneys contacted the hospital’s legal counsel and asked if some of Our Lady of Mercy’s \$6 million annual allotment could be applied to Christine’s case. The hospital’s attorneys refused, stating that New York’s program was not established to help individual patients.

INTRODUCTION

The hospital industry’s treatment of the estimated 43.6 million uninsured Americans, in addition to the millions more whose health insurance is inadequate for their needs, has been the focus of recent

debate and advocacy efforts around the country.¹ As of 2002, three million individuals in New York State alone were estimated to have no health insurance.² Advocates are confronted with increased demands for help from uninsured and underinsured patients who face overwhelming medical bills, aggressive collection agencies and limited avenues of relief.³

In a response to this crisis and to desperate calls from clients, The Legal Aid Society of New York City (Legal Aid) decided to investigate how New York State finances its care of the uninsured and the underinsured.⁴ Specifically, Legal Aid wanted to know what happened to New York State's annual allocation of approximately \$847 million to hospitals for their care of patients who cannot afford to pay their medical bills though the State's Bad Debt and Charity Care (BDCC) pool.⁵ In the summer of 2003, Legal Aid surveyed and documented the accessibility of free and discounted care for uninsured or underinsured patients at twenty-two New York City hospitals⁶ that

1. See Lucette Lagnado, *Hospitals Will Give Price Breaks to Uninsured, if Medicare Agrees*, WALL ST. J., Dec. 17, 2003, at A1 [hereinafter Lagnado, *Hospitals*] (stating “[u]nder pressure from lawmakers and consumer advocates, the hospital industry said it would consider making broad price cuts for the uninsured . . .”); HENRY J. KAISER FAMILY FOUND., NEW YORK: POPULATION DISTRIBUTION BY INSURANCE STATUS, STATE DATA 2001–2002, U.S. 2002 (2002), at <http://www.statehealthfacts.kff.org> (last visited Sept. 27, 2004).

2. DANIELLE HOLAHAN ET AL., UNITED HOSPITAL FUND, HEALTH INSURANCE COVERAGE IN NEW YORK, 2002 34 tbl.2 (2004), http://www.uhfnyc.org/usr_doc/chartbook2004.pdf.

3. See Lagnado, *Hospitals*, *supra* note 1 (noting that “[a]dding to the problem for the uninsured, many hospitals have become more aggressive in seeking payment of these bills. Hospitals have placed liens on debtors’ homes, garnished wages, seized bank accounts and, in some cases, sought the arrest of debtors who miss court dates, a practice known in some states as ‘body attachment.’”).

4. The Legal Aid Society is the nation’s oldest and largest legal services provider. The Legal Aid Society’s Health Law Unit provides health care advice and representation to thousands of health care consumers, community based organizations and providers each year through a Health Law Hotline. More information can be found at www.legal-aid.org, and a copy of the survey discussed in this article—*State Secret: How Government Fails to Ensure that Uninsured and Underinsured Patients Have Access to State Charity Funds*—can be found at <http://www.legal-aid.org/Uploads/BDCCReport.pdf>. This article’s authors were lead authors of the survey. Elisabeth Benjamin, MSPH, JD, is the Director of the Health Law Unit at the Legal Aid Society and Kat Gabriesheski, JD, was a 2003 Summer Intern.

5. N.Y. STATE DEP’T OF HEALTH, INDIGENT CARE POOL DISTRIBUTIONS (2003) (spreadsheet on file with The Legal Aid Society’s Health Law Unit) [hereinafter INDIGENT CARE POOL].

6. The twenty-two hospitals surveyed were: Beth Israel, Bronx-Lebanon, Brookdale, Cabrini, Columbia/NY Presbyterian, Cornell/NY Presbyterian, Elmhurst, Flushing, Jamaica, Lenox Hill, Maimonides, Mary Immaculate, Memorial Sloan-Kettering, Montefiore, Mount Sinai, NY Methodist, NYU Med. Ctr., St. John’s, St. Luke’s, St. Vincent’s Manhattan, St. Vincent’s Staten Island, and SUNY Downstate. See LEGAL

collectively receive \$316 million, or nearly 40%, of the State's allocation of BDCC funds each year.⁷

The Legal Aid study found that, unlike some neighboring states,⁸ New York (1) requires virtually no accountability for the millions of dollars allocated for BDCC funds; (2) ignores the need for a standardized application and eligibility system and notification to low-income New Yorkers on how to access this money; and (3) fails to regulate hospital "charge" rates for uninsured and underinsured low-income families or to set reasonable standards for billing and collection practices.⁹

Section I of this article sets forth the history and components of the BDCC funding pool. Section II explores the scope of the Legal Aid study, including its methodology and findings, and its recommendations are described in Section III. Section IV provides an analysis of the responses by New York hospitals, as indicated by their regional trade groups, including the allegation that federal law prohibits them from offering discounted care to the uninsured. The conclusion asks what more should be done with the information gathered by the study.

I.

BACKGROUND: NEW YORK'S BAD DEBT AND CHARITY CARE POOL

A. *What is the BDCC Pool?*

Every year, the New York State Department of Health provides nearly a billion dollars of Bad Debt and Charity Care funds to state hospitals. In 2003, hospitals were allocated \$847 million for the un-

AID SOCIETY, STATE SECRET: HOW GOVERNMENT FAILS TO ENSURE THAT UNINSURED AND UNDERINSURED PATIENTS HAVE ACCESS TO STATE CHARITY FUNDS 19 (2003), <http://www.legal-aid.org/Uploads/BDCCReport.pdf> [hereinafter STATE SECRET].

7. See INDIGENT CARE POOL, *supra* note 5, at 19. A similar study was completed in the summer of 2000 by the Long Island Health Access Monitoring Project. See LONG ISLAND HEALTH ACCESS MONITORING PROJECT, LONG ISLAND COALITION FOR A NATIONAL HEALTH PLAN, HOSPITAL COMMUNITY BENEFITS AND FREE CARE PROGRAMS: AN INITIAL STUDY OF SEVEN LONG ISLAND HOSPITALS iii (2001) (stating that study's "overall objective was to determine what local hospitals say and do about community benefits and free care for the uninsured"), <http://www.communitycatalyst.org/acrobat/NY-7-hosp-pilot.pdf>.

8. New Jersey and Massachusetts also have "charity care" pools but provide a greater nexus between the funds and individual patient accounts via generalized applications and eligibility requirements. See N.J. ADMIN. CODE tit. 10, § 10.52-11.5 (2004); MASS. REGS. CODE tit. 14.6, §§ 10.03, 10.04 (2004).

9. See discussion *infra* Part III.B. See also Lagnado, *Hospitals*, *supra* note 1 (noting that "[a]t the heart of the issue is the hospitals' common practice of charging full listed prices").

compensated care purportedly provided to patients in 2001.¹⁰ Historically, hospitals attempted to recover their losses from bad debt¹¹ and charity care¹² by increasing charges for those patients or payers.¹³ In an attempt to mitigate this practice, as well as to redistribute the care of the uninsured across a wider range of hospitals, the legislature adopted the New York Prospective Hospital Reimbursement Methodology in 1983.¹⁴ This legislation, among many other things, included a methodology for raising a funding pool to reimburse hospitals for some of the financial burden caused by bad debt and charity care.¹⁵

The BDCC pool is funded by third-party payers (except for Medicare), which are assessed add-on charges. The charge is allocated among geographical regions within the state, and is dependent on whether the hospital is a major public hospital or a voluntary non-profit, private proprietary, or non-major public general hospital.¹⁶ Current legislation also provides for an assessment based on the gross revenues of general hospitals, which is placed into a statewide pool.¹⁷ In January 1997, these funding pools became a part of the 1996 Health Care Reform Act (HCRA),¹⁸ which was recently extended through June 2005.¹⁹ The HCRA includes other funding pools that benefit the hospital industry as well, such as the Graduate Medical Education

10. See INDIGENT CARE POOL, *supra* note 5, at 19.

11. "Bad debt" typically refers to the failure to collect from bills issued either directly to patients or to third-party insurers. STATE SECRET, *supra* note 6, at 14.

12. "Charity care" typically refers to free or low-cost care based on financial need. *See id.*

13. See *St. Joseph's Hosp. Health Ctr. v. Dep't of Health of N.Y.*, 677 N.Y.S.2d 194, 197 (4th Dep't 1998).

14. Christine S. Spencer, *Do Uncompensated Care Pools Change the Distribution of Hospital Care to the Uninsured?*, 23 J. HEALTH POL. POL'Y & L. 53, 54, 70 (1998) (arguing funding pool largely unsuccessful at meeting redistribution goals). *See also* N.Y. PUB HEALTH LAW § 2807 (McKinney 2003). The most relevant regulations adopted pursuant to these statutes are N.Y. COMP. CODES R. & REGS. tit. 10, §§ 86-1.11, 86-1.65 (1995-1999).

15. N.Y. PUB HEALTH LAW § 2807-a(8)(e) (McKinney 2002).

16. *Id.* "Major public general hospital" means all state-run hospitals, those run by the New York City Health and Hospitals Corporation, and all other public general hospitals with annual inpatient operating costs of over twenty-five million dollars. *Id.* § 2807-k(1)(a).

17. N.Y. PUB HEALTH LAW § 2808-c(1) (McKinney 2002).

18. Letter from Richard Pellegrini, Director, Bureau of Financial Management & Information Support, (Nov. 4, 1996), at <http://www.health.state.ny.us/nysdoh/hcra/main.htm>.

19. Jerry Geisel, *New York Extends, Raises Hospital Bill Surcharge*, BUS. INS., June 23, 2003, at 3. The recent budget extension of HCRA also raised the hospital surcharge, which is added to patient accounts to help fund the indigent care pool, to 8.85%, up from 8.18%. *Id.*

funding, which collected approximately \$1.4 billion annually from 1997 through 1999 to support teaching hospitals in the state.²⁰

The New York Department of Health (DOH) is required under state law to determine each hospital's reimbursement rate for services provided to BDCC patients on a prospective basis and calculated based upon an established base year.²¹ For example, the 2003 rate was calculated according to each hospital's claimed provision of BDCC services during base year 2001. Hospitals are notified of the upcoming rates at least sixty days before the start of the year.²²

New York Public Health Law § 2807-k governs the general hospital indigent care pool,²³ which allocates money to general hospitals for their BDCC needs according to set rate tables.²⁴ The hospitals' needs are defined as losses from bad debts *reduced to cost* (rather than a hospital's inflated "charge" rate), and the costs of charity care provided by the hospital—excluding any services given as an employment benefit or as a courtesy.²⁵ The hospitals are not supposed to include the cost of services, other than emergency room visits, which have been denied reimbursement by a third-party payer for lack of medical necessity or for lack of compliance with prior authorization requirements.²⁶ It is important that the hospitals actually reduce their claims of bad debt and charity care to cost because their charge rates are usually artificially inflated negotiating tools for setting rates for third party payers, which never actually have to pay the higher rates.²⁷ Nonetheless, as discussed below, most hospitals apply these rates to their uninsured patients, who are the least likely to be able to afford them. Because there is virtually no government monitoring of the

20. PUB. POL'Y INST. OF N.Y. STATE, INC., MISGUIDED MONEY: A REEXAMINATION OF THE \$2.6 BILLION IN SUBSIDIES PROVIDED BY TAXPAYERS AND INSURANCE SURCHARGES TO HELP FINANCE NEW YORK'S MEDICAL INSTITUTIONS § 3 (1998), <http://www.bcny.org/ppi/misgd3.htm> (last visited Sept. 27, 2004).

21. N.Y. PUB HEALTH LAW § 2807(7) (McKinney 2002).

22. *See* St. Joseph's Hosp. Health Ctr. v. Dep't of Health of N.Y., 677 N.Y.S.2d 194, 199 (4th Dep't 1998).

23. This statute encompasses major general hospitals, which consist of all public hospitals run by the state, hospitals operated by the New York City Health and Hospitals Corporation (HHC), and those with over \$25 million in annual inpatient operating costs. N.Y. PUB HEALTH LAW § 2807-k(1)(a) (McKinney 2002).

24. *Id.* § 2807-k(3)–(5).

25. *Id.* § 2807-k(1)(d).

26. *Id.* § 2807-k(1)(e).

27. Lucette Lagnado, *A Young Woman, an Appendectomy, and a \$19,000 Debt*, WALL ST. J., Mar. 17, 2003, at A1 (stating that "[m]ost major U.S. hospitals are required to set official 'charges' for their services, but then agree to discount or even ignore those charges when getting paid by big institutions such as insurance companies or the government.") [hereinafter Lagnado, *A Young Woman*].

hospitals' reported BDCC submissions, it is unknown whether the hospitals follow the State guidelines and reduce their charge rate to cost when calculating the amount of BDCC they spend each year.²⁸

Hospitals must comply with minimal reporting requirements established by the DOH, which include monthly and annual reports detailing the amount of bad debt and charity care provided by the hospital.²⁹ Also, if a hospital has an obstetrical care unit, it must provide accessible prenatal care to the uninsured in order to be eligible for funding.³⁰ However, there are no public or patient notice requirements for BDCC money distribution or state regulations governing the mechanism through which patients may have their accounts "relieved" by the funding.

B. Debt Collection—Who Receives These Funds in the Hospital?

State law requires that New York's general hospitals must implement minimum collection policies and procedures—approved by the Commissioner of Health—in order to participate in the pool.³¹ Neither state law nor regulations describe what minimum collection practices are appropriate. Without proper regulations and limits, this type of requirement has led to widespread use of aggressive billing practices by hospitals—which include charging exorbitant interest rates (9%), garnishing wages, and attaching liens to uninsured individuals' homes.³²

Most importantly, there is no corresponding requirement that hospitals have a system to identify charity care patients and provide them notice about BDCC funds.³³ Without such a system, or any eligibility guidelines, many patients who could benefit from this funding

28. See ALAN G. HEVESI, OFFICE OF THE STATE COMPTROLLER, NEW YORK STATE, THE HEALTH CARE REFORM ACT (HCRA): THE NEED TO RESTORE ACCOUNTABILITY TO STATE TAXPAYERS 17 (2003), <http://www.osc.state.ny.us/press/releases/apr03/HCRA.pdf> (last visited Oct. 28, 2004).

29. N.Y. PUB HEALTH LAW § 2807-k(9) (McKinney 2002).

30. *Id.* §§ 2807-k(10), 2807-c(16)(e); N.Y. COMP. CODES R. & REGS. tit. 10, § 86-1.65(j)(2) (Supp. 2004).

31. N.Y. PUB HEALTH LAW § 2807-k(9) (McKinney 2002). This is similar to requirements in the Medicare law, which are discussed in Part V *infra*.

32. See, e.g., Alison Leigh Cowan, *Yale Hospital Plans to Halt Foreclosure for Bill Collection*, N.Y. TIMES, May 9, 2003, at B2. Legal Aid's Health Law Unit has assisted low-income uninsured and underinsured patients who have been subjected to all of these practices and more.

33. Mary Sisson, *NY System Strands Charity Patients*, CRAIN'S N.Y. BUS., Nov. 10–16, 2003, at 1 ("But unlike other states that provide charity care funding, New York state has set up its system so that the money goes directly to hospitals. As a result, people who need free or discounted care—those without insurance, money or access to Medicaid—often end up with huge bills.").

stream are placed into collections instead.³⁴ Because of the lack of a public notice requirement about BDCC funding, uninsured and underinsured patients have no idea that BDCC funds even exist. Under New York law, hospitals do not have to inform their patients that charity funds are available, nor provide charity care in any specified amount or form.³⁵ Indeed, the few hospital representatives surveyed by Legal Aid who were aware of the funding conceded that it was used entirely as a way to offset their bad debt, rather than to proactively provide for free or low-cost care.³⁶ Neither the statutes nor the regulations provide any means to ensure that the neediest patients receive or otherwise benefit from these funds. The lack of any auditing procedures by the DOH contributes to the mystery of who actually receives free or reduced cost care from any of these hospitals.³⁷

Although many hospitals receive a significant amount of money from the pool,³⁸ the receipt of these funds cannot be used in court as a patient's defense when he or she is sued by a hospital for collection of fees incurred during the stay.³⁹ It is entirely within the hospital's discretion whether to provide care for free or to turn a patient over to a debt collection agency, regardless of the patient's ability to pay and the hospital's receipt of BDCC funding every year.

C. Accountability

In 1996, New York State hospitals reported that they had provided more than \$1.5 billion in bad debt and charity services to their patients, about twice as much as they receive from the BDCC pool.⁴⁰

34. See *id.* (noting that when hospitals receive their BDCC reimbursement, they are not required to credit the accounts of patients who cannot pay).

35. Margaret Ramirez, *Sick Feeling Over Costs*, NEWSDAY, Nov. 3, 2003, at A12 (stating that "Patricia J. Wang, senior vice president of finance for the Greater New York Hospital Association, said patients are not notified about charity funds because the money isn't available to individuals.").

36. STATE SECRET, *supra* note 6, at 22–23.

37. See HEVESI, *supra* note 28, at 17.

38. In 2000, New York hospitals received a total of \$765 million dollars for the BDCC pool, with \$156 million going to public hospitals, \$546 million to all voluntary hospitals, \$36 million to high-need hospitals and \$27 million to Supplemental Indigent Care Distributions, which goes to teaching hospitals with BDCC needs. MANATT, PHELPS AND PHILIPS, BREAKDOWN OF ALLOCATIONS UNDER THE NEW YORK STATE HEALTH CARE REFORM ACT OF 2000 Table I (2002) (on file with The Legal Aid Society Health Law Unit).

39. N.Y. PUB. HEALTH LAW § 2807-k(14) (McKinney 2003) (stating that a hospital's receipt of BDCC funds "shall not be admissible as a defense, offset or reduction in any action or proceeding relating to any bill or claim for amounts due for hospital services provided").

40. PUB. POL'Y INST. OF N.Y. STATE, INC., *supra* note 20, at § 3.

The hospitals' self-reported spending allocations included \$391 million for inpatient bad debt, \$604 million for outpatient bad debt, \$158 million for inpatient charity care, and \$393 million for outpatient charity care.⁴¹ There is no requirement that hospitals submit claim reports or any other authentication for their BDCC numbers, although the DOH does have authority to conduct audits if it chooses to do so.⁴²

In his April 2003 report, *The Health Care Reform Act (HCRA): The Need to Restore Accountability to State Taxpayers*, New York State Comptroller Alan Hevesi admonished the administration of the HCRA, including management of the BDCC pool, for being "off-budget" and therefore having little, if any, accountability to the state or its taxpayers.⁴³ There is no independent auditing or monitoring system in place to track hospitals' submissions or the pool's administration. The BDCC pool is administered by the Excellus Health Plan through a contract with New York State.⁴⁴ The revenue for this fund is collected and distributed by Excellus—completely outside the purview of the normal auditing and accounting procedures of the Office of the Comptroller.⁴⁵

Because of this lack of official oversight, the State is unable to answer even basic questions about how the pool's funds have been spent, such as:

- (1) How many patients have benefited from the BDCC pool?
- (2) Where do these patients live?
- (3) Which hospital served the largest number of charity care patients?
- (4) Which hospital provided the most charity care in dollars?
- (5) How many patients had bad debt written off?
- (6) How did each hospital spend its allocation of the BDCC pool funds?

Arguably, hospitals in receipt of BDCC funds have an obligation to provide accountability about these allocations—allocations stemming from the benefits they acquire under New York law as non-profit hospitals. All twenty-two of the hospitals that Legal Aid surveyed are "charitable" entities and receive substantial financial benefits from the government, including immunity from payment of federal, state and local taxes.⁴⁶ In exchange for these benefits, the IRS has held that

41. *Id.*

42. *Id.*

43. HEVESI, *supra* note 28, at 2.

44. *Id.* at 1.

45. *Id.*

46. New York State does not allow for-profit hospitals. *See* N.Y. PUB. HEALTH LAW § 2801-a(1) (McKinney 2003). Nonprofit hospitals are exempt from taxation.

non-profit hospitals must prove that they give care to the poor in order to retain their tax-exempt status.⁴⁷ Similarly, New York State law requires hospitals to issue “Community Service Plans” to “demonstrate” and “report” efforts to “provide charity care services and to improve access to health care services by the underserved”⁴⁸ Despite these charitable obligations, however, Legal Aid’s study revealed that few hospitals responsibly allocate BDCC funds to the low-income uninsured and underinsured patients they purport to serve.

II.

THE LEGAL AID SURVEY: HOW DO THESE FUNDS WORK?

A. *Methodology Used*

In an attempt to understand how this money is used by hospitals in New York City, as well as to gather information on billing and pricing practices in order to help the city’s uninsured and underinsured population become better health care consumers, Legal Aid staff and interns systematically surveyed twenty-two New York City hospitals in the Summer of 2003. The twenty-two hospitals were chosen so as to represent a diverse sampling of hospitals from all five boroughs. Legal Aid compiled the results of the survey in a report entitled *State Secret: How Government Fails to Ensure that Uninsured and Underinsured Patients Have Access to State Charity Funds*, which is available to the public through The Legal Aid Society’s website.⁴⁹

The investigation was comprised of five central components. First, surveyors telephoned each hospital to determine what billing or payment information is available to consumers over the phone. The ability to obtain such information in an efficient manner by calling the hospital is important to all patients, but especially to those who are sick and disabled. Our surveyors began the calls by trying the hospital’s general phone number. They would attempt to speak with someone in the billing department who would be able to answer questions

See Alice A. Noble et al., *Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives*, 26 J.L. MED. & ETHICS 116, 116 (1998); Kevin M. Wood, *Legislatively-Mandated Charity Care for Nonprofit Hospitals: Does Government Intervention Make Any Difference?*, 20 REV. LITIG. 709, 710–11 (2000–2001) (noting, however, that “society now perceives very little difference between nonprofit and for-profit hospitals”).

47. *Hospitals Must Show It Serves Indigent for Exemption*, LEXSTAT 2001 TNT 48-45 (Feb. 5, 2001).

48. N.Y. PUB. HEALTH LAW § 2803-1 (McKinney 2002).

49. STATE SECRET, *supra* note 6.

for an uninsured patient.⁵⁰ If the surveyor was able to reach an individual in the billing office, she would then ask a standard set of questions about the availability of sliding fee scales, charity care, and payment options (described below). At least three phone calls were made to each hospital in an attempt to receive answers to these questions.

The second part of the survey involved site visits to each of the hospitals.⁵¹ Each surveyor used identical survey instruments, which included both a visual inspection section as well as interview questions for hospital financial staff. The visual survey required the surveyor to mark each time they located a sign that displayed hospital policies involving payment options, such as the existence of sliding fee scales, charity care funds, or the Patient Bill of Rights.⁵² It was also noted whether or not the signs were in languages other than English.

The site visits began at the main desk, where the surveyor would try to locate the billing office. At each office, the Legal Aid staff person explained what information she was looking for and always asked to speak with someone more knowledgeable, such as a supervisor or manager.

The surveyors asked the following questions:⁵³

- (1) Where does an individual uninsured or underinsured patient who has difficulty paying a bill go for help if they are ineligible for Medicaid assistance?
- (2) Is there a sliding fee scale program available? Does it apply to inpatient services?
- (3) Are payment plan options available? What are their terms?
- (4) Are there any charity care programs for the uninsured? Does your hospital have any "charity care" funds? Can a patient apply for your Bad Debt and Charity Care funds? Describe the process, if any.
- (5) Are any of the financial assistance policies or guidelines written, and are they available to the surveyor?

50. Different hospitals had different terms for their departments, such as patient accounts, billing, finances, collections, payment offices, etc. For convenience, we will refer to any office where a patient might get information about a potential bill as a "billing office."

51. A copy of the on-site survey instrument is attached as Appendix A to the report. See STATE SECRET, *supra* note 6, App. A.

52. The New York State Hospital Patients' Bill of Rights offers no statutory or regulatory protections for New York State health consumers when they seek care in the hospital. See N.Y. COMP. CODES R. & REGS. tit. 10, § 405.7 (2001).

53. STATE SECRET, *supra* note 6, at App. A. This information was confirmed by the hospital's admitting or pre-admitting offices.

(6) Are there any financial requirements, such as a deposit, for an uninsured patient to access non-emergency services, like an elective surgery?

After the site visits, the surveyors followed up with additional phone calls to individuals who had not been available during the site visit and with more senior supervisors and managers in the various billing, patient accounts, and financial services offices of each hospital.

At any hospitals where financial staff had been unable or unwilling to cooperate during the site visits, attempts were made by phone, fax, and email to members of the hospital's public relations and/or central executive offices. During these contacts the surveyor included more detailed information pertaining to the nature of the study and the specific questions being asked. At least three phone calls were made to each hospital during this follow-up period.⁵⁴

Legal Aid staff members also made "secret shopper" phone calls to each hospital to obtain information on "charge" rates for an uninsured patient's overnight stay for elective surgery.⁵⁵ The caller asked for the rate exclusive of charges such as the physician's fee or drug costs. This line of questioning was made in the context of shopping around for a hospital in which to have a hysterectomy, one of the most common elective surgeries.⁵⁶

Finally, Legal Aid staff members tracked various low-income clients who were either uninsured or underinsured and who had outstanding medical bills from one of the surveyed hospitals.⁵⁷ None of these clients was eligible for Medicaid at the time of hospitalization, but because of the size of the medical bills, each is struggling under the weight of his or her debt. On their behalf, Legal Aid staff members have sent letters and placed phone calls to the hospitals' financial services directors to request that the individual hospitals' bad debt and charity care funds be used towards these individuals' bills.

54. *Id.* at 18.

55. *Id.*

56. Hysterectomies are the second most commonly performed surgical procedures for women of reproductive age in the United States. *See, e.g.,* Homa Keshavarz et al., *Hysterectomy Surveillance—United States, 1994–1999*, MORBIDITY & MORTALITY WEEKLY REP., July 12, 2002, at 1, <http://www.cdc.gov/mmwr/PDF/SS/SS5105.pdf>.

57. One such uninsured client's story was profiled in *The Wall Street Journal* last year. Rebekah Nix, a twenty-five-year-old magazine intern, was charged \$14,000—the highest "self-pay" rate—by New York Methodist Hospital after an emergency appendectomy landed her in the hospital for two days. Lagnado, *A Young Woman*, *supra* note 27. In contrast, Methodist Hospital charges insurers substantially less for a hospital stay for the same services; commercial HMOs are billed at about \$2,500, Medicaid is billed at about \$5,000, and Medicare is billed at about \$7,800. *Id.*

III. THE FINDINGS

A. *BDCC Funds are Not Available to Individual Uninsured and Underinsured Patients*

Although collectively the twenty-two hospitals surveyed by Legal Aid receive roughly \$316 million dollars of bad debt and charity care compensation per year,⁵⁸ the study found that not one seemed to use the funds to pay off the accounts of uninsured and underinsured patients. As set forth above, the laws that govern the administration of BDCC funds do not require hospitals to allow patients to access these funds individually, but there is nothing in them to prohibit such a distribution either. Instead, the hospitals routinely use the funds to compensate themselves for bad debt accounts on the back end, while still harassing their most needy uninsured patients through collection agencies.

At each hospital, Legal Aid surveyors informed the financial representative that our research indicated that the hospital received the relevant specific amount of BDCC funds from New York State. The surveyors then asked the representative several questions. First, they asked how a patient could access these funds to help pay for his or her care. Second, they had a series of questions prepared that would determine the eligibility rules that the hospitals use to provide uninsured patients charity funds.⁵⁹ Finally, the surveyors asked for a copy of the hospital's written policy governing the eligibility criteria and how to apply for these BDCC funds.

The survey revealed that none of the hospitals voluntarily makes BDCC funds accessible to individual uninsured and underinsured patients through an application process.⁶⁰ It also revealed that each of the hospitals' financial staff is almost completely unaware of the exist-

58. INDIGENT CARE POOL, *supra* note 5.

59. Criteria that we presumed relevant for determining eligibility for State BDCC funds included an assessment of the patient's family income and resources, the number of people in the patient's household, the size of the patient's medical bill, proof that the patient had been rejected from Medicaid or another public insurance program, the gravity of the patient's medical condition, whether it was a repeat or one-time-only patient, and proof of the patient's uninsured status. However, none of the hospitals we surveyed used these or any other criteria for the allocation of charity care.

60. Lenox Hill's attorneys—through written answers provided to their public relations staff—claimed to have a charity care fund from “private donors” available for “a patient who demonstrates need.” However, Lenox Hill would not disclose the criteria for accessing these funds, if any, and would not provide us a copy of their application for its “private” charity care program. Fax and email to Lenox Hill legal counsel (July 31, 2003) (on file with Legal Aid Society Health Law Unit).

tence of BDCC funds. Instead, uninsured and underinsured patients are routinely charged the highest, self-pay rates for hospital services (described in more detail below).⁶¹

At thirteen of the twenty-two hospitals surveyed, the patient accounts representatives with whom our surveyors spoke were completely unaware that BDCC funds existed.⁶² Typical was the response by the associate director of financial services at Bronx-Lebanon Hospital, that “there are no Bad Debt and Charity Care Funds.”⁶³ In fact, Bronx-Lebanon receives more than \$22 million BDCC funds each year.⁶⁴ Similarly, a credit and collections supervisor at SUNY Downstate claimed that the hospital might have had charity care funds in the past, “but not anymore,”⁶⁵ even though SUNY Downstate receives nearly \$6 million in yearly BDCC funds.⁶⁶

Representatives at eight of the twenty-two hospitals were vaguely aware of the BDCC funds, but they could not supply our surveyors with any policies that outlined how these funds work or how to apply them to a patient’s medical expenses.⁶⁷ For example, the billing staff at Montefiore Medical Center—which receives roughly \$18 million in BDCC funds a year⁶⁸—seemed to believe that if this funding source did exist, it is only accessible with the permission of senior management.⁶⁹ A representative of Cornell/NY Presbyterian—which receives more than \$60 million of BDCC per annum⁷⁰—asserted that “there is a fund” but “I can’t tell you who it is from or how much it is”—nor could the representative explain the hospital’s policies, eligibility criteria or degree of access to the funds for individual cases.⁷¹

61. The Public Policy and Education Fund awarded “F” grades to all twenty-six New York City hospitals for their failure to provide publicly available free or charity care policies in response to their phone survey. PUB. POL’Y & ED. FUND OF N.Y., HOSPITAL FREE CARE: CAN NEW YORKERS ACCESS HOSPITAL SERVICES PAID FOR BY OUR TAX DOLLARS? 21–24 (2003), at http://www.citizenactionny.org/reports/Hospital_Free_Care_Report_Final.pdf.

62. These hospitals were Beth Israel, Bronx-Lebanon, Lenox Hill, Maimonides, Mary Immaculate, Memorial Sloan-Kettering, Montefiore, Mount Sinai, NYU Med. Ctr., St. John’s, St. Vincent’s Manhattan, St. Vincent’s Staten Island, and SUNY Downstate. See STATE SECRET, *supra* note 6, at 21.

63. *Id.*

64. INDIGENT CARE POOL, *supra* note 5.

65. STATE SECRET, *supra* note 6, at 22.

66. INDIGENT CARE POOL, *supra* note 5.

67. These hospitals were Brookdale, Cabrini, Cornell/NY Presbyterian, Elmhurst, Flushing, Jamaica, NY Methodist, and St. Luke’s. STATE SECRET, *supra* note 6, at 22.

68. INDIGENT CARE POOL, *supra* note 5.

69. STATE SECRET, *supra* note 6, at 22.

70. INDIGENT CARE POOL, *supra* note 5.

71. STATE SECRET, *supra* note 6, at 22.

Only at Elmhurst Hospital, which is operated by New York City's Health and Hospitals Corporation, was the staff aware that the BDCC funds are intended for uninsured or underinsured patients. According to an Elmhurst representative, the hospital uses BDCC funds to offer a sliding fee scale for uninsured patients.⁷² Despite this policy, even Elmhurst does not have a specific mechanism other than the sliding fee scale to enable a needy patient to apply for BDCC funds.⁷³

In sum, the Legal Aid Society study revealed that, in the absence of legislative or regulatory mandate, the New York hospital industry fails to voluntarily provide meaningful access to the hundreds of millions of dollars in BDCC funds it is allocated each year.

B. Little Notice of Charges and Charity Care Provided to Patients

Under New York State law, there is no legal requirement for a hospital to disclose its billing and charge information to the public.⁷⁴ Most hospitals take advantage of this fact by refusing to share even the most basic financial information. This lack of relevant information makes it nearly impossible for a health care consumer in New York to compare hospitals based on price—unlike consumers in any other field. For example, when a New Yorker buys a car, by law car dealers must disclose information pertinent to the sale to their customers, such as the recommended manufacturer's list price and gas mileage. Unfortunately, there are no similar consumer protections for hospital patients and no laws to require hospitals to provide accurate information about charity care, billing policies or payment plans.

Even if most individuals do not think to compare hospitals before actually needing one, or do not think of health care as a consumer-based commodity, this information could be vital to advocacy groups, such as Legal Aid, in their work on behalf of the uninsured. Also, if hospitals were forced to disclose this information to the public, it would help legislators to understand where gaps exist in financially accessible care. It might also be a catalyst for a more consumer-friendly atmosphere at hospitals.

As described below, in the absence of statutory patient protections, hospitals routinely refuse to disclose information about their policies for the uninsured and underinsured, billing rates and payment plans. Legal Aid surveyors discovered almost immediately that an un-

72. *Id.*

73. *Id.*

74. See N.Y. PUB. HEALTH LAW §§ 2807-k, -w (McKinney 2002); N.Y. COMP. CODES R. & REGS. tit. 10, § 400.18 (Supp. 2004).

insured New York City patient has a much harder time learning about New York City hospitals' policies for the uninsured than a car shopper has in finding out the specifications of a car.

Legal Aid's investigation was designed to approximate the experience of an underinsured or uninsured New Yorker who attempts to find out hospital billing and charge information over the phone and in person. The surveyors recorded practical considerations such as: (1) the time required to obtain answers; (2) whether a patient accounts department was easily accessible from the main hospital building; and (3) the availability of assistance in languages other than English.⁷⁵

The amount of time and energy exerted by the surveyors just to find answers to basic questions pertaining to a hospital's charges and billing practices was far greater than could be expected to be endured by the average patient, let alone a patient who was timid or unsophisticated or a patient with a serious health problem or disability. Even the surveyors' significant dedication of time and effort yielded little concrete information on some hospital's services provided to uninsured and underinsured patients. Legal Aid graded each hospital on how easy it was for a patient to receive this information:⁷⁶ seven hospitals earned an A, six a B, three a C, two a D and four hospitals failed.⁷⁷ The four hospitals that earned a failing grade refused to answer any of Legal Aid's policy and practice questions. Two hospitals provided answers only after Legal Aid contacted their public relations and/or executive offices. At three hospitals, surveyors were forced to spend at least two hours, or had to speak with more than five employees, before receiving answers to all of their questions. At six, our surveyor was provided with the information within two hours and spoke with five or fewer employees. Only at seven of the twenty-two hospitals in the Legal Aid survey were our staff members able to get responses to

75. STATE SECRET, *supra* note 6, at 25.

76. Hospitals that answered the questions within one hour and after speaking with one to three people received an "A"; hospitals that took between one to two hours after querying less than five staff persons received a "B"; hospitals that took more than two hours and required querying more than five staff persons received a "C"; hospitals that would only answer our questions after we contacted public relations staff or their executive offices received a "D"; and hospitals which refused to cooperate received an "F." STATE SECRET, *supra* note 6, at 26.

77. Columbia/NY Presbyterian, Jamaica, St. Luke's, Montefiore, NYU Med. Ctr., St. Vincent's Staten Island, and SUNY Downstate received an "A." Beth Israel, Bronx-Lebanon, Cabrini, Elmhurst, Flushing, and St. John's received a "B." Brookdale, Cornell/NY Presbyterian, and Mt. Sinai received a "C." Lenox Hill and NY Methodist received a "D." Maimonides, Mary Immaculate, Memorial Sloan-Kettering, and St. Vincent's Manhattan received an "F." *Id.*

their questions within one hour and by consulting with three or fewer employees.⁷⁸

One serious consequence of a hospital's initial failure to respond to these inquiries is that patients are forced to physically travel to their hospital to learn about charity care, charges, billing, and payment options. At seven hospitals, our surveyors discovered that the billing offices were located more than a fifteen minute walk from the main hospital building.⁷⁹ Out-stationing these offices results in considerable hardship for patients who are ill or who have job and family obligations. Furthermore, once at the hospital, our surveyors occasionally found financial staff and hospital administrators unnecessarily bureaucratic, reluctant to respond, and sometimes rude.⁸⁰ This is also a complaint often heard from low-income clients who have tried to settle bills themselves before coming to Legal Aid for assistance.⁸¹

The Legal Aid surveyors also found that only three of the twenty-two hospitals had posted signs that described programs for the uninsured or underinsured.⁸² Both on the phone and in person, the surveyors consistently found it difficult to identify and locate the appropriate person with whom to speak about billing and payment options for the uninsured and underinsured. For example, at nine hospitals, employees assumed that a request for information on behalf of the uninsured or underinsured should be referred to billing staff responsible for Medicaid patients.⁸³ Our surveyors reported that even hospital administrators often proposed Medicaid and Family Health Plus as complete solutions to patients' financial difficulties, despite the fact that the Le-

78. *Id.* at 27.

79. This information is based on surveyor reports from Beth Israel, Brookdale, Cornell/NY Presbyterian, Lenox Hill, Mary Immaculate, Mount Sinai, and St. Luke's Roosevelt. *Id.*

80. At two hospitals—Cornell/NY Presbyterian and Maimonides—the patient accounts representatives claimed that they could not answer general billing questions because of HIPAA (the federal law that protects patient privacy). *Id.* at 27 n.62. This response represents a gross misinterpretation of the law; HIPAA protects patients' health information, not hospitals' general policies. See Press Release, United States Department of Health and Human Services, Fact Sheet: Protecting the Privacy of Patients' Health Information (Apr. 14, 2003), <http://www.hhs.gov/news/facts/privacy.html> (last visited Oct. 27, 2004).

81. See Ramirez, *supra* note 35 (noting that “[a]lthough Guzman tried negotiating with hospital officials to work out a reasonable payment plan after being treated last September, Mount Sinai officials balked at working something out”).

82. Only St. Vincent's Hospital in Manhattan posted information about federal charity care funds, and only Mount Sinai and Bronx-Lebanon posted information about their sliding fee scale programs. STATE SECRET, *supra* note 6, at 28.

83. These hospitals were Beth Israel, Brookdale, Cornell/NY Presbyterian, Jamaica, Maimonides, Mary Immaculate, St. John's, St. Luke's, and SUNY Downstate. *Id.* at 28 & n.65.

gal Aid surveyors explained that they sought information on behalf of uninsured or underinsured patients who are *not eligible for Medicaid*.⁸⁴

C. Hospitals' "Charge" Rates

Another major reason that uninsured and underinsured patients incur insurmountable medical debt is because hospitals routinely charge them higher rates than patients who have insurance. They charge an uninsured patient, with no bargaining power, what is termed a "self-pay" or "charge" rate. These base rates for medical procedures are heavily discounted for powerful HMOs and insurance companies that have the ability to negotiate with the hospitals, and they are far above what the government pays on behalf of Medicare or Medicaid.⁸⁵ They are often thought of as the rates charged to wealthy self-pay clients who fly in from other countries for expensive treatments; unfortunately, they are also the prices charged to low-income New Yorkers without health insurance coverage.

Legal Aid's clients have experienced firsthand the financial hardship incurred by this practice. For example, in February 2003, a Legal Aid client's teenage daughter woke up with terrible chest pains. Terrified, the family rushed their daughter to St. Francis Hospital on Long Island. The Emergency Room doctor determined that she had an extreme case of the flu and sent her home with Advil. A few weeks later, the family received an "Explanation of Benefits" from their HIP insurance plan denying St. Francis' \$240 claim for the emergency room visit on the ground that the daughter's health coverage had lapsed a month earlier. In September 2003, the family received a bill from St. Francis' collection agency for \$1,310.50—over a 500%

84. *Id.* Medicaid eligibility in New York is restricted to those individuals with an annual income of \$7,908 and asset limits of \$3,950. There are some instances where individuals may be eligible to "spend down" excess income on medical bills in order to qualify. However, these income limits are extremely low, and many individuals who cannot afford to buy health insurance do not qualify. See New York State Department of Health, *Info for Consumers: Need Help Paying for Medical Care?*, at <http://www.health.state.ny.us/nysdoh/medicaid/mainmedicaid.htm> (last modified Aug. 2004). As for New York's Family Health Plus low-cost insurance program, there is no retroactive eligibility. Therefore, should an individual be found eligible after incurring medical expenses, Family Health Plus would not help pay for those bills. See New York State Department of Health, *Info for Consumers: Family Health Plus: What Will Happen When I Apply?*, at http://www.health.state.ny.us/nysdoh/fhplus/what_will_happen.htm (last modified Aug. 2004).

85. See Lagnado, *A Young Woman*, *supra* note 27.

markup from the rate the hospital had originally charged the HIP insurance plan.⁸⁶

In an effort to learn more systematically what deregulated prices or charge rates hospitals quote to uninsured patients, Legal Aid surveyors called the hospitals and asked how much an overnight stay for an elective surgery, such as a hysterectomy, would cost. Surveyors explained to each hospital that they only wanted the overnight stay charge, excluding all other charges, such as surgeons' fees and anesthesia costs. The responses received from the hospitals' pre-admitting staff varied widely; the price quotes ranged from \$1,100 at Mary Immaculate to \$11,422 at the NYU Medical Center.⁸⁷ In contrast, commercial insurers pay a "per diem" rate between \$800 and \$1,400 for such a stay, depending on the hospital and its location.⁸⁸ The wide disparity in hospital prices for the uninsured reminds us that health care consumers must be given easy access to this type of billing information, especially since many uninsured patients chose to forego medical care rather than pay such steep self-pay rates.⁸⁹ Accordingly, Legal Aid's investigation next examined how uninsured and underinsured patients apply for sliding fee discounts and other payment plans for medically necessary inpatient stays.

D. Sliding Fee Scales

Some hospitals offer a discounted fee schedule to low-income uninsured or underinsured patients. This fee schedule is usually called a "sliding fee" scale. New York City's public hospital system, the

86. This example is based on Legal Aid's interview with the family, a review of their bills and confirmation of their charges with hospital representatives.

87. STATE SECRET, *supra* note 6, at 31. Kat Gabriesheski, this article's co-author and one of Legal Aid's surveyors, called the NYU Medical Center on July 17, 2003, and received a quote of \$11,422. Because NYU's rate quote was an outlier compared with the other hospitals' quoted "charge rates," Ms. Gabriesheski called again on a later date for verification. This time, however, the pre-admitting office refused to provide any information because, it was claimed, a patient must be "in the system to receive this information." Thus, NYU could have been listed as either the most expensive hospital of the twenty-two surveyed or the only hospital that refused to provide a rate quote for the requested overnight surgical stay. *Id.*

88. The Medicare program pays \$1,101.75 for a hysterectomy performed in Manhattan. This rate includes the doctor's fees and the hospital costs. *See* Am. Med. Ass'n, at <http://www.webstore.ama-assn.org/search/cptlookup> (CPT code 58150) (last visited May 5, 2004).

89. *See* LISA DUCHON ET AL., THE COMMONWEALTH FUND, SECURITY MATTERS: HOW INSTABILITY IN HEALTH INSURANCE PUTS U.S. WORKERS AT RISK viii (2001), http://www.cmwf.org/usr_doc/duchon_securitymatters_512.pdf; THE ACCESS PROJECT, PAYING FOR HEALTH CARE WHEN YOU'RE UNINSURED: HOW MUCH SUPPORT DOES THE SAFETY NET OFFER? 10 (2003), http://www.accessproject.org/downloads/d_finreport.pdf.

Health and Hospitals Corporation (“HHC”), has long made its sliding fee scale program available to its uninsured and underinsured patients.⁹⁰ The latest HHC fee schedule applies a discount based upon the uninsured patient’s family size and income.⁹¹ However, there is no state law that requires the non-profit private and voluntary hospitals to disclose their sliding fee scale and other reduced payment programs.

The availability of sliding fee scales in the health care context is important given the inexorable rise in the number of uninsured and underinsured patients who cannot afford medical treatments. Sliding fee scales are particularly valuable for inpatient, non-emergency treatment. Although many such treatments, such as chemotherapy for cancer patients, are considered elective as opposed to emergency services, they often include procedures that can significantly reduce pain and suffering and decrease the chance of death. These procedures are generally far more expensive than clinic services, and rates routinely climb into the tens of thousands of dollars.

Although most of the twenty-two hospitals surveyed in the Legal Aid study have certified to the New York State Department of Health that they make some services available to low-income uninsured patients,⁹² our surveyors discovered that these vague certifications fail to guarantee affordable care to uninsured or underinsured patients. At St. John’s Hospital and the NYU Medical Center, the billing staff told our surveyors that the hospital did not offer a sliding fee scale program. Three other hospitals did not respond to Legal Aid’s requests for information about sliding fee scale policies for the uninsured.⁹³ Although seventeen hospitals claimed to have sliding fee programs,

90. NEW YORK LAWYERS FOR THE PUBLIC INTEREST, *THE RIGHTS OF THE UNINSURED IN NEW YORK CITY TRAINING MANUAL, SUPPLEMENT III-E* (2001) (indicating that fee scales for inpatient services have existed since the 1970s at HHC) (on file with the Legal Aid Society Health Law Unit).

91. See N.Y. CITY HEALTH & HOSPS. CORP., *HHC OPTIONS: MAKING QUALITY HEALTH CARE AFFORDABLE* 5–8 (June 2004) (on file with The Legal Aid Society Health Law Unit).

92. All of the hospitals surveyed, except for Cabrini and Maimonides, certified in 1997 that “they would provide all medically necessary care to medically indigent patients coming to the hospital for services” in order to receive federal funding through a program designed to help them “transition to Medicaid managed care.” *COMM’N ON THE PUBLIC’S HEALTH SYS., CHCCDP: ARE WE GETTING OUR MONEY’S WORTH? MONITORING THE USE OF COMMUNITY HEALTH CARE CONVERSION DEMONSTRATION PROJECT FUNDS* 1, 11, 18–22 (2003) (on file with the Journal of Legislation and Public Policy).

93. These hospitals were Memorial Sloan-Kettering, Mary Immaculate, and St. Vincent’s Manhattan. *STATE SECRET, supra* note 6, at 34.

only three actually apply these programs to *inpatient* bills—where discounts are most needed.⁹⁴

Very few hospitals had written fee scale policies to aid financial staff in determining eligibility requirements. Only four out of the twenty-two hospitals surveyed had written policies that were available to the public.⁹⁵ The majority of the hospitals would not voluntarily provide Legal Aid with copies of their sliding fee policies, if there even were any. When a surveyor asked to see a copy of the sliding fee scale policy at Cabrini Medical Center, she was told that “this is a hospital . . . we can’t give out that information.” Staff at Jamaica Medical Center said no because “they are hospital documents.”⁹⁶ By contrast, the Health and Hospital Corporations hospitals (the Legal Aid study included only one HHC hospital: Elmhurst) routinely make their sliding fee scale programs known and information about them available in pamphlets distributed in the hospitals’ billing offices.

E. Payment Plans

Legal Aid surveyors also found that several of the hospitals in the study offered onerous payment plans before patients are even admitted for treatment. For example, at eight of the twenty-two hospitals surveyed, uninsured patients are regularly asked to pay *100 percent* of their anticipated bill prior to admission.⁹⁷ Lenox Hill Hospital revealed that their policy is to demand \$6,000 up front, with the possibility for a reduction to \$3,000.⁹⁸ Similarly, Columbia/NY Presbyterian requires a sixty percent deposit and the NYU Medical Center requires a fifty percent deposit prior to admission.⁹⁹ The inflexibility of most plans is likely to deter patients from seeking treatment for a serious condition as well as cause considerable financial hardship.¹⁰⁰

94. The three hospitals that apply their sliding fee programs to inpatient stays are Cabrini, Elmhurst (a New York City public hospital), and Flushing Medical Center. *Id.*

95. These hospitals were Elmhurst, Montefiore, NY Methodist, and SUNY Downstate. *Id.*

96. *Id.* at 33.

97. The hospitals which said they require uninsured patients to pay 100 percent of their estimated charges in advance were Beth Israel, Bronx-Lebanon, Cabrini, Jamaica, Memorial Sloan-Kettering, Mt. Sinai, St. Luke’s Roosevelt, and St. Vincent’s Staten Island. *Id.* at 35.

98. *Id.* at 36.

99. *Id.*

100. See DUCHON, *supra* note 89, at 8–9; THE ACCESS PROJECT, *supra* note 89, at 10–11.

Most of the hospitals Legal Aid surveyed offer more than one payment option and claim to consider income, bill amount, or the size of a patient's household when establishing a payment plan. But the cumulative impact of the hospitals' imposition of charge rates, up-front payment demands, stringent time limits, and woefully inadequate discounts demonstrate that payment plans are remarkably unrealistic for uninsured and underinsured patients who might seek inpatient care.

Should an uninsured patient be fortunate enough to be admitted without a deposit (usually through the emergency room), many hospitals have unrealistic post-treatment payment plans. At least six of the twenty-two hospitals allow discounts—almost always capped at twenty percent—off the total bill *only* if a patient is able to pay the whole bill, or a large percentage, up front.¹⁰¹ Uninsured or underinsured patients are unlikely to be able to satisfy either of these two conditions; they typically receive large bills, and their annual income is often less than eighty percent of what they owe. In contrast, Elmhurst Hospital, a New York City public hospital, requires only a minimum deposit of \$200 with the remainder determined according to a patient's income.¹⁰² Many hospitals also place inflexible limits on the amount of time a patient has to pay the bill, usually less than one year—only five are more flexible, or permit longer payment periods.¹⁰³

F. Collection Agencies

The New York State BDCC statute explicitly encourages hospitals to vigorously pursue uninsured and underinsured patients.¹⁰⁴ Accordingly, hospitals regularly refer their overdue bills to collection agencies. Some hospitals do this on a routine basis, such as after a bill remains unpaid for a certain amount of time (often between sixty days and one year). Direct referrals to collection agencies are generally made without any inquiry into a patient's financial circumstances because, as the Patient Accounts Manager at Beth Israel Medical Center claimed, “[t]he patient can tell us anything [about his or her financial

101. These hospitals are Beth Israel, Flushing, Lenox Hill, Mount Sinai, NY Methodist, and St. Vincent's Staten Island. STATE SECRET, *supra* note 6, at 36 & n. 80.

102. *Id.* at 37.

103. These hospitals are Brookdale, Bronx-Lebanon, Elmhurst, St. John's, and St. Vincent's Staten Island. *Id.* at 36.

104. See N.Y. PUB. HEALTH LAW § 2807-k(9) (McKinney 2002) (stating that “[i]n order for a general hospital to participate in the distribution of funds from the pool, the general hospital must implement minimum collection policies and procedures . . .”).

status]. There is no way for us to verify their story. That's why we refer them to collection agencies."¹⁰⁵

If a patient notifies Brookdale Hospital that he or she is having trouble paying the amount owed, the hospital brings that patient in for what it calls an "interrogation" to identify what amount the patient can afford to pay.¹⁰⁶ At Jamaica Hospital, however, the staff refuses to even negotiate payment plans. Instead, patients are referred to a collection agency in order to negotiate payment options when they are unable to pay the full amount.¹⁰⁷

Research reports and academic articles describe how medical facilities' inflexible payment plans and reluctance to negotiate with patients early in the billing process unnecessarily subject the uninsured and underinsured to aggressive pursuit by creditors, ruined credit, and personal bankruptcy filings.¹⁰⁸ One recent study found that nearly half of all bankruptcies were filed for a medical reason or for medical debt, and more than 500,000 middle class families turned to the bankruptcy courts for help following an illness or injury in 1999.¹⁰⁹ This study also revealed that vulnerable groups, such as female-headed households¹¹⁰ and the elderly,¹¹¹ were even more likely to experience a health-related bankruptcy. Tellingly, many of these families were not uninsured, but only underinsured—nearly eighty percent had some form of basic health insurance.¹¹²

105. STATE SECRET, *supra* note 6, at 37.

106. *Id.*

107. *Id.*

108. *See, e.g.*, DUCHON, *supra* note 89, at 9, 12; ACCESS PROJECT, THE CONSEQUENCES OF MEDICAL DEBT: EVIDENCE FROM THREE COMMUNITIES 14–16 (2003), http://www.accessproject.org/downloads/med_consequences.pdf; Melissa B. Jacoby et al., *Rethinking the Debates over Health Care Financing: Evidence from the Bankruptcy Courts*, 76 N.Y.U. L. REV. 375, 410 (2001) (characterizing the bankruptcy system as the "insurer of last resort to families and individuals who cannot pay health-care-related costs.").

109. Jacoby, *supra* note 108, at 389–90.

110. *Id.* at 392, 395 (finding that female-headed households were less numerous in the population than they are in bankruptcy courts and that the highest filing rate for medical-related bankruptcy in 1999 was for women in a household with no adult male present).

111. *Id.* at 397–98 (finding that nearly half of the debtors sixty-five and older in the study identified illness or injury as a reason for bankruptcy filing, notwithstanding Medicare and retirement benefits).

112. *Id.* at 401.

IV. REACTIONS

A. *Legal Aid's Recommendations*

Based on its extensive findings, The Legal Aid Society proposed the following recommendations to New York's legislature:¹¹³

New York policy makers should transform the BDCC funding stream and make these funds accountable along the lines adopted by our neighboring states.

(1) Enact a statute to establish a simple, uniform statewide application and eligibility process for hospitals to use to administer free care and sliding fee programs based upon standardized income guidelines. This process should be simple to administer and non-bureaucratic.

(2) Require hospitals to notify patients of the availability of charity care funds, sliding fees and other payment policies whenever the hospitals seek payment, i.e., prior to admission and/or at post-discharge billing. Require posting of signs and booklets regarding these policies in inpatient accounts departments.

(3) Require hospitals to charge uninsured and underinsured families the lowest, not the highest, rates—the Medicaid rate, for example.

(4) Require hospitals to follow fair and standardized collection practices.

(5) Enact legislation to immunize low-income families who are income-eligible for public insurance coverage from suit by hospitals that receive BDCC funds.

(6) Establish an appropriate auditing system of BDCC funds which: (a) accounts for the number of uninsured patients served through the funding mechanism; (b) rewards hospitals which serve larger numbers of uninsured with increased BDCC funding; and (c) ensures that patients' accounts are credited if funds are provided for their care, i.e., they are not also put into collections.

Should these recommendations be implemented, The Legal Aid Society argues, health advocacy groups would not only support the BDCC program, but urge for its expansion. However, without meaningful improvements in the BDCC pool's administration, Legal Aid and other advocates have urged lawmakers to consider other concrete alternatives—such as expanding insurance access—that are meaningful to the uninsured patients these programs are purportedly designed to serve. For example, the \$847 million in BDCC funds each year

113. STATE SECRET, *supra* note 6, at 44–45.

could be used to fully insure an additional 227,000 low income New Yorkers through the State's Family Health Plus program.¹¹⁴

B. The American Hospital Association's Reaction and Advocates' Response

Confronted with various advocacy reports, press accounts, the recent congressional investigation into the billing practices of hospitals nationwide, and other forms of public pressure, the American Hospital Association (AHA) asserted in December 2003 that the Medicare statute prohibits hospitals from using less aggressive collection tactics on low-income uninsured families.¹¹⁵ It wrote a letter to Tommy Thompson, head of the U.S. Department of Health and Human Services, in which the trade group claimed that the Medicare regulations "make it far too difficult and frustrating" to reduce prices for their uninsured patients.¹¹⁶

But as a rule, the Medicare program does not review a hospital's self-pay charge in order to establish Medicare rates.¹¹⁷ Generally, Medicare rate-setting is not based on an "average" of other payers' charges or rates. Rather, rates are typically based on a calculation of local wage and consumer price adjustments.¹¹⁸ For example, Medicare calculates its reimbursement rates for an acute hospitalization as follows: First, the government sets Diagnosis Related Groups (DRGs), which capture the relative intensity of an individual health encounter or hospitalization. Second, once the DRG is assigned to the patient, the actual reimbursement varies by hospital and depends on such factors as geographic location, teaching status, and proportion of low-income patients.¹¹⁹

114. Calculations conducted by Elisabeth Benjamin after learning from the State Department of Health that the average monthly per member capitation rate for Family Health Plus is \$311.

115. Lagnado, *Hospitals*, *supra* note 1 (reporting that the trade group claimed Medicare's "rules 'create a very strong presumption that hospitals must use aggressive efforts to collect from all patients'").

116. *Id.*

117. 69 Fed. Reg. 48,916, 48920 (Aug. 11, 2004) (to be codified at 42 C.F.R. pts. 403, 412, 413, 418, 460, 480, 482, 483, 485 & 489) (explaining that the Medicare rate is determined by (1) calculating the base payment rate, (2) multiplying the adjusted base payment rate by the DRG relative weight, and (3) including add-on payments for treatment of a high percentage of low-income patients, provision of indirect medical education, use of new technology or medical services, and exposure to outlier costs).

118. See WEI YU, HEALTH ECON. RES. CTR., HOW DO I CALCULATE MEDICARE REIMBURSEMENT FOR AN ACUTE HOSPITALIZATION?, at http://www.herc.research.med.va.gov/FAQ_I18.htm (last updated Apr. 14, 2003) (last visited September 25, 2004).

119. *Id.* Of course, there are exceptions to this general rule, e.g., high cost outlier cases. See 69 Fed. Reg. at 48920 (explaining that a hospital may be eligible for an

Furthermore, Medicare explicitly permits hospitals to provide “free care or care at a reduced charge to patients who are determined to be financially indigent.”¹²⁰ The federal government’s *Medicare Provider Manual* describes a simple mechanism for hospitals to follow “[t]o assure that the provisions of such free [c]are or care at a reduce[d] rate will not affect the acceptance of the provider’s established charge schedule as customary.”¹²¹

Federal law does prohibit providers from billing Medicare beneficiaries a *higher* charge than non-Medicare beneficiaries.¹²² But the purpose of this prohibition is to avoid excess charges to government-sponsored health programs, thereby avoiding government subsidization of commercial insurance payers. It is not intended to regulate hospital billing of uninsured patients. As the *Medicare Provider Manual* notes, “[i]t is the intent of the law that the Medicare program shall reimburse no more than a private payment patient would be asked to pay, even if there is only one ‘patient liable for payment on a charge basis.’”¹²³

Accordingly, “[s]etting uniform prices is not the same as receiving uniform reimbursements.”¹²⁴ Hospitals routinely negotiate steep discounts for commercial insurers. Federal law does not bar New York’s *non-profit* hospitals from negotiating steep discounts with the uninsured. In fact, in early- and mid-2003, *for-profit* hospitals, such as Hospital Corporation of America (HCA) and Tenet Healthcare Corporation, announced reduced rates for their uninsured patients.¹²⁵

In addition, the fact that the hospitals routinely charge their privately *insured* patients less than their customary charges is now under serious scrutiny not only by the media and Legal Aid, but also by the

additional payment over the national base Medicare payment rate for costs incurred in unusually expensive cases).

120. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE PROVIDER REIMBURSEMENT MANUAL PART I ch. 26 § 2606.2(D) (last modified Sept. 16, 2004), at http://www.cms.hhs.gov/manuals/pub151/PUB_15_1.asp (last visited Oct. 20, 2004).

121. *Id.* The mechanism is: (1) the provider must have a published full charge schedule; (2) the provider’s revenues for patient care must be based upon the application of the published charge schedule; (3) the provider must maintain written policies for its process of making patient indigency determinations; and (4) the provider must maintain sufficient documentation in support of its “indigency allowances.” *Id.*

122. 42 U.S.C. § 1320a-7(b)(6)(A) (2003 & Supp. 2004).

123. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 120, at § 2604.3(B).

124. CAROL PRYOR ET AL., THE COMMONWEALTH FUND, UNINTENDED CONSEQUENCES: HOW FEDERAL REGULATIONS AND HOSPITAL POLICIES CAN LEAVE PATIENTS IN DEBT 10 (2003), <http://www.accessproject.org/downloads/unintended.pdf>.

125. See Rhonda L. Rundle, *Tenet to Unveil New Protections for the Uninsured*, WALL ST. J., Jan. 28, 2003, at A3; Lucette Lagnado, *Hospitals Urged to End Harsh Tactics for Billing Uninsured*, WALL ST. J., July 7, 2003, at A9.

federal government. Indeed, the Department of Health and Human Services Office of the Inspector General recently proposed regulations which seek to remedy this system and explained that it was concerned that hospitals are “simply overcharging Medicare.”¹²⁶ The regulations would require hospitals to include “negotiated rates” with managed care companies when they calculate their “usual charges.”¹²⁷

The new rule also provides important protections for the uninsured. Specifically, it proposes to *not* include in the hospital “usual charge” calculation “[c]harges for services provided to uninsured patients free of charge or at a substantially reduced rate”¹²⁸

C. The Federal Government Weighs In on the Side of the Uninsured

In February 2004, Health and Human Services Secretary Tommy Thompson responded to this debate and to the American Hospital Association’s demand for specific guidance by stating that “nothing should stop the industry from taking steps to offer discounts to the uninsured” and that hospitals are not required “to engage in any specific level of collection effort for Medicare or non-Medicare patients.”¹²⁹ Although the Medicare statute requires providers to make a “reasonable collection effort” to pursue debts, the *Medicare Provider Reimbursement Manual* clearly sets forth a mechanism whereby a provider can determine that a patient is “indigent” or “medically indigent.”¹³⁰ Once an individual is judged “indigent” for this purpose, that person’s “*debt may be deemed uncollectible*” and the hospital is not required to pursue standard debt collection practices.¹³¹

126. See 68 Fed. Reg. 53,939, 53,940 (Sept. 15, 2003) (to be codified at 42 C.F.R. pt. 1001).

127. *Id.* at 53,941.

128. *Id.*

129. Lucette Lagnado, *HHS Chief Scolds Hospitals for Their Treatment of Uninsured*, WALL ST. J., Feb. 20, 2004, at A1.

130. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 120, at §§ 310, 312. Medicare’s guidelines for the determination of indigence are straightforward and merely require that the provider: (1) determine that the patient is medically indigent, *e.g.*, by asking patient to sign a declaration stating his inability to pay; (2) take into account the patient’s total resources, including an analysis of assets—but only those that are convertible to cash and unnecessary for daily living; (3) determine that there is no other source besides the patient that is legally responsible for the bills; and (4) keep documentation of these efforts. *Id.* at § 312.

131. *Id.* at § 312 (emphasis added).

D. HANYS Guidelines

The Healthcare Association of New York State (HANYS), the trade group that represents the state's 230 not-for-profit hospitals, recently responded to the increased national scrutiny, calls for reform by the Legal Aid study, and the presence of several reform bills in Albany.¹³² It proposed voluntary guidelines for its member hospitals that would offer immediate price reductions to patients with incomes below 200 percent of the federal poverty level (currently around \$9,300 a year).¹³³ HANYS also urged its hospitals to provide other valuable discounts to individuals and families with incomes above that level. The guidelines suggest that hospitals should discontinue their practices of charging the uninsured higher prices than HMOs, insurers, and the government (through Medicare and Medicaid).¹³⁴

The trade group also addressed the practice of aggressive collections by specifically discouraging hospitals from forcing home foreclosures or using "body attachments," a practice whereby patients are actually arrested and jailed for failing to show at medical debt related court appearances.¹³⁵ However, even under these voluntary guidelines, hospitals are still able to charge interest, garnish wages, place patients into collection actions, and put liens on individuals' homes.¹³⁶

V.

CONCLUSION: HOW CAN THE UNINSURED BE GOOD HEALTH CARE CONSUMERS?

New York City is a self-touted "medical Mecca." But for the uninsured and the underinsured, securing access to affordable care is confusing, frustrating, and uncertain—in short, it is an exercise in fu-

132. Lucette Lagnado, *New York State Hospitals Agree to Cut Prices for Uninsured*, WALL ST. J., Feb. 2, 2004, at B1 [hereinafter Lagnado, *New York State*] (noting that "[a]mid mounting criticism of hospitals' treatment of the uninsured and warnings of tough legislative remedies, hospitals in New York state have agreed to a voluntary program to cut prices and provide charity care for their poorest patients. They have also pledged to restrict punitive collection tactics.").

133. See HANYS, FINANCIAL AID/CHARITY CARE POLICY AT NEW YORK'S NOT-FOR-PROFIT HOSPITALS 2-3 (2004), <http://www.hanys.org/publications/upload/Financial-Aid-Charity-Care-Policy-at-New-York-s-Not-for-Profit-Hospitals-Guidelines-from-the-Healthcare-Association-of-New-York>; UNITED STATES DEP'T OF HEALTH AND HUMAN SERVS., THE 2004 HHS POVERTY GUIDELINES: ONE VERSION OF THE [U.S.] FEDERAL POVERTY MEASURE at <http://aspe.hhs.gov/poverty/04poverty.shtml> (last revised May 3, 2004) (last visited October 28, 2004).

134. HANYS, *supra* note 133, at 2.

135. *Id.* at 5.

136. Lagnado, *New York State*, *supra* note 132 (noting that even charitable entities, such as hospitals, can charge nine percent interest rates). See also HANYS, *supra* note 133, at 5.

tility. For example, uninsured patients are routinely asked to pay more than their annual income in advance of treatment. Unlike consumers who are shopping for cars, uninsured and underinsured health consumers have few consumer protections when they confront a medical crisis. They are often left without practical information necessary to obtain care at a manageable cost.

Caring for uninsured and underinsured patients imposes financial difficulties for hospitals that provide treatment to people in need.¹³⁷ Nonetheless, under the State Health Department's supervision, New York hospitals administer billions of dollars of "off budget" government health spending, purportedly to benefit low-income patients, through a variety of funding pools, including the BDCC pool, with virtually little or no oversight.¹³⁸

But from the patient's perspective, New York's BDCC funds are totally ineffective in their intended purpose of providing care for the uninsured and underinsured. Our study shows that all twenty-two hospitals we approached fail to establish voluntary policies for the administration of these funds to the patients they are designed to assist.

New York's program, thus, stands in sharp contrast to our neighboring states. Connecticut, New Jersey, and Massachusetts have all established legal frameworks that ensure that their version of these funds are actually made available to low-income uninsured and underinsured patients. Each of our neighboring states requires hospitals that receive Charity Care funds to provide notice to their patients about the existence of the funds and to establish specific eligibility criteria for individual patients.¹³⁹

The difficulties experienced by Legal Aid surveyors in accessing information about hospital charges and billing practices for uninsured or underinsured patients suggest the harsh reality that affordable care is largely unavailable for this group. More broadly, these results indicate that it is almost impossible for poor patients to become informed health care consumers. Instead, they are left to seek out information

137. See Testimony of Kenneth E. Raske, President, Greater New York Hospital Association, Before the New York Senate Finance and New York State Assembly Ways and Means Committee 5 (Feb. 3, 2004) (stating that "[i]n addition to the negative impact that the lack of health insurance has on the lives of uninsured New Yorkers and their families, a failure to provide employee health benefits places an unacceptable financial burden on New York State's entire health care community."), http://www.gnyha.org/testimony/2004/pt2004-2005_Budget.pdf (last visited October 28, 2004).

138. HEVESI, *supra* note 28, at 17.

139. See MASS. REGS. CODE tit. 14.6, §§ 10.03, 10.04, 10.08 (2004); CONN. GEN. STAT. § 19a-649 (2003); N.J. ADMIN. CODE tit. 10, § 10:52-11.5 (2004).

on sliding fee scales and payment plans that is not readily available, or to work out an unfeasible repayment schedule after collection agencies have pursued them.

In light of the public outcry, a three-stage response to caring for the uninsured and underinsured at hospitals is necessary. First, the onus now lies upon the hospital industry to justify the use of the nearly billion dollars in annual BDCC funds by: (1) making BDCC fund information accessible to these patients; (2) improving payment options; and (3) decreasing the rates charged to the uninsured. Second, the State Department of Health must assert its regulatory authority and demand accountability and transparency for the BDCC pools it has the responsibility to administer. Third, the State legislature should follow the lead of our neighboring states and establish a more just and equitable system of BDCC funding for the uninsured. Currently, three such bills are under consideration in the State Assembly. Sponsored by Assemblyman Grannis and several other Assembly members, these bills would require hospitals who received BDCC funds to report the number of uninsured or underinsured patients were served by these funds, establish uniform standards and procedures for the provision of financial assistance to low- and middle-income patients without health insurance, and adopt reasonable policies and procedures to charge and collect payments from low- and middle-income patients that take into account their ability to pay.¹⁴⁰

Absent meaningful legislative reform, New York State's generous allocation of charity care funding to hospitals that purport to serve uninsured and underinsured patients will continue to be a billion-dollar allocation in name only.

140. Assemb. A09217, 2003–2004 Reg. Sess. (N.Y. 2003); Assemb. A09218, 2003–2004 Reg. Sess. (N.Y. 2003); Assemb. 09219, 2003–2004 Reg. Sess. (N.Y. 2003), <http://assembly.state.ny.us/leg/> (last visited October 28, 2004).

