Clearinghouse REVIEW

November–December 2005
Volume 39, Numbers 7–8

Journal of Poverty Law and Policy

INSIDE:

The Medicare Part D Maze
The New Bankruptcy Law
Civil Rights Action on Sewer Overflows
Ex-Prisoners Reentering the Community
Using the Media
Medical Debt

EQUAL JUSTICE UNDER LAW

The Rehnquist Court's FINAL CHAPTER ON ACCESS TO COURTS

Sargent Shriver
National Center on Poverty Law
Founded 1967
Taking action to end poverty

Medical Debt

By Chi Chi Wu

Chi Chi Wu
Staff Attorney

National Consumer Law Center
77 Summer St., 10th Floor
Boston, MA 02110
617.542.8010
cwu@nclc.org

[**Editor's note:** The following is adapted from an excerpt from NATIONAL CONSUMER LAW CENTER, FAIR DEBT COLLECTION, Chapter 14 (5th ed. 2004). The full Chapter 14 covering medical debt issues (including the impact of the doctrine of necessaries and subrogation), together with sample pleadings on CD-ROM, is available in FAIR DEBT COLLECTION. For orders, call 617.542.9595 or go to www.nclc.org.]

Rationing and denial of health care services to low-income Americans continue to be perennial problems. More than forty-three million Americans, or over 15 percent of the U.S. population, lack health insurance.[1] When consumers are uninsured or their insurance coverage is inadequate, the result is medical debt.

The amount of medical debt burdening low-income consumers is enormous. According to one study, 46 percent of uninsured consumers have outstanding medical debts.[2] Another study reported that medical debtors have an average of almost $9,000 in medical bills.[3]

Medical debt is especially onerous because it is often sudden, unplanned, and unavoidable, and debtors may be vulnerable due to illness or infirmity. The problem is further exacerbated by the fact that not only is medical care extremely expensive but also uninsured consumers are often charged several times more for the same medical services than private insurers or Medicaid.[4]

Low-income consumers may have a variety of health law and consumer law defenses to debt collection efforts by doctors, hospitals, and their collection agencies. What consumer law defenses may be available? Other resources should be consulted regarding health law defenses.[5]

I. Aggressive Debt Collection and Practical Considerations

Many hospitals and health care providers are quick to send unpaid medical bills to collections. Some hospitals significantly reduced the amount of time they wait before

[1] U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2002 (2003).

[2] DENNIS ANDRULIS ET AL., THE ACCESS PROJECT, PAYING FOR HEALTH CARE WHEN YOU'RE UNINSURED, (2003).

[3] THE ACCESS PROJECT, THE CONSEQUENCES OF MEDICAL DEBT: EVIDENCE FROM THREE COMMUNITIES (2003).

[4] See Part V.A *infra.*

[5] ALAN ALOP, DEFENDING HOSPITAL COLLECTION CASES, A PRACTICAL GUIDE (rev. ed. 2001) (available on the companion CD-ROM accompanying NATIONAL CONSUMER LAW CENTER, FAIR DEBT COLLECTION (5th ed. 2004)); NATIONAL HEALTH LAW PROGRAM, AN ADVOCATE'S GUIDE TO THE MEDICAID PROGRAM (2001).

sending unpaid bills to collection agencies, from the traditional 150 to 210 days to as few as 30 to 60 days.[6] Studies find that about one-third of uninsured consumers have been contacted by a collection agency.[7]

Medical debt collection agencies can be especially aggressive. Documented tactics include liens on homes, wage garnishments, and bank account attachments.[8] Some hospitals have even been known to use the tactic of a *capeas* or body attachment.[9] One hospital that engaged in aggressive debt collection techniques lost its tax-exempt status as a result.[10] The issue of aggressive medical debt collection has drawn the attention of Congress.[11]

In response to negative publicity, the American Hospital Association, a private trade association, issued guidance to hospitals on billing and collection practices.[12] In particular, the association recommended that hospitals make information on their price lists publicly available, provide financial counseling to low-income uninsured patients, establish policies regarding helping patients apply for public assistance or hospital-based charity care, establish policies to offer discounts to low-income patients who do not receive charity care, and define standards for third-party debt collectors acting on their behalf.[13]

A very effective method of dealing with medical debt is to find someone else to pay for it. Advocates should make sure that their clients have applied for any assistance programs to which they are entitled. This may include government or private programs, such as

- Medicaid,[14]
- Medicare Savings Programs,[15]
- an overlooked insurance source,[16]

---

[6]Jennifer Steinhauer, *Will Doctors Make Your Credit Sick?*, New York Times, Feb. 4, 2001 (quoting American Collector's Association). See also The Access Project, *supra* note 3.

[7]Lisa Duchon et al., The Commonwealth Fund, Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk, (2001).

[8]Connecticut Center for a New Economy, Yale, Don't Lien on Me (2003) (finding that Yale-New Haven Hospital placed liens on an estimated 7.5 percent of owner-occupied homes in New Haven during the past nine years); Marilyn Weber Serafini, *Sticker Shock*, National Journal, Oct. 18, 2003, at 3180.

[9]Lucette Lagnado, *Hospitals Try Extreme Measures to Collect Their Overdue Debts*, Wall Street Journal, Oct. 30, 2003, at A1 (documenting how one Illinois hospital sought 164 arrest warrants for medical debtors since 1995). A *capeas* or body attachment is an arrest warrant that creditors or collection agencies obtain when a debtor fails to show up for a court hearing.

[10]Lucette Lagnado, *Hospital Found "Not Charitable" Loses Its Status as Tax Exempt*, Wall Street Journal, Feb. 19, 2004 (describing how the Illinois Department of Revenue revoked the tax-exempt status of Provena Covenant Medical Center in part because of Provena's aggressive use of lawsuits and other debt collection methods to collect from uninsured patients).

[11]In July 2003 a congressional committee sent requests for information to several hospital chains as part of an investigation into hospital-billing and debt-collection practices for the uninsured. Press Release, Tauzin, Greenwood Investigate Hospital Billing Disparities for the Uninsured, July 16, 2003.

[12]Board of Trustees of the American Hospital Association, Hospital Billing and Collection Practices—Statement of Principles and Guidelines (2003).

[13]*Id.*

[14]If the client is an immigrant not eligible for Medicare or Medicaid, an excellent resource manual is available on helping immigrants obtain health coverage is Claudia Schlosberg, The Access Project, Immigrant Access to Health Benefits: A Resource Manual, (2002), available at www.accessproject.org/publications.htm.

[15]These programs help low-income Medicare recipients pay for Medicare premiums and can save eligible individuals up to $700 per year. Some programs may also cover coinsurance and deductibles for certain people. To learn more, see www.medicare.gov.

[16]Overlooked insurance sources can include workers' compensation, homeowner's insurance, auto insurance, or insurance from a current or former employer or spouse.

- charity or "free care" eligibility,[17]
- pharmacy assistance programs,[18]
- church or social service assistance programs, or
- low-cost dental care from dental school programs.

Informal negotiation over medical debt can be especially effective. Hospitals and other medical providers may be more willing to reduce bills because of the fact that these bills are often several times more than both what the hospital's actual costs are and what the hospital would receive from Medicaid or Medicare.[19]

Medical debt is generally unsecured debt and less of a priority than essential expenses such as food, housing costs (rent or mortgage), utilities, or other secured debt (e.g., car payments).[20] Thus clients should be advised to pay the higher-priority bills first.[21] Clients should be advised to be very careful about converting medical debt into secured debt, for example, by taking out a second mortgage to pay for medical bills.[22]

A nonmonetary consideration that is unique to medical debt is whether the debtor will be able to continue to get care from the particular facility. In nonemergency situations, hospitals and other providers are usually allowed to turn away a patient because of prior debt.[23] They may also require that the patient pay a deposit before services are provided.[24] However, there may be "safety net" facilities nearby, such as a public hospital or a community health center. In emergency situations, the debtor should be able to obtain care from a hospital regardless of past debt under the Emergency Medical Treatment and Active Labor Act(EMTALA), an "antidumping" statute.[25]

II. Applicability of Fair Debt Collection Practices Act to Abusive Medical Collection Agencies

The full panoply of laws that protect consumers from abusive debt collection tactics is available to patients who have been subject to such tactics by health care providers and their collectors. A summa-

[17]These programs arise from the implicit duty of nonprofit hospitals, because of their charitable status, to provide a certain amount of free care to low-income patients. In some states, this obligation is explicit and mandatory. Uninsured low-income patients are often not informed about these free care or charity programs or given information on other forms of financial assistance (including Medicaid). See ANDRULIS ET AL., *supra* note 2(2003) (reporting that one-half of medical debtors stated that providers never offered to help them find out if financial assistance was available).

[18]See the search engine available for such programs at www.medicare.gov/Prescription/Home.asp.

[19]See Part V.D.1. *infra*.

[20]These considerations are discussed in more detail in NATIONAL CONSUMER LAW CENTER, IN SICKNESS AND IN DEBT: USING CONSUMER LAW TO HELP ELDERS FACING OVERWHELMING MEDICAL BILLS (2001). Another book, the NCLC GUIDE TO SURVIVING DEBT (2002), describes these considerations in layperson's language. Both are available from the National Consumer Law Center's Publications Department at 617.542.9595.

[21]This advice is especially important given that one-third of medical debtors had trouble paying their rent or mortgage due to medical bills. THE ACCESS PROJECT, *supra* note 3. These debtors are at risk of eviction or foreclosure because they may have paid their medical bills instead of the rent or mortgage.

[22]In 1997, ten percent of home equity lines of credit and two percent of closed-end home equity loans were used in part to pay medical debt. Glenn B. Canner, Thomas A. Durkin, and Charles A. Luckett, *Recent Developments in Home Equity Lending*, FEDERAL RESERVE BULLETIN, April 1998. Homeowners with high medical bills are tempting targets for predatory lenders. This is especially true when the homeowner's medical bills have been sent to collections, thus impairing their credit histories and making them ineligible for any loan but a subprime one. See, e.g., Jeffrey Steele, *It's a Crying Shame*, CHICAGO TRIBUNE, March 13, 2001 (describing how predatory lenders are able to data-mine credit histories for homeowners with outstanding medical debt). Some uninsured consumers also use credit cards to pay for medical bills, a practice which providers encourage. *See* THE ACCESS PROJECT, *supra* note 3; TAMARA DRAUT & HEATHER C. MCGHEE, RETIRING IN THE RED: THE GROWTH OF DEBT AMONG OLDER AMERICANS, Feb. 26, 2004.

[23]THE ACCESS PROJECT, *supra* note 3 (one-third of medical debtors in study reported that providers refused or delayed care due to prior medical bills). Patients themselves are often deterred from seeking medical care because of debt to a facility or provider. See Hugh F. Daly et al., *Into the Red to Stay in the Pink: The Hidden Cost of Being Uninsured*, HEALTH MATRIX: JOURNAL OF LAW-MEDICINE, Winter 2002.

[24]One study found that 30 percent of consumers with prior medical bills were asked to pay upfront. THE ACCESS PROJECT, *supra* note 3.

[25]42 U.S.C. § 1395dd. See Part III.B *infra*.

ry of the major laws that protect consumers and any nuances in the application of those laws to medical collection situations follows.

The Fair Debt Collection Practices Act clearly applies to medical debt.[26] There have been many instances of medical collection agencies and even providers violating the Act's prohibition against

- harassment,[27]
- deception,[28] and
- unfair debt collection practices.[29]

There have also been examples where these medical bill collectors failed to provide consumers with appropriate notices under the Fair Debt Collection Practices Act.[30] The medical bill collectors also have sued consumers in an inappropriate forum.[31] Claims under the Act may be asserted in individual suits against the collection agency, as one of several counts in a broader health services class action, or as a counterclaim or third-party complaint to a suit filed by a collection agency or a hospital.

Coverage of Various Actors in Medical Debt Collection. That the Fair Debt Collection Practices Act applies primarily to collection agencies and collection lawyers, and usually not to creditors, is not so significant in the health care field since hospitals and doctors are major users of collection agencies.[32] In addition, while hospitals and doctors are generally "creditors" not subject to the Act, there are a number of instances in which they have formed in-house or affiliated collection entities.[33] These entities may be subject to the Act.

---

[26] E.g., *Pipiles v. Credit Bureau*, 886 F.2d 22 (2d Cir. 1989); *Campion v. Credit Bureau Services*, 2000 U.S. Dist. LEXIS 20233 (E.D. Wash. Sept. 19, 2000); *Finnegan v. University of Rochester Medical Center*, 21 F. Supp. 2d 223 (W.D.N.Y. 1998); *Creighton v. Emporia Credit Services,* 981 F. Supp. 411 (E.D. Va. 1997); *Adams v. Law Offices of Stuckert and Yates*, 926 F. Supp. 521 (E.D. Pa. 1996) (even though the consumer and the physician expected the consumer's insurer to pay the bill, still considered consumer's debt because the consumer was ultimately responsible for paying); *Bingham v. Collection Bureau*, 505 F. Supp. 864 (D.N.D. 1981); Thomas Isgrigg, Federal Trade Commission (FTC) Informal Staff Letter (Dec. 22, 1992); FTC Official Staff Commentary § 803(5).

[27] See, e.g., *Joseph v. J.J. MacIntyre Companies*, 238 F. Supp. 2d 1158 (N.D. Cal. 2002) (barrage of phone calls to disabled senior citizen, despite requests to stop), later op., 281 F. Supp. 2d 1156 (N.D. Cal. 2003) (collector's motion for summary judgment denied).

[28] See, e.g., *Shula v. Lawent*, 2002 WL 31870157 (N.D. Ill. Dec. 23, 2002) (agency collecting doctor's bill; deceptive to demand specific amount of court costs in absence of court order where Illinois law made award of costs discretionary); *Weiss v. Collection Center*, 667 N.W.2d 567 (N.D. 2003) (consumers stated Fair Debt Collection Practices Act claim against clinic's collector for sending letter informing consumers that collector had obtained information from Department of Motor Vehicles about consumer's vehicle; letter could be read by unsophisticated consumer as threat to seize vehicle); *Avila v. Van Ru Credit Corporation*, 1995 WL 41425 (N.D. Ill. 1995) (class certification in a Fair Debt Collection Practices Act A case involving, inter alia, attempts to collect debts arising from student loans and medical or hospital bills by deceptively using attorney's letterhead); *Robinson v. Credit Service Company*, 1991 WL 186665 (D.N.J. 1991) (dunning a parent of a 20-year-old child for the child's medical bill may misrepresent the parent's liability, in violation of the Fair Debt Collection Practices Act); *Jones v. Ginn* (N.D. Ohio 1992) (Clearinghouse No. 48,160) (consent judgment) (in settlement of case, hospital's debt collectors enjoined from (1) communicating to consumers that their failure to pay would cause other patients to suffer, (2) bringing civil suit against consumers in a distant forum, i.e., state court located in state other than that in which consumer resides and (3) sending statement failing to disclose that notice is attempt to collect debt and that information obtained will be used for that purpose).

[29] *Edwards v. McCormick*, 136 F. Supp. 2d 795 (S.D. Ohio 2001) (demanding payment of medical bill from nondebtor spouse and threatening forced sale of home contrary to state exemption law violated Fair Debt Collection Practices Act); *Finnegan v. University of Rochester Medical Center*, 21 F. Supp. 2d 223 (W.D.N.Y. 1998) (denying motion to dismiss where collector continued to attempt to collect debt it knew was disputed and reported the debt to credit reporting agency).

[30] *Finnegan*, 21 F. Supp. 2d at 223 (consumer stated Fair Debt Collection Practices Act claim against hospital collection agency for failing to send validation notice); *Jones v. Ginn* (Clearinghouse No. 48,160) (N.D. Ohio 1992).

[31] *Jack Mailman & Leonard Flug, D.D.S., v. Whaley*, 2002 WL 31988623 (N.Y. City Civ. Ct. Nov. 25, 2002) (venue improper under state or federal statute, where Brooklyn consumers were sued in "remote," i.e., difficult to access by public transportation, Staten Island court; court expresses disapproval of attorney-collector's practice of bringing large volume of collection cases there and orders collector to bring future suits in the county where the debtor resides); *Jones v. Ginn* (Clearinghouse No. 48,160) (N.D. Ohio 1992).

[32] See The Access Project, *supra* note 3.

[33] National Consumer Law Center, Fair Debt Collection § 4.3.2.

An example of one such entity was described in detail in *Orenbuch v. North Shore Health Systems*.[34] In *Orenbuch* a group of hospitals formed the Regional Claims Recovery Service, a debt collection agency that was an unincorporated subdivision of a corporation that provided the hospitals' administrative support. The collection agency had its own employees and computer system at a separate location. The agency also actively marketed its services to hospitals outside the North Shore family and used its own letterhead. That the agency was subject to the Fair Debt Collection Practices Act was undisputed.[35]

Other examples of similar entities have been described in informal staff letters of the Federal Trade Commission (FTC).[36] For example, the FTC discussed the example of a nonprofit hospital that created a separate collection organization to collect debts for itself and other health care providers.[37] According to the FTC, if a hospital and a debt collection agency have common ownership, the agency should indicate its affiliation with the hospital when collecting the hospital's debts unless the agency is functionally independent of the hospital.[38] However, if an affiliated collection agency is actually staffed and run by another collection agency, the affiliated collection agency should operate under the name of the collection agency since it controls the employees.[39]

Even if a health care provider does not use a separate entity or affiliate to collect its debts, the provider's own conduct may subject it to the Fair Debt Collection Practices Act. For example, if a hospital's internal bill collector misrepresents that he or she is calling from a collection agency or a private law firm, both the employee and the hospital are covered by the Act.[40] Indeed, one FTC informal staff letter indicated that a hospital staff attorney's plan to send collection letters on letterhead, implying that he was a private practitioner without disclosing his hospital employment, would violate the Act and subject both the hospital and the attorney to liability under the Act.[41]

III. Other Federal Statutes Applicable to Medical Debt

Consumers who have medical debts may have recourse to other federal laws.

A. Truth in Lending Act

Many hospitals offer payment plans to consumers who owe large amounts of medical debt.[42] Under certain circumstances, these plans are covered by the federal Truth in Lending Act (TILA).[43] A noncredit transaction, such as the typical

---

[34]*Orenbuch v. North Shore Health Systems*, 250 F. Supp. 2d 145 (E.D.N.Y. 2003).

[35]*Id.* (finding no violation of the Fair Debt Collection Practices Act for failure to disclose the relationship between debt collection agency and affiliated hospitals). See also *Healy v. Jzanus Limited*, 2002 WL 31654571 (E.D.N.Y. Nov. 20, 2002) (magistrate's recommendation) (Fair Debt Collection Practices Act applied to unincorporated association called "Medicaid Recovery Services" that sought information for Medicaid application but also included in its letters a "balance due" and statement that "this is an attempt to collect a debt").

[36]See National Consumer Law Center, Fair Debt Collection § 3.2.5, for a discussion of the legal status of FTC informal staff letters.

[37]Healy, FTC Informal Staff Letter (Dec. 2, 1981) (noting that the use of an attorney letterhead by the collector's staff attorney without indicating the attorney's employment by the collector would violate the Fair Debt Collection Practices Act subjecting the collector and the attorney to liability).

[38]Roach, FTC Informal Staff Letter (Nov. 8, 1983).

[39]*Id.*; *Orenbuch*, 250 F. Supp. 2d at 145 (2003) (not deceptive to use name under which affiliated but functionally separate collector was licensed; disclosure of corporate affiliation not required).

[40]National Consumer Law Center, Fair Debt Collection § 4.2.4.

[41]McDonald, Informal Staff Letter (April 10, 1980).

[42]When health care providers do provide financial assistance to uninsured consumers, the most common form of "assistance" is a payment plan. Andrulis et al., *supra* note 2.

[43]15 U.S.C. §§ 1601–1640. See National Consumer Law Center, Truth in Lending ch. 2 (5th ed. 2003). Cf. *Jack Mailman & Leonard Flug, D.D.S., v. Whaley*, 2002 WL 31988623 (N.Y. City Civ. Ct. Nov. 25, 2002) (consumer credit transaction within meaning of state consumer credit statute; imposition of service charge showed that time payments were contemplated).

medical bill, can be converted to a credit transaction subject to the TILA if several requirements are met. First, the creditor and the consumer must enter into an agreement that gives the consumer the right to defer payment of the debt.[44] Second, the agreement must provide for the imposition of a finance charge or payment of the debt in more than four installments.[45] Note that the imposition of late charges is not allowed to be equated with finance charges to bring the agreement under the TILA; if the debt is still structured as an account receivable that is due in full, the imposition of late charges does not make it a credit transaction subject to the TILA.[46] If there is a payment plan, there must be a written agreement reflecting payment terms, not simply "an informal workout arrangement," to bring it within the scope of the TILA.[47] And the consumer must be able to show that the creditor "regularly" extends consumer credit. The Federal Reserve Bank defines "regularly" to mean that the creditor must have extended credit more than twenty-five times in the preceding calendar year (or more than five times for transactions secured by a dwelling).[48]

In addition to the above factors for establishing TILA coverage, the credit arrangement must be "consummated," that is, offered by the creditor and accepted by the consumer.[49] The hospital's mere offer of an installment plan is insufficient to establish TILA coverage.[50]

If the TILA does cover the a medical bill payment plan, the creditor is required to disclose clearly certain terms of that credit to the consumer before consummation.[51] When the TILA applies to a payment plan for a medical debt and the creditor fails to make key TILA disclosures, the creditor is liable to the consumer for actual damages, statutory damages (twice the finance charge, but no less than $100 or more than $1,000), and attorney fees.[52] Suit may be brought to recover TILA damages within one year of the violation.[53] Or, in most states, TILA violations may be raised at any time as a recoupment or counterclaim to the provider's collection suit.[54]

---

[44]15 U.S.C. § 1602(e); Reg. Z, 12 C.F.R. § 226.2(a)(14) (definition of "credit"). See *Pollice v. National Tax Funding*, 225 F.3d 379 (3d Cir. 2000) (installment payment agreement entered into between consumer and collection agency to repay delinquent water bills was credit transaction subject to the Truth in Lending Act (TILA)). See generally NATIONAL CONSUMER LAW CENTER, TRUTH IN LENDING § 2.2.4.1; NATIONAL CONSUMER LAW CENTER, THE COST OF CREDIT: REGULATION AND LEGAL CHALLENGES § 10.3.2.3 (2d ed. 2000 & Supp.).

[45]15 U.S.C. § 1602(f)(1); Reg. Z, 12. C.F.R. § 226.2(a)(17)(i)(A). See NATIONAL CONSUMER LAW CENTER, TRUTH IN LENDING § 2.3.4.

[46]Reg. Z, 12 C.F.R. § 226.4(c)(2); FRB Official Staff Commentary § 226.4(c)(2)-1, reprinted in NATIONAL CONSUMER LAW CENTER, TRUTH IN LENDING app. C). See *Bright v. Ball Memorial Hospital Association,* 616 F.2d 328 (7th Cir. 1980) (because the entire lump sum was due, and there was no new formal written arrangement for time payments, a 0.75 percent per month charge was a "late charge."). See generally NATIONAL CONSUMER LAW CENTER, TRUTH IN LENDING § 3.9.3.4.

[47]*Bright*, 616 F.2d at 328; *Finnegan v. University of Rochester Medical Center*, 21 F. Supp. 2d 223 (W.D.N.Y. 1998) (arrangement with hospital to hold off on collection while debtor pursued social security appeal was an "informal workout agreement," not an extension of credit for purposes of the TILA). See NATIONAL CONSUMER LAW CENTER, TRUTH IN LENDING § 2.3.4.3.

[48]Reg. Z, 12 C.F.R. § 226.2(a)(17)(i). See NATIONAL CONSUMER LAW CENTER, TRUTH IN LENDING § 2.3.3.

[49]Reg. Z, 12 C.F.R. § 226.2(a)(13); FRB Official Staff Commentary § 226.2(a)(13), reprinted in NATIONAL CONSUMER LAW CENTER, TRUTH IN LENDING app. C. See NATIONAL CONSUMER LAW CENTER, TRUTH IN LENDING § 4.3.2.

[50]E.g., *Bright*, 616 F.2d at 328 (7th Cir. 1980) (no evidence that consumer accepted hospital's payment plan offer, so the TILA did not apply).

[51]See NATIONAL CONSUMER LAW CENTER, TRUTH IN LENDING ch. 4, for a description of disclosures required for closed-end credit. Disclosures for open-end credit are discussed in Chapter 5.

[52]*Id*. ch. 8.

[53]*Id*. § 7.2.

[54]15 U.S.C. § 1640(e). See also NATIONAL CONSUMER LAW CENTER, TRUTH IN LENDING § 7.2.5.

B. EMTALA

If a debtor is refused treatment at an emergency room because of medical debt, a counterclaim may exist pursuant to the Emergency Medical Treatment and Active Labor Act.[55] The EMTALA is a federal statute prohibiting hospitals from turning away a patient in need of emergency medical treatment, for example, because the patient may not be able to pay for the care.[56] The EMTALA also prohibits delay in providing medical screening or care in order to inquire about payment for care.[57] The EMTALA should prohibit a hospital from turning away, because of prior bills owed to that hospital, a patient in need of emergency care.[58] The EMTALA applies to private hospitals which accept Medicare or Medicaid and to certain public hospitals.[59]

The EMTALA provides for a private cause of action

(i) against hospitals,[60]

(ii) but not physicians,[61]

(iii) who violate its provisions.[62]

The patient may obtain any remedies available under applicable tort law in the state where the hospital is located, such as actual damages, attorney fees, and, in some states, punitive damages.[63] In addition, violation of the EMTALA may constitute a violation of a state unfair and deceptive acts and practices (UDAP) statute.[64] Some states may have emergency admission requirements that are more detailed or stricter than the federal statute.[65] Note that the EMTALA does not provide for *free care*; if an uninsured patient does receive treatment, the patient may be held liable for medical bills.

C. Debt Collection and Privacy of Medical Information

Another potential counterclaim may be for violations of medical privacy rules by providers when they send medical information to debt collectors. In 2003 the U.S. Department of Health and Human

---

[55] 42 U.S.C. § 1395dd.

[56] See *St. Anthony Hospital v. U.S. Department of Health and Human Services*, 309 F.3d 680 (10th Cir. 2002) (Congress enacted the Emergency Medical Treatment and Active Labor Act (EMTALA) to address the problem of hospital emergency rooms "refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance," citing H.R. Rep. No. 99-241, pt. 1, at 27 (1985)); *Battle v. Memorial Hospital*, 228 F.3d 544 (5th Cir. 2000) (the EMTALA's purpose is "to prevent 'patient dumping,' which is the practice of refusing to treat patients who are unable to pay").

[57] 42 U.S.C. § 1395dd(h).

[58] See *Ziegler v. Elmore County Health Care Authority*, 56 F. Supp. 2d 1324 (M.D. Ala. 1999) (denying hospital's motion for summary judgment on EMTALA claim of child whose recovery was delayed and suffering prolonged after being turned away from emergency room because mother owed bill).

[59] The EMTALA applies to public hospitals operated by subdivisions of the state such as counties and municipalities, but not hospitals which are operated by the state itself and have Eleventh Amendment immunity. See *Root v. New Liberty Hospital District*, 209 F.3d 1068 (8th Cir. 2000) (public hospital operated by local hospital district may be sued under the EMTALA, which preempts state sovereign immunity statute); *Drew v. University of Tennessee Regional Medical Center Hospital*, 2000 U.S. App. LEXIS 8936 (6th Cir. May 1, 2000) (11th Amendment barred EMTALA suit against the state university hospital, which is an arm of the state); *Lebron v. Ashford Presbyterian Community Hospital*, 975 F. Supp. 407 (D. P.R. 1997) (University of Puerto Rico is a state entity protected from EMTALA liability by the Eleventh Amendment).

[60] 42 U.S.C. § 1395dd(a).

[61] See *Eberhardt v. City of Los Angeles*, 62 F.3d 1253 (9th Cir. 1995); *King v. Ahrens*, 16 F.3d 265 (8th Cir. 1994) (no cause of action against individual physician); *Delaney v. Cade*, 986 F.2d 387 (10th Cir. 1993) (plain language of statute indicates actions may be brought against hospitals but not doctors); *Baber v. Hospital Corporation of America*, 977 F.2d 872 (4th Cir. 1992) (no cause of action against individual physician); *Gatewood v. Washington Healthcare Corporation*, 933 F.2d 1037 (D.C. Cir. 1991).

[62] 42 U.S.C. § 1395dd(d)(2).

[63] *Id.*

[64] *Coast Plaza Doctors Hospital v. UHP Healthcare*, 129 Cal. Rptr. 2d 650 (Cal. App. 2002) (hospital stated a claim for violation of California unfair and deceptive acts and practices (UDAP) law with allegation that health maintenance organization (HMO) caused patients to be transferred in violation of the EMTALA).

[65] See, e.g., MASS. GEN. LAWS ch. 111, § 70E (detailed requirements for safe and comfortable transfer); N.Y. PUB. HEALTH LAW § 2805-b (certain general hospitals may not transfer for inability to pay; violation of this section, or preventing access to required services, is a misdemeanor).

Services (HHS) issued rules governing the privacy of medical information pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996.[66] The HIPAA Privacy Rule applies to health care providers as well as health plans and clearinghouses.[67] In general, the HIPAA Privacy Rule permits health care providers to disclose individually identifiable health information only in certain circumstances unless the individual's written consent is obtained.[68] These circumstances include, among others, treatment, payment, and health care operations activities.[69]

In terms of payment activities, the HIPAA Privacy Rule does generally permit the disclosure of medical information without the consumer's consent.[70] The disclosure is limited to certain parties, including the provider's "business associates," presumably including third-party collection agencies.[71] However, the health care provider must make reasonable efforts to disclose only the minimum amount of protected health information needed to accomplish the intended purpose of the disclosure.[72] Thus the provider should not disclose the consumer's entire medical record to the debt collector unless it can specifically justify why the entire record is reasonably needed for debt collection. Note that the HIPAA rules do not provide for a private right of action, but patients may be able to seek relief under some state UDAP statutes.[73] Some states may have health information privacy laws that are more protective than the HIPAA Privacy Rule.[74]

D. Credit Reporting Issues and Medical Debt

Another way in which medical debt affects consumers is through their credit histories. Providers often send a medical debt to a collection agency. This results in a derogatory item on the consumer's credit report.[75] Also, it decreases the consumer's credit score.[76] Federal Reserve researchers found that 52 percent of all accounts reported by collection agencies were collections for medical debts.[77]

The impact of medical debt on a consumer's credit report is especially egregious when the medical debt is one which an insurer arguably should have paid. Disputes among health insurers, providers, and consumers occur frequently and can be of extended duration. Many medical bills are referred

---

[66]Health Insurance Portability and Accountability Act (HIPAA) of 1996, Pub. Law No. 104-191. The HIPAA Privacy Rule is at 45 C.F.R. pts. 160, 164. A summary of the HIPAA Privacy Rule is available from the U.S. Department of Health and Human Services (HHS) Office of Civil Rights, which is responsible for its implementation. HHS Office of Civil Rights, Summary of the HIPAA Privacy Rule (May 2003), available at www.hhs.gov/ocr/hipaa.

[67]45 C.F.R. § 160.102.

[68]*Id.* § 164.502.

[69]*Id.* §§ 164.502, 164.506.

[70]*Id*. An exception to this rule is psychotherapy notes, which may not be disclosed without the patient's authorization for payment purposes. *Id.* § 164.508(a)(2).

[71]The HHS Office of Civil Rights stated that the HIPAA Privacy Rule did not prevent health care providers from using third-party collection agencies. See U.S. Department of Health and Human Services, Does the Privacy Rule conflict with FDCPA?, at www.hhs.gov/ocr/hipaa (click "Your Frequently Asked Questions on Privacy") (updated July 18, 2003). Note that the provider must include certain provisions (including safeguards for the health information used or disclosed by that business associate) in its contract with a business associate such as a debt collection agency. The provider may not contractually authorize its business associate to make any use or disclosure of protected health information that would violate the HIPAA Privacy Rule. 45 C.F.R. § 164.504(e).

[72]45 C.F.R. §§ 164.502(b), 164.514(d).

[73]See generally NATIONAL CONSUMER LAW CENTER, UNFAIR AND DECEPTIVE ACTS AND PRACTICES § 3.2.7 (5th ed. 2001 & Supp.).

[74]For a summary of state health information privacy laws, see HEALTH PRIVACY PROJECT, STATE HEALTH PRIVACY LAWS (2d ed. 2002), available at www.healthprivacy.org.

[75]See NATIONAL CONSUMER LAW CENTER, FAIR CREDIT REPORTING § 3.3.3.8 (5th ed. 2002 & Supp.).

[76]See *id.* § 14.5.2.1.

[77]Robert Avery et al., *An Overview of Consumer Data and Credit Reporting*, FEDERAL RESERVE BULLETIN, Feb. 2003, at 69.

to collection agencies during these disputes but are ultimately paid by insurers.[78] A consumer's credit history and credit score may be damaged as a result of a debt being sent to collection agencies during a dispute, or even when the insurer is simply slow in paying the bill. Consumers in these situations may want to file a written dispute with the credit bureaus.[79] Even if the derogatory item is not removed, the fact that it is disputed may mean that it will not be considered in the consumer's credit rating.[80]

The reporting of a medical debt to a credit bureau may also present medical privacy issues. A study of credit history files noted the high degree of information that could be inferred from the information in medical collection entries listed on a consumer's credit report. The names of many medical creditors are specific enough to allow for identification of categories of treatment. For example, information in collection entries identified categories of medicine, such as perinatology, or neonatal health clinics.[81]

The Fair Credit Reporting Act does contain some restrictions on the use of medical information in credit reports. The Act prohibits credit bureaus from furnishing for employment purposes, or in connection with a credit or insurance transaction, a credit report that contains medical information unless the consumer consents.[82] The Fair and Accurate Credit Transactions Act of 2003 amended this provision of the Fair Credit Reporting Act to require that the consent for employment and credit purposes (but not for insurance) must be written, must be specific, and must describe the use of the information.[83] Moreover, the medical information must be relevant for processing or effecting the employment or credit transaction at issue.[84]

The Fair and Accurate Credit Transactions Act added a number of protection provisions for medical information in credit reports. This Act prohibits credit bureaus from including the name, address, or telephone number of medical information furnishers unless the bureaus format the information such that they do not disclose either the specific provider or the nature of the medical services.[85] In order to help credit bureaus comply with this requirement, providers and medical information furnishers must notify credit bureaus of their status as such.[86] This Act also prohibits creditors from obtaining or using a consumer's medical information in connection with evaluating creditworthiness unless permitted by regulations of the federal banking agencies.[87] More information on the Fair and Accurate Credit Transactions Act's provisions regarding medical information is available.[88]

E. Nursing Home Reform Law

If the medical debt is owed to a nursing home facility, a number of regulations for

---

[78]Steinhauer, *supra* note 6; CONSUMER FEDERATION OF AMERICA & NATIONAL CREDIT REPORTING ASSOCIATION, CREDIT SCORE ACCURACY AND IMPLICATIONS FOR CONSUMERS 31 (2002), available at www.consumerfed.org/121702CFA_NCRA_Credit_Score_Report_Final.pdf.

[79]For information on the Fair Credit Reporting Act's dispute mechanisms, see NATIONAL CONSUMER LAW CENTER, FAIR CREDIT REPORTING § 13.5.1.

[80]*Id*. § 14.8.2.

[81]CONSUMER FEDERATION OF AMERICA & NATIONAL CREDIT REPORTING ASSOCIATION, *supra* note 78.

[82]Fair Credit Reporting Act, 15 U.S.C. § 1681b(g). See NATIONAL CONSUMER LAW CENTER, FAIR CREDIT REPORTING § 4.5.5.

[83]Fair Credit Reporting Act § 604(g)(1)(B)(ii), 15 U.S.C. § 1681b(g)(1)(B)(ii), added by Fair and Accurate Credit Transactions Act, Pub. L. No. 108-159, § 411 (2003).

[84]Fair Credit Reporting Act § 604(g)(1)(B)(i), 15 U.S.C. § 1681b(g)(1)(B)(i), added by Pub. L. No. 108-159, § 411 (2003).

[85]Fair Credit Reporting Act § 605(a)(6), 15 U.S.C. 1681c(a)(6), added by Pub. L. No. 108-159, § 412 (2003). There is an exception to this prohibition for insurance companies other than property and casualty insurers. *Id*.

[86]Fair Credit Reporting Act § 623(a)(9), 15 U.S.C. 1681s-2(a)(9), added by Pub. L. No. 108-159, § 412 (2003).

[87]Fair Credit Reporting Act § 604(g)(2)(5), 15 U.S.C. 1681b(g)(2)(5), added by Pub. L. No. 108-159, § 411 (2003).

[88]NATIONAL CONSUMER LAW CENTER, FAIR CREDIT REPORTING § 4.5.5 (2004 Supp.).

the nursing home industry may provide a defense or cause of action. The federal Nursing Home Reform Law prohibits a facility from requiring a resident's family or friends to become financially responsible for expenses.[89] The Nursing Home Reform Law regulations require that nursing facilities inform consumers of all charges, including (for Medicaid recipients) those charges not covered by Medicaid.[90]

The Nursing Home Reform Law does not provide for a private right of action, but violation of this law may be actionable under a state UDAP statute.[91] State laws may include additional protection, such as requirements for financial disclosure and restrictions on transfer or discharge for nonpayment.[92] State statutes vary widely as to the existence and scope of a private remedy for violations.[93]

IV. State Remedies for Medical Debt Collection Abuses

The most suitable remedies for health collection harassment often utilize state debt collection statutes, state UDAP statutes, the tort of intentional infliction of emotional distress, and other state remedies.[94] These remedies may allow suit directly against the health care provider as well as against a collection agency for abusive collection tactics.

State Debt Collection Statutes. State debt collection statutes were passed mostly in the 1960s and 1970s to protect consumers against abusive debt collection practices.[95] The statutes often apply to both creditors and collection agencies.[96] They often provide for private actions, attorney fees, and actual damages (and sometimes statutory damages).[97]

State UDAP Statutes. State UDAP statutes often proscribe unfair or deceptive debt collection tactics.[98] In some states, UDAP statutes provide for recovery of double or treble actual damages as well as attorney fees. Thus a harassed consumer with substantial actual damages may recover more under the UDAP statute than the Fair Debt Collection Practices Act.[99]

A claim may be available for unfair or deceptive acts and practices by providers

---

[89]Nursing Home Reform Law, 42 U.S.C. § 1395i-3(c)(5)(A)(ii). See National Consumer Law Center, Unfair and Deceptive Acts and Practices § 5.11.3.2.2.

[90]42 C.F.R. § 483.10(b)(5)–(6). For more information regarding the Nursing Home Reform Law and its regulations, see Eric M. Carlson, Long-Term Care Advocacy (2003).

[91]See National Consumer Law Center, Unfair and Deceptive Acts and Practices § 5.11.3.1.

[92]See, e.g., Fla. Stat. § 400.022 (financial disclosures and billing); La. Rev. Stat. § 40:2010.8 (financial disclosures; discharge or transfer); Minn. Stat. § 144.6501 (may not require cosigner to assume personal liability; must disclose this requirement in bold capitals).

[93]See Mass. Gen. Laws ch. 111, § 70E ("in addition to any other action allowed by law or regulation" civil cause of action for malpractice); Mich. Comp. Laws § 333.20203 (guidelines only; do not expand or limit rights under other law; no civil or criminal liability for noncompliance); Minn. Stat. § 144.6501 (nursing home contracts are consumer contracts within meaning of consumer protection statutes). But see *Darviris v. Petros*, 795 N.E.2d 1196 (Mass. App. Ct. 2003) (violation of Mass. Gen. Laws ch. 111, § 70E, not UDAP, despite regulation making violations of certain statutes per se UDAP).

[94]See, e.g., *Joseph v. J.J. MacIntyre Companies*, 238 F. Supp. 2d 1158 (N.D. Cal. 2002) (claims for state and Federal debt collection violations, UDAP, and common-law torts; barrage of phone calls to disabled senior citizen, despite requests to stop), later op., 281 F. Supp. 2d 1156 (N.D. Cal. 2003) (collector's motion for summary judgment denied).

[95]National Consumer Law Center, Fair Debt Collection, § 11.2.

[96]*Id.* app. E & § 11.2.3.

[97]*Id.* § 11.2.5.

[98]*Id.* § 11.3.3. See also *id.*, Unfair and Deceptive Acts and Practices §§ 2.2.2, 2.3.10, 5.1.1.

[99]For an example of a UDAP case involving medical debt collection, see *Joseph v. J.J. MacIntyre Companies*, 238 F. Supp. 2d 1158 (N.D. Cal. 2002) (state debt collection, UDAP, and tort claims for barrage of phone calls to disabled senior citizen), later op., 281 F. Supp. 2d 1156 (N.D. Cal. 2003) (collector's motion for summary judgment denied).

beyond collection issues.[100] For example, a Connecticut court held that failure to inform indigent patients of the availability of free care under Hill-Burton or the state free care statute may have been a violation of the Connecticut Unfair Trade Practices Act.[101] Even providers have brought UDAP claims against insurers.[102]

Some state UDAP statutes exempt transactions between consumers and physicians or members of learned professions in general.[103] These exemptions may not, however, apply to a transaction with a service provider such as a health maintenance organization (HMO).[104] Because other courts have created an exception for the professional aspects of medical care, but not the entrepreneurial aspects, misrepresentations about billing would probably not be exempt.[105]

State Tort Law. The tort of intentional infliction of emotional distress has widespread recognition and is often applied in the debt-collection context. The advantage of this tort is the likelihood of recovery of punitive damages in an egregious case where the collector's malice is readily apparent. Some courts permit large punitive damage awards against tortfeasors who make large profits in hopes of deterring similar misconduct by others.[106] The difficulty with this tort is that it is available in many states only for clearly outrageous conduct resulting in very severe distress.[107] The courts often impose a greater duty of care upon debt collectors who are dealing with people known to be disabled or convalescing.[108]

Other state remedies may be applicable in particular instances, such as

[100] See, e.g., *Palmer v. Saint Joseph Healthcare, P.S.O., Incorporated*, 77 P.3d 560 (N.M. Ct. App. 2003) (Medicare law did not preempt UDAP and common-law claims against HMO that raised premiums and cut back services shortly after promising that these would not change for a year; detailed discussion of Medicare preemption). But see *Trevino v. Christus Santa Rosa Healthcare Corporation*, 2002 WL 31423711 (Tex. App. Oct. 30, 2002) (improperly triaged patient gave birth in the bathroom; hospital billed her for labor and delivery; billing for services not performed not a UDAP violation where that section of statute applies only to repairs of goods); *SWA Incorporated v. Straka*, 2003 WL 21434637 (Ohio App. June 19, 2003) (daughter who did not sign nursing home admission agreement not a consumer within meaning of UDAP because no transaction with home; where home sued daughter for mother's care, remedy for baseless suit was motion for sanctions, not UDAP counterclaim).

[101] *Yale New Haven Medical Center v. Mitchell*, 683 A.2d 1362 (Conn. Super. 1995) (correcting opinion at 662 A.2d 178).

[102] *Coast Plaza Doctors Hospital v. UHP Healthcare*, 129 Cal. Rptr. 2d 650 (Cal. App. 2002) (hospital alleged sufficient facts to state a claim for violation of California UDAP law with allegation that HMO caused patients to be transferred in violation of the EMTALA).

[103] See, e.g., Ohio Rev. Code Ann. § 1345.01 (transactions among attorneys, physicians, or dentists and their clients or patients). See generally National Consumer Law Center, Unfair and Deceptive Acts and Practices § 2.3.10.

[104] *Summa Health System v. Viningre*, 749 N.E.2d 344 (Ohio Ct. App. 2000) (HMO misrepresented financial aspects of patient's care).

[105] *Janusauskas v. Fichman*, 826 A.2d 1066 (Conn. 2003) (UDAP claim will lie for entrepreneurial matters such as solicitation of business and billing practices but not for professional "competence or strategy"; where advertising not false, informed consent is malpractice question, not UDAP violation); *Haynes v. Yale-New Haven Hosp.*, 699 A.2d 964 (Conn. 1997) (Connecticut Unfair Trade Practices Act applies to "entrepreneurial aspects" such as "solicitation and billing practices" but not to professional negligence or competency issues; extensive collection of cases); *Simmons v. Stephenson*, 84 S.W.3d 926 (Ky. App. 2002) (UDAP claim will lie for "entrepreneurial, commercial or business aspects" of health care but not "misconduct in the actual performance of medical services or the actual practice of medicine"; no UDAP violation where surgeon told patient to come back in six months, when patient required immediate additional surgery to correct faulty result); *Nelson v. Ho,* 564 N.W.2d 482 (Mich. App. 1997) (UDAP statute, which makes no specific reference to medicine or law, applies only to business or commercial aspects of practice). But see *Macedo v. Dello Russo*, 840 A.2d 238 (N.J. 2004) (learned professionals beyond reach of New Jersey UDAP statute when operating in their professional capacities; misrepresentation of licensure not a UDAP violation); *Phillips v. A Triangle Women's Health Clinic*, 573 S.E.2d 600 (N.C. Ct. App. 2002), aff'd without op., 2003 WL 22518932 (N.C. Nov. 7, 2003) (much broader learned profession exemption; misrepresentation of professional qualifications not a UDAP violation). See National Consumer Law Center, Unfair and Deceptive Acts and Practices § 2.3.10.

[106] See National Consumer Law Center, Fair Debt Collection § 6.5.

[107] See, e.g., *Weiss v. Collection Center Incorporated*, 667 N.W.2d 567 (N.D. 2003) (consumer stated claim for Fair Debt Collection Practices Act violation but not intentional infliction of emotional distress; letter which could be read by unsophisticated consumer as threat to seize vehicle for $255 clinic bill not extreme and outrageous); *Ziegler v. Elmore County Health Care Authority*, 56 F. Supp. 2d 1324 (M.D. Ala. 1999) (mother whose sick child was denied treatment at hospital because she owed past-due bill failed to state claim for outrage, where child recovered fully and mother alleged no ill effects from her emotional distress).

[108] See National Consumer Law Center, Fair Debt Collection § 10.2.

- limitations on collection fees,[109]
- unconscionability,[110]
- usury,[111] or
- common-law claims such as fraud.[112]

Special Exemption Statutes for Medical Debts. A few states, recognizing the special burden created by health care debts, have enacted statutes limiting health care debt collection or otherwise assisting debtors facing health problems. Responding in part to reports of aggressive debt collection by a New Haven hospital, Connecticut passed the most comprehensive law to protect medical debtors. This law prohibits a hospital that receives "free bed funds" (i.e., charity care funds) from suing a medical debtor unless it determines that the debtor is not eligible for the free bed funds.[113] The law also requires hospitals to include information about free bed funds and other free care programs in all bills and collection notices.[114] Hospitals are prohibited from collecting from the uninsured more than the actual cost of services, and thus cannot collect the list price or "gross charges," which are much higher.[115] Furthermore, a hospital cannot sue the debtor unless it has determined whether the debtor qualifies for this "Uninsured Patient Discount."[116] If a hospital has information that a debtor qualifies for free beds funds, the Uninsured Patient Discount, or any other program that can reduce a medical debt, the hospital's debt collectors must cease collection, even if there is a judgment against the debtor, until eligibility for these programs is determined.[117] The law provides an increased homestead exemption for hospital debts, limits the amount of pre- and postjudgment interest, and prohibits wage garnishment, bank account executions, and lien foreclosures if a medical debtor is complying with a court-ordered installment payment plan.[118]

California prohibits county hospitals from adding interest to a medical debt and from enforcing liens against the

---

[109] E.g., *HCA Health Services v. Peters* (D. Va. 1989) (Clearinghouse No. 44,663) (where parent assumed financial responsibility for emergency care for child and signed contract before admittance which was open-ended, speculative, and under the complete control of health care provider, court held unenforceable as unreasonable provision for 25 percent collection attorney fees). See NATIONAL CONSUMER LAW CENTER, FAIR DEBT COLLECTION § 11.8.

[110] See *Phoenix Baptist Hospital and Medical Center v. Aiken*, 877 P.2d 1345 (Ariz. Ct. App. 1994) (husband signed contract when wife had just had heart attack, husband was distraught, could not read contract without his reading glasses, which he did not have with him, and contract was not explained to him; court held that this was contract of adhesion, sent case back to trial court for factual findings whether husband reasonably expected his separate property to be covered and whether contract was unconscionable); NATIONAL CONSUMER LAW CENTER, UNFAIR AND DECEPTIVE ACTS AND PRACTICES §§ 4.3, 4.4. See also *Muse v. Charter Hospital Incorporated*, 452 S.E.2d 589 (N.C. App. 1995) (malpractice judgment proper where hospital's policy of requiring patients to be discharged when their insurance was used up "interfered with" treating physician's medical judgment), aff'd without op., 342 N.C. 403, 464 S.E.2d 44 (1995).

[111] Cf. *Egge v. Healthspan Services Company*, 115 F. Supp. 2d 1126 (D. Minn. 2000) (usury not shown where consumer never paid debt; illegal interest was never collected—an essential element under Minnesota statute).

[112] *Joseph v. J.J. MacIntyre Companies*, 238 F. Supp. 2d 1158 (N.D. Cal. 2002) (barrage of phone calls to disabled senior citizen; consumer stated claims for intrusion on seclusion and tort-in-se), later op., 281 F. Supp. 2d 1156 (N.D. Cal. 2003) (collector's motion for *Fry* judgment denied); *Summa Health System v. Viningre*, 140 Ohio App. 3d 780, 749 N.E.2d 344 (2000) (fraud judgment affirmed where HMO told patient who had been injured by HMO's misreading of test that she would not be required to pay for further testing and surgery but then negotiated malpractice settlement making no mention of bills and billed her for the surgery). But see *SWA Incorporated v. Straka*, 2003 WL 21434637 (Ohio App. June 19, 2003) (misrepresentations in nursing home admission materials not actionable where incorrect statement caused no damage to patient or family).

[113] 2003 Conn. Acts No. 03-266 § 3.

[114] CONN. GEN. STAT. § 19a-509b.

[115] *Id.* § 19a-673. See NATIONAL CONSUMER LAW CENTER, FAIR DEBT COLLECTION § 14.7 (discussing how hospitals often charge the uninsured several times more than insurers because the uninsured are charged "gross charges" but insurers receive large discounts.).

[116] 2003 Conn. Acts No. 03-266 § 3.

[117] *Id.* No. 03-266 § 6.

[118] CONN. GEN. STAT. §§ 37-3a(b), 52-352b(t), 52-356a, 52-356d.

family home while the debtor or his dependent children reside there.[119] Illinois restricts the percentage of a personal injury recovery which may be subject to a lien by certain health care providers.[120] Kansas forbids wage garnishments for two months after the return to employment of a debtor after the debtor's or a family member's illness which has kept the debtor out of work for two or more weeks.[121]

Nevada forbids execution on the primary residence for health care debts during the lifetime of the debtor and certain specified dependents.[122] So does Ohio.[123] In these states, a lien which may be foreclosed only after the residence ceases to be occupied by the protected persons may be created. North Carolina forbids wage garnishment for a health care debt if (1) the debtor's income does not exceed 200 percent of poverty, or (b) the debtor is making payments of 10 percent of disposable income, or (c) the debtor is making reasonable efforts to obtain payment from a third-party payor. Where garnishment is permitted, the creditor must first make reasonable efforts to obtain payment from a third-party payor and comply with special notice and hearing requirements.[124] West Virginia provides a larger homestead exemption for debts resulting from "catastrophic illness or injury."[125]

Many states have statutes detailing health care patients' rights, often called patients' bills of rights. Although these statutes generally focus on issues such as privacy and informed consent, they may also be useful in a debt collection case. Massachusetts, for example, requires from providers itemized bills, explanations of charges, and (upon request) information about financial aid and free care.[126]

V. Defenses to a Hospital Collection Action

Practitioners defending consumers sued over medical debt have a number of viable defenses. Aggressive advocacy can often result in very favorable outcomes. Medical debt collectors are accustomed to obtaining default judgments and are not used to being forced to put on a case.[127] Since few health collection suits go to trial, collectors may overlook a necessary element of proof more frequently than in other types of cases. Practitioners may prevail because of such a failure of proof as well as by establishing the consumer's defenses and counterclaims.

---

[119] CAL. WELF. & INST. CODE § 17401. This protection has been limited to medical debts incurred by indigent patients: *Joseph v. J.J. MacIntyre Companies*, 238 F. Supp. 2d 1158 (N.D. Cal. 2002).

[120] However, this protection is of limited value since the Illinois Supreme Court has permitted each different type of health care provider to recover up to that percentage, effectively allowing cumulative liens to devour an entire recovery. *Burrell v. Southern Truss*, 679 N.E.3d 1230 (Ill. 1997) (where Illinois has five different health care lien statutes, for hospitals, physicians, home health care, etc., limit was construed to mean one-third per group.). For more on the ability of medical providers to seek liens on personal injury recovery, see NATIONAL CONSUMER LAW CENTER, FAIR DEBT COLLECTION § 14.7.

[121] KAN. STAT. ANN. § 60-2310.

[122] NEV. REV. STAT. § 21.095 provides that the primary dwelling (including a mobile home) and land may not be executed upon for a medical bill during the lifetime of the debtor, debtor's spouse, a joint tenant who was a joint tenant when judgment was entered, or debtor's dependent disabled adult child, or during the minority of any child of the debtor.

[123] OHIO REV. CODE §§ 2329.66A(1)(b) and .661 provide that, for debts for health care services or supplies, the homestead exemption has no dollar limitation. See *Edwards v. McCormick*, 136 F. Supp. 2d 795 (S.D. Ohio 2001) (threatening forced sale of home contrary to state exemption is Fair Debt Collection Practices Act violation); *Wickliffe Country Place v. Kovacs*, 765 N.E.2d 975 (Ohio Ct. App. 2001) (remanding for determination whether services provided by nursing home were "health care services and supplies," in which case lien would be precluded).

[124] N.C. GEN. STAT. § 131E-49.

[125] W. VA. CODE § 38-9-3(b) provides a blanket $5,000 exemption which increases to $7,500 for hospital or medical expenses for catastrophic illness or injury.

[126] MASS. GEN. LAWS ch. 111, § 70E.

[127] An analysis of collection actions filed by a Connecticut hospital revealed that 70 percent of the debtors never filed an appearance with the court. Only 9 percent of debtors were represented by counsel. CONNECTICUT CENTER FOR A NEW ECONOMY, UNCHARITABLE CARE: YALE-NEW HAVEN HOSPITAL'S CHARITY CARE AND COLLECTIONS PRACTICES (2003).

A medical debt collector may sue under various theories, each with different elements and different burdens of proof. The burdens of proof may also differ from state to state. For example, a health collection suit may be an action for breach of contract, on a promissory note, on an open account or an account-stated theory, for breach of an implied contract, or for *quantum meruit*. Practitioners should pay attention to the differences in proof required. In particular, if a medical collection action is based on an implied contract, in *quantum meruit*, on an account stated, or on a contract without a definite, agreed price, the collector may be required to prove the ordinary and reasonable value of the service provided in order to recover.[128] Proof of the health provider's license may be a necessary element to recover under any theory.[129]

A. Account-Stated Actions

Health providers' collection suits frequently are based on an account-stated theory. This is often an inappropriate claim because there was no prior agreement on the price or value of the services.[130] Furthermore, there is an argument that the account-stated theory should be impermissible with respect to consumer debts covered under the Fair Debt Collection Practices Act because it deprives the consumer of the Act's right to dispute a debt.[131]

Collection suits based on the theory of account stated frequently fail to allege the necessary elements of such an action, subjecting the complaint to dismissal.[132] The way courts interpret and apply the elements of an action on an account may vary widely.[133] Also, the provider may be required to prove the ordinary and reasonable price of its services.[134]

B. Defenses to Contract Claims

A potential defense to a hospital collection action based on breach of contract is duress. A hospital's requirement that a debtor agree to pay the patient's medical bills in order for the patient to be admitted or discharged may give rise to the

---

[128]See Part V.D *infra*.

[129]See, e.g., *Reddix v. Chatham County Hospital Authority*, 134 Ga. App. 860, 216 S.E.2d 680 (1975) (hospital required to show licensed; while hospital testified it was licensed, it failed to introduce the license, the best evidence of that fact), overruled by *Merrill Lynch v. Zimmerman,* 285 S.E.2d 181 (Ga. 1981) (testimony of license is sufficient). Cf. *Brockett v. Davis,* 762 N.E.2d 513 (Ill. App. Ct. 2001) (statute requiring licensing of professional corporations not intended to protect public against unqualified practitioners; statute requiring licensing of healthcare professionals is; tortfeasor challenging validity of victim's medical bills may not challenge lack of corporate license but may raise question whether treatment provided by unlicensed persons).

[130]*Bingham Memorial Hospital v. Boyd*, 8 P.3d 664 (Idaho App. 2000) (where critically ill patient never signed contract, cause of action was quasi-contract, not open account, and attorney fees could not be awarded under open account statute); *Dreyer Medical Clinic v. Corral*, 591 N.E.2d 111 (Ill. App. Ct. 1992) (sending of bill and lack of objection by recipient insufficient to prove account stated; here provider failed to prove several essential elements); 13 Corbin Contracts §§ 1312, 1313 (1962–2002 interim ed.) ("The rendition of a bill by a doctor … may be an offer of compromise or liquidation of the claim; but the mere retention of this bill in silence, unaccompanied by other circumstances, should seldom, if ever, be held an acceptance of the offer."). See also *Protestant Hospital Builders v. Goedde,* 98 Ill. App. 3d 1028, 424 N.E.2d 1302 (1981).

[131]15 U.S.C. § 1692g. See National Consumer Law Center, Fair Debt Collection § 5.7. Note that Section 1692g(c) provides that a court may not treat a consumer's failure to dispute a debt under that section as an admission of liability. Thus, to the extent that an account-stated action would require the court to construe the consumer's silence as acceptance of a bill, one could argue that Section 1692g(c) prohibited such an assumption.

[132] Alop, *supra* note 5; *Dreyer Medical Clinic v. Corral*, 591 N.E.2d 111 (Ill. App. 1992) (account stated is method of proving damages; creditor must first prove liability; creditor failed to prove several essential elements); *Saint Tammany Parish Hospital v. Burris*, 804 So. 2d 960 (La. App. 2001) (reversing summary judgment for hospital on open-account claim where hospital failed to identify the patient properly—patient named only as "the minor child of" alleged debtor—or to allege that debtor was responsible for child's bill; hospital also failed to prove notice—essential to its claim for attorney fees). See also *Reddix v. Chatham County Hospital Authority*, 134 Ga. App. 860, 216 S.E.2d 680 (1975), overruled on other grounds by *Merrill Lynch v. Zimmerman,* 285 S.E.2d 181 (Ga. 1981); *Culverhouse v. Jackson*, 127 Ga. App. 635 (1972); 1A C.J.S. Account Stated § 2 (1985).

[133]See generally 1 C.J.S. Account *Action on §§ 1-38* (1985).

[134]*St. Luke's Episcopal-Presbyterian Hospital v. Underwood*, 957 S.W.2d 496 (Mo. App. 1997) (in action on account, hospital must prove reasonableness of charges; testimony of "credit assistant" that charges were in line with those of other hospitals in the area was relevant and should have been admitted). See also 1 Am. Jur. 2d *Accounts and Accounting* § 35 (1994); 1 C.J.S. Account *Action on* §§ 15, 28 (1985). For more on reasonable value, see generally Part V.D. *infra*.

complete contractual defense of duress especially if the debtor is not the patient but a relative or friend.[135]

Duress consists of the following three elements:

- *The creditor's exercise of coercion.* Coercion is any form of constraint or compulsion improperly exercised upon the debtor. One form of compulsion may be refusal to admit a patient unless a relative or friend agrees to give a third-party guarantee. Mandatory emergency admittance statutes such as the EMTALA may be critical in these situations, showing that the refusal to admit the patient was unlawful.[136] Another form of constraint may be the act or threat of a hospital detaining a patient by refusing to discharge the patient until a bill is paid.[137] Although coercion directed at one other than the debtor usually does not constitute actionable duress, an exception is often made where the other person is the debtor's close relative.[138]
- *The debtor's loss of volition as a result of the coercion.* A hospital's resort to a threat not to admit or discharge a patient may go a long way toward meeting this subjective test, particularly where the patient or the relative or friend refused to sign a note prior to the threat but did so afterward.
- *A promissory note or contract executed as a result of the wrongful coercion.* Where a hospital sues on a note or contract for health care, practitioners should probe their client about the circumstances surrounding the signing of the contract to determine if coercion was applied. Because of the power of hospitals over people's lives, the possibilities for coercion in signing such notes abound. However, many hospitals do not rely on contracts or notes when suing on hospital bills, and the duress defense is available only against a suit on a contract or note.

This defense may be lost if the consumer pays voluntarily after the coercion has ceased.[139] Even if a contract is voided for

---

[135]See, e.g., *Greenfield v. Manor Care Incorporated*, 705 So. 2d 926 (Fla. Dist. Ct. App. 1997) (surviving spouse allowed to raise defense of imposition, where contract provision allowing immediate eviction of resident for nonpayment prevented her from challenging alleged overcharges at time of payment), overruled on other grounds, *Beverly Enterprises-Florida Incorporated v. Knowles*, 766 So. 2d 335 (Fla. Dist. Ct. App. 2000). But see *Heartland Health Systems v. Chamberlin*, 871 S.W.2d 8 (Mo. Ct. App. 1993) (mother of a patient had not signed contract under duress when she believed guarantee was needed to provide treatment to her 18-year-old son who was bleeding out of his ears and mouth and had a bone sticking out through the skin). An unreported case exemplifies how the duress defense can be successfully utilized. A hospital had brought a $56,000 suit against the patient's widow who had signed an agreement in the belief that it was necessary to gain admittance for her husband, who was in great pain and vomiting, while waiting for emergency treatment. In the hospital he later died of cancer. The jury voided the bill. *Jury Voids Dead Man's Hospital Bill*, WASHINGTON POST, May 8, 1979, at C1.

[136]See Part III.B *supra* for discussion of the EMTALA. Compare *Heartland Health System v. Chamberlin*, 871 S.W.2d at 11 (no duress because the hospital could have withheld its services unless and until mother of patient agreed to pay for services; the EMTALA not raised).

[137]*See Gadsden General Hospital v. Hamilton,* 212 Ala. 531, 103 So. 553 (1925) (hospital's threat not to release plaintiff until she paid her bill, combined with her resultant stay in the hospital eleven hours after she was medically capable of release, amounted to false imprisonment, even though she was *not* physically restrained). See also *Williams v. Rentz Banking Company*, 112 Ga. App. 384, 145 S.E.2d 256 (1965), rev'd on other grounds, 114 Ga. App. 718, 152 S.E.2d 825 (1966) (a debtor's signing a note only after bank officials refused to allow debtor to leave the bank can be duress).

[138]See *Greenfield v. Manor Care Incorporated*, 705 So. 2d 926 (Fla. Dist. Ct. App. 1997) (surviving spouse allowed to raise defense of "imposition," where contract provision allowing immediate eviction of resident for nonpayment prevented her from challenging alleged overcharges at time of payment), overruled on other grounds, *Beverly Enterprises-Florida Incorporated v. Knowles*, 766 So. 2d 335, (Fla. Dist. Ct. App. 2000); *Bedard v. Notre Dame Hospital*, 89 R.I. 195, 151 A.2d 690 (1959) (action for trespass on the case upheld where hospital detained son until bill for son's treatment was paid); *Robertson v. Shinn Grocery Company*, 34 S.W.2d 367 (Tex. Civ. App. 1930) (threat of arrest of son coerced signing of deed of trust).

[139]*Greene v. Alachua General Hospital Incorporated*, 705 So. 2d 953 (Fla. App. 1998) (where hospital sent bill after patient was out of hospital, and not under pressure greater than that felt by any debtor, defense of imposition not proven); *Hall v. Humana Hospital Daytona Beach*, 686 So. 2d 653 (Fla. Dist. Ct. App. 1996) (granting summary judgment against class of patients who had already paid their bills in class action seeking to recover alleged overcharges for pharmaceuticals, medical supplies, laboratory services; patients alleged "imposition," i.e., that they had been coerced into signing contract which included price list). Cf. *Watts v. Promina Gwinnett Health System Incorporated*, 242 Ga. App. 377, 530 S.E.2d 14 (Ga. App. 2000) (patient's voluntary payment of hospital bill out of proceeds of tort judgment barred claim that charges were unreasonable and not authorized by hospital's agreement with HMO or patient's assignment of benefits).

duress, the consumer may be liable in *quantum meruit*.[140]

When a relative or friend of the patient signs an admission form containing a clause making the relative or friend financially responsible for the patient's bills, the court may find that there was no actual intent to accept financial responsibility.[141] Alternatively the court may conclude that the contract documents simply do not impose personal liability on the relative.[142]

C. Quantum Meruit

Quantum meruit or implied contract is especially important in the health care context. It may be asserted as a basis for liability after a contract has been invalidated for duress or on other grounds.[143] It also may be asserted where consent could not be obtained or even if consent has been refused.[144] The elements of *quantum meruit* are that a benefit was conferred and accepted, under circumstances such that the recipient should know that the provider expected to be paid, and that accepting the benefit without paying would be unjust.[145]

---

[140] *Milford Hospital v. Champeau,* 2001 Conn. Super. LEXIS 1166 (April 27, 2001) (duress not shown although wife alleged she was told she "had to" sign contract before admission of her seriously ill husband; even if duress defense made out, couple was liable in *quantum meruit*, and wife was liable under necessaries statute); *Galloway v. Methodist Hospitals Incorporated*, 658 N.E.2d 611 (Ind. App. 1995) (consumers alleged there was no contract because of "extreme duress" where husband, a lawyer, signed for wife's admission for an obstetrical emergency but did not sign for financial responsibility; however, court found both spouses liable in *quantum meruit*, and the bill was prima facie evidence of amount owed). See generally Part IV.C. *infra*.

[141] *Samaritan Health System v. Caldwell*, 191 Ariz. 479, 957 P.2d 1373 (Ariz. App. 1998) (where wife signed admission agreement only as attorney in fact pursuant to husband's durable power of attorney, debt not enforceable against her separate property); *Phoenix Baptist Hospital and Medical Center v. Aiken*, 877 P.2d 1345 (Ariz. 1994) (same); *St. John's Episcopal Hospital v. McAdoo*, 405 N.Y.S.2d 935 (N.Y. Civ. Ct. 1978) (court refused to enforce liability provision that was buried in assignment of insurance benefits form; contract of adhesion; hospital should know contracts will be signed under circumstances when reasonable person too distraught to read whole document); *Columbia Hospital v. Hraska*, 72 Misc. 2d 112, 338 N.Y.2d 527 (N.Y. Civ. Ct. 1972). See also *Wright v. Polk General Hospital*, 95 Ga. App. 821, 99 S.E.2d 162 (1957) (no consideration); *Baton Rouge General Hospital v. Superior Cleaners*, 231 La. 820, 93 So. 2d (1957) (no intent). But see *Trocki Plastic Surgery Center v. Bartkowski*, 344 N.J. Super. 399, 782 A.2d 447 (2001) (wife's alleged inability to understand agreement no defense, where no allegation of duress, fraud, or coercion).

[142] See, e.g., *Slovik v. Prime Healthcare Corporation*, 2002 WL 1350448 (Ala. Civ. App. June 21, 2001) (nursing home's dealings with patient's stepson/personal representative did not amount to contract by which he agreed to be personally liable).

[143] *Milford Hospital v. Champeau*, 2001 Conn. Super. LEXIS 1166 (Conn. Super. April 27, 2001) (even if contract signed by wife were invalid, couple was liable in *quantum meruit* for husband's treatment); *Yale New Haven Hospital v. Gargiulo*, 1999 WL 989422 (Conn. Super. Oct. 18, 1999) (if no express contract between patient and hospital, implied contract to pay reasonable value of the services rendered); *Galloway v. Methodist Hospitals Incorporated*, 658 N.E.2d 611 (Ind. App. 1995) (even if contract, signed by husband at time of wife's admission for obstetrical emergency, was invalid, both spouses were liable in *quantum meruit*); *Commissioner of the Department of Social Services v. Fishman*, 280 A.D.2d 396, 720 N.Y.S.2d 493 (2001) (New York statute provides that furnishing medical benefits by Department of Social Services creates implied contract with responsible relative, here the spouse of nursing home patient); *Layton Physical Therapy Company v. Palozzi*, 777 N.E.2d 306 (Ohio App. Ct. 2002) (if parents do not pay for necessaries, here medical care, minor child secondarily liable in quasi-contract); *Dallas County Hospital District v. Wiley y*, 2002 WL 1286515 (Tex. App. June 12, 2002) (lien invalid, but *quantum meruit* claim may go forward).

[144] *Ex parte University of Southern Alabama v. Grubb*, 737 So. 2d 1049 (Ala. 1999) (patient was liable for her share of bill at hospital which paramedics chose because it had helicopter landing pad, where she accepted treatment there willingly, even though she requested a different hospital where her insurance would have paid 100 percent of bill); *Yale New Haven Hospital v. Alsever,* 2000 Conn. Super. LEXIS 3612 (Dec. 22, 2000) (granting summary judgment on quasi-contract liability, but reserving amount of damages for trial where some services allegedly performed over patient's objection); *Bingham Memorial Hospital v. Boyd*, 8 P.3d 664 (Idaho App. 2000) (patient's estate was liable in implied contract even though critically ill patient did not sign any papers); *Credit Bureau Enterprises v. Pelo*, 608 N.W.2d 20 (Iowa 2000) (patient liable in *quantum meruit* for expenses of involuntary commitment to private psychiatric hospital, where treatment was necessary to prevent serious bodily harm or pain, provider reasonably believed that patient would consent if able to do so, and refusal of consent not binding where patient was incompetent).

[145] *Cardiology Associates v. Sussman*, 2000 Conn. Super. LEXIS 1544 (June 16, 2000) (patient liable in implied contract, where provider showed that it provided services under circumstances such that it could expect to be paid, and billed for the fair, reasonable, and customary amount); *Bingham Memorial Hospital v. Boyd*, 8 P.3d 664 (Idaho App. 2000).

The provider may also be required to show the reasonable value of the services rendered.[146]

D. Reasonable Value

A critical issue in many medical debt collection cases is the reasonable value of the medical services rendered. The provider should bear the burden of proving reasonable value.[147] However, some courts have placed the burden on the debtor or held the provider to a very minimal level of prima facie proof.[148] The question of reasonable value is a pure question of fact for a jury and thus should allow the debtor to defeat the collector's motion for summary judgment or directed verdict.[149]

Two factors that courts look at to determine reasonable value are (1) internal factors of the hospital, including the hospital's cost of operations and its budgetary needs, and (2) charges for comparable services by similar hospitals.[150]

A hospital or medical provider often attempts to meet its burden by having a staff member testify as to the above factors. Courts have allowed such testimony and held it sufficient to establish reasonable

[146]*McMeans v. Medical Liabilities Recoveries Incorporated,* 2002 WL 31835746 (Cal. App. Dec. 19, 2002) (hospital lien limited to reasonable value of necessary services, testimony of chief executive officer as to customary rates not probative where she had no personal knowledge of care provided); *Milford Hospital v. Champeau*, 2001 Conn. Super. LEXIS 1166 (April 27, 2001) (question of reasonableness relevant only to damages, not liability, where hospital asserted claims for *quantum meruit*, unjust enrichment, and spousal liability for necessaries); *Yale New Haven Hospital v. Alsever*, 2000 Conn. Super. LEXIS 3612 (Dec. 22, 2000) (granting summary judgment to hospital on quasi-contract claim, but only as to liability; amount of damages required trial due to question whether services were necessary or were competently performed; some services apparently provided over patient's objection); *Cardiology Associates,* 2000 Conn. Super. LEXIS at 1544 (same); *Estate of Bonner*, 954 S.W.2d 356 (Mo. App. 1997) (medical provider must prove that services were rendered, were medically necessary, and price was reasonable, but need not present expert evidence on medical necessity unless patient/debtor raised that issue; court properly allowed some charges and disallowed others after hearing evidence about treatment plan and patient's condition); *Temple University Hospital v. Healthcare Management Alternatives Incorporated*, 832 A.2d 501 (Pa. Super. 2003) (hospital that treated Medicaid-HMO members when it had no contract entitled to recover in *quantum meruit*; must show reasonable value of its services; posted rates not probative where posted rates were 300 percent of costs and hospital received this amount in only one-third percent of cases); *Doe v. H.C.A. Health Services of Tennessee*, 46 S.W.3d 191 (Tenn. 2001) (patient liable only for reasonable charges where hospital charges were set forth only in a confidential, changing, internal price list). See ALOP, *supra* note 5.

[147]*Greenfield v. Manor Care Incorporated*, 705 So. 2d 926 (Fla. Dist. Ct. App. 1997) (where no price specified, only a reasonable price may be charged), overruled on other grounds, *Beverly Enterprises–Florida Incorporated v. Knowles,* 766 So. 2d 335, (Fla. Dist. Ct. App. 2000); *Payne v. Humana Hospital Orange Park*, 661 So. 2d 1239 (Fla. Dist. Ct. App. 1995) (where contract allegedly did not specify the price for medical services, patient not bound to pay "unreasonable" charges and stated a claim in a class complaint); *Victory Memorial Hospital v. Rice*, 493 N.E.2d 117 (Ill. 1986); *Reddix v. Chatham County Hospital Authority*, 134 Ga. App. 860, 216 S.E.2d 680 (1975) (hospital failed to prove reasonableness and value of services), overruled on other grounds by *Merrill Lynch v. Zimmerman,* 285 S.E.2d 181 (Ga. 1981); *Culverhouse v. Jackson*, 127 Ga. App. 635 (1972) (physician failed to prove ordinary and reasonable value of services); *Fowle v. Parsons,* 141 N.W. 1049 (Iowa 1913); *Estate of Bonner*, 954 S.W.2d at 356*; Saint Luke's Episcopal-Presbyterian Hospital v. Underwood*, 957 S.W.2d 496 (Mo. App. 1997) (in action on account, hospital must prove reasonableness of charges; testimony of "credit assistant" that charges were in line with those of other hospitals in the area was relevant and should have been admitted); *Piggee v. Mercy Hospital,* 186 P.2d 817 (Okla. 1947) (summary judgment inappropriate); *Temple University Hospital*, 832 A.2d at 501; *Doe v. H.C.A. Health Services of Tennessee*, 46 S.W.3d 191 (Tenn. 2001) (where price not specified in contract, hospital can require patient to pay only "fair value" of goods and services). See ALOP, *supra* note 5.

[148]*Trocki Plastic Surgery Center v. Bartkowski,* 344 N.J. Super. 399, 782 A.2d 447 (2001) (reasonableness shown, where consumers received bill and did not complain about the charges or about the quality of the service); *Washington County Memorial Hospital v. Hattabaugh*, 717 N.E.2d 929 (Ind. App. 1999) (burden of proof was on consumers who claimed services were not worth what hospital charged; amount billed was prima facie evidence of value of services); *Sholkoff v. Boca Raton Community Hospital*, 693 So. 2d 1114 (Fla. Dist. Ct. App. 1997); *Hahnemann University Hospital v. Dudnick*, 678 A.2d 266 (N.J. Super. App. Div. 1996) (burden is on patient to show that charges are not "usual, customary and reasonable"; charges were in accord with other teaching institutions in the area and had been approved by state Insurance Commission; charges were reasonable; that insurance company paid its share without protest was further evidence of reasonableness); *Galloway v. Methodist Hospitals Incorporated*, 658 N.E.2d 611 (Ind. App. 1995) (amount of bill was prima facie evidence of amount owed in *quantum meruit*; charges were reasonable where they were comparable to other facilities in the area and based upon hospital's budgetary needs).

[149]*Shellnut v. Randolph County Hospital*, 469 So. 2d 632 (Ala. Civ. App. 1985); *Fowle v. Parsons,* 141 N.W. 1049 (Iowa 1913); *Piggee v. Mercy Hospital,* 186 P.2d 817 (Okla. 1947) (summary judgment inappropriate). Cf. *Sisters of the Third Order of Notre Dame v. Summerson*, 577 N.E.2d 177 (Ill. App. 1991).

[150]*Victory Memorial Hospital v. Rice*, 493 N.E.2d 117 (Ill App. Ct. 1986); *Ellis Hospital v. Little*, 409 N.Y.S.2d 459 (N.Y. App. Div. 1978) (price shown to be fair and reasonable where hospital itemized the services provided, treasurer testified as to relationship of prices to hospital's costs, and officer of another hospital testified as to customary charges in the community); *Doe v. HCA Health Services*, 46 S.W.3d 191 (Tenn. 2001). Cf. *Majid v. Stubblefield*, 589 N.E.2d 1045 (Ill. App. 1992) (doctor's evidence of rates charged by the only two other practitioners of his specialty in a rural three-county area was sufficient despite patient's evidence of lower rates over a larger, more diverse area).

value.[151] Some courts even held that conclusory statements by a hospital employee that the charges were fair and reasonable were sufficient, so long as such statements were uncontroverted.[152] Thus defense counsel must challenge such statements by attacking them on cross-examination and by presenting evidence supporting any of the theories discussed here.[153]

1. Discriminatory Pricing: How the Poor Pay More

One of the most potentially powerful ways to prove that a hospital bill is unreasonable is to show that the patient is being charged more than third-party payors such as HMOs, private insurers, and Medicare. This disparity results from "discriminatory" or "variable" pricing—a phenomenon described as follows by the hospitals' own trade group, the American Hospital Association:

> While a hospital charges all patients receiving the same service the same price, what varies dramatically is how much a hospital is actually paid for the care it provides. The Medicare and Medicaid programs set payments that are not only less than charges, but also often less than the actual cost of caring for these patients. Private insurers negotiate discounts from charges on behalf of the enrollees they cover. As pressure increases from private insurers and managed care companies for deeper discounts, charges have increased, as hospitals struggle to balance government under-funding and find the resources to care for those without insurance. But in the absence of health care coverage for all in America, people without insurance face bills reflecting these higher charges, with no one to negotiate on their behalf. They are victims of America's fragmented and inconsistent health care payment system.[154]

The result is that uninsured patients pay several times more than HMOs, insurance companies, and the government and thereby effectively subsidize these entities. Uninsured individuals also end up paying several times more than the hospital's actual cost of services.[155]

Discriminatory pricing has been documented in a number of reported cases. In one case involving a dispute between a hospital and an HMO, the chief financial officer of a hospital admitted that his hospital received 80 percent or more of its posted rates no more than 6 percent of the time.[156] Opposing counsel's expert

[151] *Galloway*, 658 N.E.2d at 613; *Saint Luke's Episcopal-Presbyterian Hospital v. Underwood*, 957 S.W.2d 496, 498–99 (Mo. App. 1997); *Ellis Hospital v. Little*, 65 A.D.2d 644, 409 N.Y.S.2d 459, 461 (1978). But see *McMeans v. Medical Liabilities Recoveries Incorporated*, 2002 WL 31835746 (Cal. App. Dec. 19, 2002) (hospital lien limited to reasonable value of necessary services; testimony of chief executive officer as to customary rates not probative where she had no personal knowledge of care provided); *Majid v. Stubblefield*, 226 Ill. App. 3d 637, 589 N.E.2d 1045 (1992) (court allowed office manager to testify that physician's charges were similar to other physician charges in the region but suggested that such hearsay testimony was permissible only because it was a small claims court proceeding); *Advocacy Organization for Patients and Providers v. Auto Club Insurance Association*, 2003 WL 21519853 (Mich. App. July 3, 2003) (providers customary charges do not define "reasonable charges" for purposes of no-fault auto insurance).

[152] See *Ex parte University of South Alabama v. Grubb*, 737 So. 2d 1049, 1053 (Ala. 1999); *Heartland Health System v. Chamberlin*, 871 S.W.2d 8, 11 (Mo. App. 1993) (hospital employee's assertion that charges were reasonable and customary sufficient to shift burden to patient to challenge necessity and reasonableness of particular items); *Saint Joseph Hospital v. Blake*, 1989 Ohio App. LEXIS 2838 (July 19, 1989).

[153] Compare *Estate of Bonner,* 954 S.W.2d 356 (Mo. App. 1997) (because patient's estate put accuracy of records at issue by cross-examination, trial court acted within discretion in disallowing certain charges), with *Bingham Memorial Hospital v. Boyd*, 8 P.3d 664, 669 (Idaho App. 2000) (appellate court declined to examine reasonableness of award to hospital given failure by patient's estate to challenge amount of charges). Cf. *Victory Memorial Hospital v. Rice,* 143 Ill. App. 3d 621, 493 N.E.2d 117, 120 (1986) (patient is "free to attack the reasonableness of the charges through cross-examination and presentation of this case").

[154] American Hospital Association, Alert: Four Related Issues Drawing Media and Congressional Attention—Know Your Organization's Policies, June 10, 2003. See also Gina Kolata, *Medical Fees Are Often Higher for Patients Without Insurance*, New York Times, April 2, 2001, at A1; Irene Wielawski, *Gouging the Medically Uninsured: A Tale of Two Bills*, Health Affairs, Sept.–Oct. 2000.

[155] Marilyn Weber Serafini, *Sticker Shock*, National Journal, Oct. 18, 2003, at 3180 (chart of average markup of gross charges—what the uninsured pay—from hospitals' cost; showing in some states, hospital charges were 200 percent over costs).

[156] *Temple University Hospital v. Healthcare Management Alternatives Incorporated*, 832 A.2d 501 (Pa. Super. 2003).

economist testified that the hospital received the full amount of its posted charges only about 1 percent to 3 percent of the time and that the posted rates had risen from 172 percent of actual costs in 1994 to 300 percent in 1996. He also noted that private insurers typically paid only 112 percent of costs in 1996, and Medicaid and Medicare paid even less. The hospital's chief financial officer admitted that none of the twelve private insurers who had contracts with the hospital paid published rates.[157]

While legal challenges by medical debtors to discriminatory pricing have met with mixed success, the most effective use of this phenomenon may be as evidentiary proof to establish that the hospital's bill is unreasonably high.[158] The patient can also argue that the hospital's charges to the uninsured are not reasonable in that they are not the "usual and customary" charges since most patients pay less.[159] Discriminatory pricing may be vulnerable also to challenge under state UDAP statutes.

Discriminatory pricing is an issue for patients who had health insurance at the time of the hospitalization but are being billed for a copayment based on a percentage (e.g., 20 percent) of the bill. Finding out what the insurance company actually paid the hospital is critical. If the hospital discounted the bill in calculating the amount that the insurance company had to pay, the patient can argue that the patient should be responsible for paying only 20 percent of the discounted bill—not 20 percent of the full charges.[160]

Ironically, discriminatory pricing may be an unintentional result of the hospitals' overly restrictive interpretations of Medicaid and Medicare requirements to charge "uniform rates" (which requirements do not prohibit hospitals from accepting discounted payments) and to make reasonable collection efforts of

---

[157] *Id.*

[158] See *Greenfield v. Manor Care Incorporated*, 705 So. 2d 926 (Fla. Dist. Ct. App. 1997) (reversing dismissal of several claims against nursing home that inflated billing price of pharmaceuticals and other supplies it provided to patients), overruled on other grounds, *Beverly Enterprises–Florida Incorporated v. Knowles*, 766 So. 2d 335 (Fla. Dist. Ct. App. 2000). At least one case challenging variable pricing has resulted in a settlement. Rhonda L. Rundle, *Tenet to Unveil New Protections for the Uninsured*, WALL STREET JOURNAL., Jan. 28, 2003, at A3 (settlement with undisclosed terms between for-profit hospital chain and Latino advocacy group; hospital chain reveals its new policy prompted by this lawsuit to provide discounted rates to the uninsured). Unsuccessful challenges include *Thorne v. Doe*, 724 So. 2d 242 (La. App. 1998) (price of certain blood products administered in the hospital was 400 percent to 500 percent higher than price for same products for home administration; overcharging not shown where no showing that plaintiff was billed more than "hospital's established price"); *Parnell v. Madonna Rehabilitation Hospital Incorporated*, 602 N.W.2d 461 (Neb. 1999) (hospital entitled to lien against settlement proceeds in amount of bill, which represented "usual and customary" charges even though it accepted lower amounts in workers' compensation and Medicaid cases); *Hillsborough County Hospital v. Fernandez*, 664 So. 2d 1071 (Fla. Dist. Ct. App. 1995) (evidence that hospital entered into contracts with managed care providers for certain discounts was not sufficient to prove that rates charged to uninsured individuals were excessive). One court held that a hospital's policy of cost shifting did not violate the Social Security Act, the equal protection and due process clauses of state and federal constitutions, or public policy. *Methodist Medical Center of Illinois v. Taylor,* 140 Ill. App. 3d 713, 489 N.E.2d 351 (1986).

[159] Note that the hospital may "charge" every payer the same amount but accept as full payment from third-party payers amounts *less* than the full charges. At least one court has accepted this semantic legerdemain: *Parnell v. Madonna Rehabilitation Hospital,* 602 N.W.2d 461 (Neb. 1999) (phrase "usual and customary charges" means the amount typically billed, not the amount typically received, by medical providers).

[160] See *McConocha v. Blue Cross and Blue Shield of Ohio,* 898 F. Supp. 545 (N.D. Ohio 1995) (in a suit against the *insurer* on this theory, court ruled reasonable for the patient to expect to have to pay only 20 percent of the amount the hospital would actually receive as opposed to 20 percent of full, undiscounted charges). See also *Corsini v. United HealthCare Services Incorporated*, 145 F. Supp. 2d 184 (D.R.I. 2001) (holding that an HMO's method of calculating 20 percent copayments as a percentage of charges, as opposed to discounted fees actually paid, violated the terms of coverage); *Everson v. Blue Cross and Blue Shield of Ohio*, 898 F. Supp. 532 (N.D. Ohio 1994) (terms of coverage ambiguous as to whether the "reasonable charge" from which copayments calculated reflected agreed-upon discounts; construing the ambiguity against the insurer). But see *Hoover v. Blue Cross and Blue Shield of Alabama*, 855 F.2d 1538, 1543 (11th Cir. 1988) (health insurer did not breach its fiduciary duty by requiring members to pay 20 percent of undiscounted hospital charges); *Lefler v. United HealthCare of Utah Incorporated*, 162 F. Supp. 2d 1310 (D. Utah 2001) (HMO acted reasonably by pegging copay percentage to full, undiscounted amounts), *aff'd*, 72 Fed. App.[?] 818 (10th Cir. 2003). Cf. *Ries v. Humana Health Plan Incorporated*, 1995 WL 669583 (N.D. Ill. 1995) (breach of fiduciary duty where an HMO put $8,947 lien on member's settlement award for treatment of her injuries from a car accident, although it settled her medical bills for just $600). A similar discounting agreement was the subject of the U.S. Supreme Court's decision in *Humana v. Forsyth*, 525 U.S. 299, 119 S. Ct. 710, 142 L. Ed. 2d 753 (1999) (Nevada hospital gave discounts of 40 percent to 96 percent to an insurance company that owned it, yet the hospital billed patients for copayments calculated as a percentage of the undiscounted bill).

Medicare copayments and deductibles.[161] Recently HHS issued guidance permitting hospitals and other providers to "provide discounts to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing obligations."[162] This should be a significant support for practitioners who are negotiating with providers to seek to reduce the amount of a medical debt.[163]

2. Overbilling, Error, and Hospital Negligence

Another way to attack the reasonableness of the hospital's charges is to show an error in them. Obtaining the medical records and the pharmacy ledger or record and comparing them to an itemized list of the goods and services allegedly provided to the patient may reveal that some goods and services were not actually provided or were inadvertently billed for twice. Sometimes double-billing occurs because a separately billed service is already included in the charge for another procedure.[164] Overbilling can also result from the hospital's use of the wrong diagnostic related grouping (DRG) code to label, and therefore bill for, a procedure. Practitioners need to investigate the DRG coding through discovery or obtain expert assistance in this regard.[165] Delays caused by the hospital and infections acquired during hospitalization may also result in a longer stay and a higher bill than are reasonable.[166]

E. Other Defenses or Counterclaims in Health Collection Suits

Defenses that may be available against a health collection suit include

- failure to comply with Hill-Burton Act requirements; [167]
- failure to comply with other laws creating a duty to provide free or reduced cost care;[168]
- failure of the provider to process public aid applications or to bill Medicaid or Medicare;[169]
- breach of the hospital's charitable duty under state tax law;[170]
- breach of the duty of good faith and fair

[161]Carol Pryor & Robert Seifert, The Commonwealth Fund, Unintended Consequences: How Federal Regulations and Hospital Policies Can Leave Patients in Debt (2003).

[162]Letter from Tommy G. Thompson, Secretary of Health and Human Services, to Richard J. Davidson, President, American Hospital Association (Feb. 19, 2004).

[163]See, e.g., Vince Galloro, *Tenet to Offer Discounts*, Modern Healthcare, March 8, 2004, at 8 (for-profit hospital chain announces implementation of discount rate plan for the uninsured; plan had been on hold for one year pending HHS guidance.).

[164]See National Consumer Law Center, In Sickness and In Debt: Using Consumer Law to Help Elders Facing Overwhelming Medical Bills (2001), for a more detailed discussion of this problem and other hospital errors to look out for in examining a medical debtor's bills. See also *Decoding Your Hospital Bills*, Consumer Reports, Jan. 2003, at 19.

[165]In recent years, small companies have been set up to conduct "mini-audits" that consist of expert review of the itemized hospital bill. A list of some of these companies may be found at www.billadvocates.com/affiliates.htm.

[166]See Press Release, Duke University Medical Center, Hospital-Acquired Antibiotic-Resistant Infections Triple Costs and Lengths of Hospitalizations (Sept. 28, 1997), http://dukemednews.org/news/article.php?id=678.

[167]Hospitals that have Hill-Burton obligations are identified online at www.hrsa.gov/osp/dfcr/obtain/hbstates.htm.

[168]*Yale New Haven Hospital v. Gargiulo*, 1999 WL 989422 (Conn. Super. Oct. 18, 1999) (special defense of failure to mitigate sufficiently alleged: hospital failed to advise patient of Hill-Burton or other aid programs, or to assist her in applying). See also *Flagstaff Medical Center v. Sullivan*, 962 F.2d 879 (9th. Cir. 1992) (court applied state contract law to hold that indigent patients are third-party beneficiaries of contract between HHS and hospital which accepted Hill-Burton funds; eligible patients who were denied such care may be granted relief from debt to hospital); *Davis v. Ball Memorial Hospital*, 640 F.2d 30 (7th Cir. 1980) (regulation created an entitlement to uncompensated care); *Creditor's Service Incorporated v. Schaffer*, 659 P.2d 694 (Colo. 1982); *Yale New Haven Hospital v. Mitchell*, 683 A.2d 1362 (Conn. Super. 1995) (correcting opinion at 662 A.2d 178) (failure to notify indigent patients of the availability of free care under Hill-Burton or the Connecticut Hospital Bed fund is a defense to a hospital debt collection suit; case remanded to trial court for factual findings on issue whether failure to notify was also unfair trade practice); *Hospital Center v. Cook,* 177 N.J. Super. 289, 426 A.2d 526 (1981) (hospital's failure to comply with Act a bar to suit for services rendered). But see *White v. Moses Taylor Hospital*, 841 F. Supp. 629 (M.D. Pa. 1992) (*Flagstaff* decision considered and rejected; private right of action only to compel future compliance by hospital).

[169]*Layton Physical Therapy Company v. Palozzi*, 777 N.E.2d 306 (Ohio App. 2002) (where patient was eligible for Medicaid, and Medicaid approved the treatments, provider was barred from suing patient or parents for covered services; failure to bill Medicaid timely did not make services "uncovered" for billing purposes); *Mount Sinai Hospital v. Kornegay*, 347 N.Y.S.2d 807 (1973) (where hospital failed to submit Medicaid application, it was barred from seeking payment from the patient). See Alop, *supra* note 5.

70 Alop, *supra* note 5.

dealing, which is incorporated into health care contracts and which requires that charges not set forth specifically in the agreement be reasonable;[171]

- breach of a fiduciary duty, which at least one court has found to arise on the part of a nursing home toward its residents;[172]
- the provider's acceptance of a Medicaid or Medicare payment that by statute or regulation (42 U.S.C. §§ 1395cc(a)(1), 1396a(a)(25)(C); 42 C.F.R. § 447.15) must be considered payment in full;[173]
- the provider's application for a Medicaid or Medicare payment that by statute or regulation (42 U.S.C. §§ 1395cc(a)(1), 1396a(a)(25)(C); 42 C.F.R. § 447.15) must be considered payment in full;[174]
- negligently misinforming patient as to the extent of insurance coverage;[175]
- provisions of the provider's contract with an HMO or a state health insurance statute that bar the provider from billing an HMO member for services covered by the HMO;[176]
- the provider's failure to supply a translation of the contract for a non-English-speaking consumer;[177] and
- the provider's malpractice, which may be raised as a defense to a debt, even if consumers did not sue for malpractice.[178]

---

[171] *Greenfield v. Manor Care Incorporated*, 705 So. 2d 926 (Fla. Dist. Ct. App. 1997) (contract with nursing home included duty of good faith and fair dealing, which required that where no price term specified, only reasonable price might be charged), overruled on other grounds, *Beverly Enterprises–Florida Incorporated v. Knowles*, 766 So. 2d 335 (Fla. Dist. Ct. App. 2000).

[172] *Supra* note 171.

[173] *Evanston Hospital v. Hauck,* 1 F.3d 540 (7th Cir. 1993) (once hospital accepts Medicaid or Medicare payment, it is barred from pursuing the patient for any balance, and it cannot avoid this by returning the payment to the government), cert. denied, 510 U.S. 1091 (1994); *Olszewski v. Scripps Health*, 135 Cal. Rptr. 2d 1 (Cal. 2003) (federal Medicaid law preempted state hospital lien law that permitted lien for customary charges, but filing lien was not a UDAP because California statute provided safe harbor); *American Family Mutual Insurance Company v. Centura Health-St. Anthony Centura Hospital*, 46 P.3d 490 (Colo. App. 2002) (workers' compensation statute prescribes amount hospital may charge; hospital must return to auto insurance company the difference between permitted charge and personal injury protection benefits paid out while workers' compensation case being contested); *Public Health Trust v. Dade County School Board*, 693 So. 2d 562 (Fla. App. 1996). For more on Medicaid law and the payment in full defense, see National Health Law Program, An Advocate's Guide to the Medicaid Program (2001 ed.).

[174] *Banks v. Secretary of Indiana Family and Social Services Administration*, 997 F.2d 231 (7th Cir. 1993) (provider is precluded from seeking payment from patient after submitting claim to Medicaid, whether Medicaid pays the claim or denies it); *Serafini v. Blake*, 213 Cal. Rptr. 207 (Cal. App. 1985). See also *Layton Physical Therapy Company v. Palozzi*, 149 Ohio App. 3d 332, 777 N.E.2d 306 (Ohio App. 2002) (failure to bill Medicaid timely did not make services "uncovered" for billing purposes; where patient was eligible for Medicaid, and Medicaid approved the treatments, provider was barred from suing patient or parents for covered services).

[175] *Yale New Haven Hospital v. Vignola*, 2002 WL 377675 (Conn. Super. Feb. 15, 2002) (at admission, patient asked whether treatment was covered by her insurance, and hospital employee stated, incorrectly, that it was; hospital had no duty to ascertain insurance coverage, but when it undertook to advise patient, duty of due care arose). But see *MRI Co-operative v. Berlin,* 1993 WL 257078 (Ohio App. June 30, 1993) (assignment of insurance benefits, which provided that patient would be liable if insurance did not pay, enforced as written, even though provider's employee told patient that his insurance would cover).

[176] *Lutheran General Hospital Incorporated. v. Printing Industry of Illinois/Indiana Employee Benefit Trust,* 24 F. Supp. 2d 846 (N.D. Ill. 1998) (where hospital's agreement with employee benefit plan forbade it to dun patients for services covered by plan, and patient had properly authorized hospital to bill plan, hospital was forbidden to bill patient for covered services; remanded on issue, whether all services were covered); *Dorr v. Sacred Heart Hospital*, 597 N.W.2d 462 (Wis. App. 1999) (lien was void where auto accident victim was covered by the HMO, contract between the hospital and the HMO, as well as a provision of state statute, forbade the hospital to bill the patient for services covered by the HMO; allegation that hospital refused to present claim to the HMO and sought lien instead sufficient to state a claim for breach of contract, UDAP, and racketeering). See National Consumer Law Center, Fair Debt Collection § 14.7.2, for other cases in which providers have sought liens against patients' tort recovery even after payment of medical bills by insurers. But see *Watts v. Promina Gwinnett Health System Incorporated,* 242 Ga. App. 377, 530 S.E.2d 14 (Ga. App. 2000) (patient's payment of bill waived claim that charge violated hospital's contract with the HMO). See generally National Consumer Law Center, Unfair and Deceptive Acts and Practices § 5.11.6, for a discussion of other issues involving HMOs.

[177] See Alop, *supra* note 5; National Consumer Law Center, Unfair and Deceptive Acts and Practices § 5.2.1. A failure to provide a translation of the contract may also violate Title VI of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000d *et seq*., and its implementing regulations. Title VI prohibits discrimination on the basis of race, ethnicity, or national origin by any health care provider receiving federal funds (including Medicare and Medicaid). Consumers can file complaints for violation of Title VI with their regional office of the HHS Office for Civil Rights. There is, however, no private right of action under Title VI for this type of violation. *Alexander v. Sandoval,* 532 U.S. 275 (2001).

[178] *Washington County Memorial Hospital v. Hattabaugh,* 717 N.E.2d 929 (Ind. App. 1999) (consumers who did not sue for malpractice were allowed to introduce evidence that surgery had resulted in permanent damage, as defense to collection suit).