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Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress

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Articles

BEYOND HOSPITAL MISBEHAVIOR: AN ALTERNATIVE ACCOUNT OF MEDICAL- RELATED FINANCIAL DISTRESS

Melissa B. Jacoby & Elizabeth Warren***

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I. INTRODUCTION

Long after a person recovers physically, illness and injury can have a significant financial impact on individuals and their families. In the past several years, the news media have given front-page attention to the money side of medical problems. Featured stories described how big hospital bills turn families' lives upside down, sometimes costing them their homes, their credit ratings, access to their bank accounts, and occasionally even their liberty.¹ These stories could have been an important catalyst for discussion of how the structure of the current health care finance system produces significant financial consequences for patients and their families. So far, however, the conversation mainly has taken a different and narrower path: these patients and their families suffered, the public has been told, because hospitals misbehaved. Lawmakers and advocates focused on allegations that hospitals overcharged the uninsured, improperly applied charity care policies, and engaged in inappropriate debt collection.² Proposed solutions focused, in turn, on suing hospitals and regulating hospital billing and collection with respect to the low-income uninsured.³ We refer to this approach throughout this Article as the "hospital misbehavior model."

The hospital misbehavior model has had some short-term utility. By examining the intersection of health care finance and debtor-creditor law and policy, however, it becomes clear that tinkering with the collection activities of hospitals will not substantially reduce medical-related financial distress or the entanglement between medical problems and the debtor-creditor system.

Using data on individual bankruptcy filers—a cross-section of middle-class households—we observe that the hospital misbehavior model inadequately accounts for the financial distress that can accompany medical problems. First, the hospital misbehavior model has focused on people with a chronic lack of insurance, but even the insured face significant medical-related indebtedness.⁴ Second, hospital bills are only part of a larger picture of direct medical costs that also includes office visits, prescription drugs, and other expenses.⁵ Third, medical bills readily are converted into consumer debt that is owed to third-party lenders; in those situations, hospitals will not be the direct creditor of the patient or family members.⁶ Fourth, lost income often is a major component of medical-related financial distress, with hospital bills or other direct costs playing a much more limited role.⁷

¹ See *infra* notes 12–20 and accompanying text.

² See *infra* notes 28–32, 54–58 and accompanying text.

³ See *infra* notes 33–53 and accompanying text.

⁴ See *infra* Part III.B.

⁵ See *infra* Part III.C.

⁶ See *infra* Part III.D.

⁷ See *infra* Part III.E.

We cannot quantify precisely the extent to which bankruptcy filers' medical-related financial problems can be linked to hospital misbehavior alone. In addition, bankruptcy filers as a group may differ somewhat from the patients highlighted in discussions of hospital misbehavior.⁸ Nonetheless, we conclude that the problem is largely structural and not behavioral. The data suggest that a variety of households are struggling with far more pervasive financial fallout than can be attributed solely to hospital debt collection activities. Legal and policy solutions to alleged hospital misbehavior are likely to bring very limited relief.

In addition, although we cannot speak to whether not-for-profit hospitals have misbehaved from the perspective of tax exemption entitlements, we can report that the hospitals' collection activities are not extraordinary in the debtor-creditor world.⁹ Our health care system is premised intentionally on legal liability for part or all of the cost of medical care. Collection-related consequences flow from defaulting on obligations to pay for medical goods or services, like any other legal obligation. Indeed, a patchwork of laws give medical providers extra debt collection powers and incentives to use them.¹⁰ Inconsistent public policies are at work when lawmakers chastise hospitals for pursuing debts while they provide incentives and special powers for hospitals to do exactly that.

To achieve meaningful reform, health policymakers should relax the focus on individual wrongdoing and instead consider how the structure of the health care finance system, broadly construed to include the laws discussed in this Article, contributes to significant financial distress of patients and their families.¹¹ In addition, the negative public reaction to hospital debt collection should prompt debtor-creditor policymakers to question whether our current debt collection system is inefficient, unfair, or both as applied to consumer indebtedness generally. Even if lawmakers pursue more targeted interventions, however, they should develop their proposals in light of the data and existing relevant laws we have presented here.

In Part II, we briefly describe the news media account and the nature of the proposed and implemented responses. In Part III, we evaluate bankruptcy data to explore the mismatch between the hospital misbehavior model and medical-related financial distress among this population. In Part IV, we place allegations of hospital misbehavior into a broader context of debtor-creditor law. In Part V, we make general recommendations for future study and action.

⁸ See *infra* notes 69–72 and accompanying text.

⁹ See *infra* Part IV.

¹⁰ See *infra* Part IV.B.2.

¹¹ See *infra* Part V.

II. CONSTRUCTING THE PROBLEM OF HOSPITAL MISBEHAVIOR

In a series of investigative reports, former patients, financially devastated by aggressive hospital collection, emerged on the public's radar screen. The reporting, including prominently featured *Wall Street Journal* stories, showed what happened when people got sick, received high-priced medical care, and were unable to pay on the terms the hospitals required. Their wages were garnished,¹² their homes were liened,¹³ and their bank accounts were frozen.¹⁴ They entered into payment plans that would last for years as interest compounded regularly.¹⁵ Reporters amplified these examples with statistics on hospital lawsuits and liens, suggesting widespread impropriety.¹⁶ The stories highlighted some patients who even landed in jail when they were sued for nonpayment of their hospital bills and failed to comply with court orders.¹⁷ Each story had a victim, but the main attraction of this reporting was the villain: a large and impersonal hospital. Hospitals did at least three things wrong, according to these reports. They charged uninsured patients a higher price than most insured patients and their insurers pay.¹⁸ They billed patients who perhaps should have been eligible for charity care.¹⁹ And they engaged in aggressive debt collection to recover these sums.²⁰

¹² See, e.g., Jonathan Cohn, *Uncharitable?*, N.Y. TIMES, Dec. 19, 2004, at 51.

¹³ See, e.g., Liz Kowalczyk, *Hospital Using Liens to Collect from Patients*, BOSTON GLOBE, Oct. 17, 2004, at A1; Cullen Browder, *Wake Woman May Lose Home to Cover Late Husband's Medical Bills: Hospital Hopes to Work Toward Amicable Settlement*, WRAL.COM, July 12, 2004, <http://www.wral.com/news/3522117/detail.html>.

¹⁴ See, e.g., Lucette Lagnado, *Cold-Case Files: Dunned for Old Bills, Poor Find Some Hospitals Never Forget*, WALL ST. J., June 8, 2004, at A1.

¹⁵ See, e.g., Lucette Lagnado, *Jeanette White is Long Dead but Her Hospital Bill Lives on: Interest Charges, Legal Fees*, WALL ST. J., Mar. 13, 2003, at B1 (owing \$40,000 on a bill to Yale-New Haven Hospital that was originally \$18,000 due to ten percent interest).

¹⁶ See, e.g., Marsha Austin, *Uninsured Pay Higher Price: Hospital Collection Agents Demand Full Cost of Care*, DENV. POST, Jan. 28, 2003, at 1A (noting that hospitals in area have sued at least 210 individuals for unpaid medical bills of \$2000 or more in the past two years, and twenty-four percent of the cases are for bills of \$10,000 or more); Jodie Snyder, *Hospitals Try to Get Bills Fully Paid by Cashing in on Patients' Settlements*, ARIZ. REPUBLIC (Phoenix), Aug. 31, 2003, at A22 (finding 35,000 liens filed against patients by hospitals in two-year period, most of which were on accident lawsuits or settlements).

¹⁷ See, e.g., *Medical Seizures: Hospitals Try Extreme Measures to Collect Their Overdue Debt—Patients Who Skip Hearings on Bills Are Arrested*, WALL ST. J., Oct. 30, 2003, at A1.

¹⁸ See, e.g., Julie Appleby, *Hospitals Sock Uninsured with Much Bigger Bills*, USA TODAY, Feb. 25, 2004, at 1B; Lucette Lagnado, *Anatomy of a Hospital Bill: Uninsured Patients Often Face Big Markups on Small Items*, WALL ST. J., Sept. 21, 2004, at B1; Lucette Lagnado, *House Panel Begins Inquiry into Hospital Billing Practices*, WALL ST. J., July 17, 2003, at B1 [hereinafter Lagnado, *House Panel*].

¹⁹ See, e.g., Lucette Lagnado, *Call it Yale v. Yale: Law-School Clinic is Taking Affiliated Hospital to Court over Debt-Collection Tactics*, WALL ST. J., Nov. 14, 2003, at B1 [hereinafter Lagnado, *Call it Yale v. Yale*]; Lucette Lagnado, *New York State Hospitals Agree to Cut Prices for Uninsured*, WALL ST. J., Feb. 2, 2004, at B1 [hereinafter Lagnado, *New York State Hospitals*].

²⁰ See, e.g., Lagnado, *supra* note 15.

The news stories, supplemented by efforts of advocacy groups, prompted legislative and legal responses that themselves became a news story.²¹ The media covered a congressional committee's formal investigation of hospital practices,²² scrutiny of tax exemptions,²³ government "scolding" of hospitals,²⁴ proposed legislation,²⁵ lawsuits,²⁶ and the hospital industry's self-policing efforts.²⁷ Like the media reporting, these responses targeted the named villains: the hospitals. At a House committee investigative hearing, the committee chair insisted that the inquiry be focused on hospital overcharging and aggressive collection with respect to uninsured patients and rejected efforts of other lawmakers to broaden the discussion.²⁸ Allegations of bad behavior helped fuel scrutiny of not-for-profit hospitals' tax exempt status²⁹ and reignited a recurring debate over the propriety of tax exemptions.³⁰ In dozens of lawsuits, the plaintiffs contended that not-for-

²¹ For an example of a commentator linking the news coverage with public and lawmaker reaction, see, for example, Lawrence Singer, *Gloria Jean Ate Catfood Tonight: Justice and the Social Compact for Health Care in America*, 36 LOY. U. CHI. L.J. 613, 627 n.78 (2005).

²² See, e.g., Joanne Kenen, *U.S. House Panel Examines High Bills for Uninsured*, REUTERS NEWS, June 24, 2004; Lagnado, *House Panel*, *supra* note 18; *Politics & Policy: The Uninsured: Hospital Executives Testify on Billing Practices*, AM. HEALTH LINE, June 25, 2004, <http://www.americanhealthline.com/index.html>.

²³ See, e.g., Lucette Lagnado, *Hospital Found 'Not Charitable' Loses its Status as Tax Exempt*, WALL ST. J., Feb. 19, 2004, at B1; Lucette Lagnado, *A Nonprofit Hospital Fights to Win Back Charitable Halo*, WALL ST. J., June 29, 2004, at B1; see also Gary Washburn, *Assessor Pushed to Tax Hospital: Aldermen Back Union's Side on Resurrection*, CHI. TRIB., Aug. 3, 2004, at 1.

²⁴ See, e.g., Lucette Lagnado, *HHS Chief Scolds Hospitals for Their Treatment of Uninsured*, WALL ST. J., Feb. 20, 2004, at A1.

²⁵ See, e.g., Lucette Lagnado, *Taming Hospital Billing; Lawmakers Push Legislation to Curb Aggressive Collection Against Uninsured Patients*, WALL ST. J., June 10, 2003, at B1.

²⁶ See, e.g., Reed Abelson & Jonathan D. Glater, *Suits Challenge Hospital Bills of Uninsured*, N.Y. TIMES, June 17, 2004, at C1; Cohn, *supra* note 12 (listing suits naming more than 400 nonprofit hospitals); Lagnado, *Call it Yale v. Yale*, *supra* note 19; *Lawsuits Challenge Charity Hospitals on Care for Uninsured*, WALL ST. J., June 17, 2004, at B1.

²⁷ See, e.g., Bruce Japsen, *Hospitals Soften Billing Pain: Industry Agrees to Offer Discounts, Temper Harsh Collection Practices*, CHI. TRIB., Nov. 2, 2003, at C1; Lucette Lagnado, *Hospitals Urged to End Harsh Tactics for Billing Uninsured*, WALL ST. J., July 7, 2003, at A9; Lagnado, *New York State Hospitals*, *supra* note 19; Lucette Lagnado, *Twenty Years—And He Isn't Paying Any More*, WALL ST. J., Apr. 1, 2003, at B1 [hereinafter Lagnado, *Twenty Years—And He Isn't Paying Any More*].

²⁸ See generally *A Review of Hospital Billing and Collections Practices: Hearing Before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce*, 108th Cong. 4 (2004) [hereinafter *Hearing on Hospital Billing and Collections*].

²⁹ See, e.g., Patrick Reilly, *Indigent-Care Spending Low*, MOD. HEALTHCARE, Feb. 23, 2004, at 7 (reporting on revocation of tax exemption); Washburn, *supra* note 23 (citing letter from city council members seeking revocation because of "steep decline in charity care, implementation of restrictive charity care policies and aggressive collection procedures, including lawsuits against poor patients"). For a report considering a wider range of considerations, see Neville M. Bilimoria, *Patients Challenge Nonprofit Hospitals' Charitable-Care Practices*, 93 ILL. B.J. 134, 137 (2005).

³⁰ See, e.g., Gabriel O. Aitsebaomo, *The Nonprofit Hospital: A Call for New National Guidance Requiring Minimum Annual Charity Care to Qualify for Federal Tax Exemption*, 26 CAMPBELL L. REV.

profit hospitals breached an implied contract with the government, engaged in “profiteering,” and inappropriately tried to collect debts.³¹ Plaintiffs even have alleged that hospitals engaged in deceptive trade practices.³²

The clearest example of a response to the misbehavior model can be found in Connecticut. Shortly after detailed reports emerged of the billing and collection practices used at Yale-New Haven Hospital and other local hospitals, Connecticut lawmakers enacted new laws to protect patients from these hospital practices.³³ The laws impose a new process for Connecticut hospitals to follow when billing and collecting from “uninsured patients,” a defined term that depends on both income and lack of eligibility for government programs.³⁴ They require that the hospital first assess whether a patient meets that definition.³⁵ If the patient qualifies, the hospital may not collect more than the cost of providing services.³⁶ In addition, the hospital’s collection agents must notify the patient of her status while trying to collect that amount.³⁷ They also must provide patients with a summary of their hospital bed fund information.³⁸

The new Connecticut laws also include collection restrictions with greater breadth. The holder of a court judgment arising out of services pro-

75 (2004); Jack E. Karns, *Justifying the Nonprofit Hospital Tax Exemption in a Competitive Market Environment*, 13 WIDENER L.J. 383 (2004). See generally M. Gregg Bloche, *Health Policy Below the Waterline: Medical Care and the Charitable Exemption*, 80 MINN. L. REV. 299 (1995); John D. Colombo, *The Role of Access in Charitable Tax Exemption*, 82 WASH. U. L.Q. 343 (2004); Jill R. Horwitz, *Why We Need the Independent Sector: The Behavior, Law, and Ethics of Not-For-Profit Hospitals*, 50 UCLA L. REV. 1345, 1349 (2003); Alice A. Noble et al., *Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives*, 26 J.L. MED. & ETHICS 116 (1998).

³¹ See Bilimoria, *supra* note 29, at 135 (reporting more than fifty attempted class action lawsuits filed against more than 370 hospitals); CaseConnect, <http://www.nfplitigation.com/FCWSite/Features/Extranets/NotForProfit/FCXRedirectNotForProfit.aspx> (click on “Continue” button; then follow “Fact-sheet” hyperlink) (last visited Dec. 6, 2005) (providing lawsuit documents). But see *Federal Judge Dismisses Suit Claiming Hospital System Charged More to Uninsured*, FOOD & DRUG L. WEEK., Feb. 25, 2005, at 74 (reporting on denial of class action status and dismissal of suit).

³² See, e.g., *Williams v. Yale New Haven Hosp., Inc.*, No. CV030479268, 2004 WL 2663971 (Conn. Super. Ct. Oct. 15, 2004) (contesting charge arising from debt collection proceedings against property in which defendant no longer had interest due to divorce); *Gibson v. Yale-New Haven Hosp.*, No. CV980414230S, 2003 WL 22079573 (Conn. Super. Ct. Aug. 18, 2003); *Hospital Going to Trial*, MOD. HEALTHCARE, Jan. 17, 2005, at 4 (reporting on suit filed by Legal Assistance Foundation of Metropolitan Chicago against Resurrection Medical Center as one of the first of two lawsuits not to be dismissed).

³³ See Act of July 9, 2003, Pub. Act No. 03-266, 2003 Conn. Acts 266 (Reg. Sess.) (codified at CONN. GEN. STAT. ANN. §§ 19A-509b, 649, 673 (West 2003); CONN. GEN. STAT. ANN. § 37-3b, -3c; CONN. GEN. STAT. ANN. §§ 52-192a, -352b, -356a, -356d (West 2003)).

³⁴ See CONN. GEN. STAT. ANN. § 19A-673(a)(4).

³⁵ See *id.* § 19A-673(b) (West Supp. 2005).

³⁶ See *id.* § 19A-673(b) (West 2003).

³⁷ See *id.* § 19A-673(c).

³⁸ See *id.* § 19A-509b(d). A hospital bed fund refers to gifts of money, stock, other financial instruments, or other property made to establish a fund to provide medical care to patients at a hospital. *Id.* 19A-509b(a)(1).

vided at a hospital may not levy on or execute against a patient's property until the patient also has defaulted on a court-ordered payment plan.³⁹ Courts may not impose judgment interest that exceeds five percent in this context.⁴⁰ A debtor has a higher homestead exemption in the event of a judgment arising out of hospital services than in the event of judgments arising out of any other circumstance.⁴¹

Connecticut is not alone. Legislatures in states across the country, including California,⁴² Florida,⁴³ Illinois,⁴⁴ New York,⁴⁵ and Mississippi⁴⁶ have proposed various measures to restrict hospitals' current financial practices, particularly with respect to the uninsured.⁴⁷

Perhaps to prevent new restrictions and requirements from being enacted, hospitals furiously studied and vowed to change their billing and collection practices.⁴⁸ State hospital associations worked quickly to develop new guidelines and to rush them into print.⁴⁹ Hospitals promised to refrain

³⁹ See *id.* § 52-356a(a).

⁴⁰ See CONN. GEN. STAT. ANN. § 37-3a(b) (West 2003).

⁴¹ See CONN. GEN. STAT. ANN. § 52-352b(t) (West 2003) (providing for a \$125,000 exemption rather than a \$75,000 exemption). For other state exemptions that operate differently in the event of medical debts or medical problems, see sources cited *infra* note 183.

⁴² See Assemb. B. 1401, 2003-04 Leg., Reg. Sess. (Cal. 2003); Assemb. B. 232, 2003-04 Leg., Reg. Sess. (Cal. 2003); S.B. 24 2003-04 Leg., Reg. Sess. (Cal. 2003); Assemb. B. 774, 2005-06 Leg., Reg. Sess. (Cal. 2005).

⁴³ See S.B. 1988, 2004 Leg., Reg. Sess. (Fla. 2004); H.B. 425, 2004 Leg., Reg. Sess. (Fla. 2004); H.B. 715, 2004 Leg., Reg. Sess. (Fla. 2004).

⁴⁴ See S.B. 2579, 93rd Gen. Assemb., Reg. Sess. (Ill. 2004). See generally Bilimoria, *supra* note 29, at 137.

⁴⁵ See A.O. 2521, 2005-06 Leg., Reg. Sess. (N.Y. 2005).

⁴⁶ See S.B. 2506, 2005 Leg., Reg. Sess. (Miss. 2005).

⁴⁷ See Laura B. Benko, *Veto Power: Bill Mandating Discounts for Uninsured Gets Spiked*, MOD. HEALTHCARE, Sept. 27, 2004, at 14 (explaining veto of California bill). See generally Andrew McKinley, *Hospital Billing Practices and the Uninsured: An Emerging Legislative Response*, HEALTHCARE FIN. MGMT., Nov. 2004, at 14 (reviewing status of legislation).

⁴⁸ See PATIENT FRIENDLY BILLING PROJECT, HEALTHCARE FIN. MGMT. ASS'N, HOSPITALS SHARE INSIGHTS TO IMPROVE FINANCIAL POLICIES FOR UNINSURED AND UNDERINSURED PATIENTS (2005), available at http://www.patientfriendlybilling.org/2005report/2005_pfb_report.pdf; ANDREA B. STAITI, ROBERT E. HURLEY, & PETER J. CUNNINGHAM, CTR. FOR STUDYING HEALTH SYS. CHANGE, BALANCING MARGIN AND MISSION: HOSPITALS ALTER BILLING AND COLLECTION PRACTICES FOR UNINSURED PATIENTS (2005), available at <http://www.hschange.org/CONTENT/788/788.pdf>; Richard L. Clarke, *Charging and Collection Concerns*, HEALTHCARE FIN. MGMT., Aug. 2003, at 136; cf. Patrick Reilly, *An Ounce of Prevention*, MOD. HEALTHCARE, Feb. 2, 2004, at 6 (describing damage control measures taken by the American Hospital Association to "soften the public relations blow expected from [congressional] hearings on hospital billing practices" including sending a letter to Health and Human Services's Tommy Thompson "urging Medicare to relax federal regulations that the association says force hospitals to bill full charges to the poor").

⁴⁹ See, e.g., CAL. HOSP. ASS'N, CALIFORNIA HOSPITAL BILLING AND COLLECTION PRACTICES: VOLUNTARY PRINCIPLES AND GUIDELINES FOR ASSISTING LOW-INCOME UNINSURED PATIENTS (2004); HEALTHCARE ASS'N OF N.Y., FINANCIAL AID/CHARITY CARE POLICY AT NEW YORK'S NOT-FOR-PROFIT HOSPITALS: GUIDELINES FROM THE HEALTHCARE ASSOCIATION OF NEW YORK STATE (2004);

voluntarily from otherwise legal activities under certain circumstances.⁵⁰ Some hospitals released liens they had placed on patients' property.⁵¹ At least one hospital attempted to "settle" a lawsuit that had not even been filed; under the agreement, it would have paid millions of dollars to patients and promised to limit its future debt collection.⁵² In the frenzy to be responsive, some hospitals may have agreed to do things they cannot control or apply consistently, such as promising not to authorize a collection effort that would result in a bankruptcy.⁵³

There may be many reasons why the issue has been framed in terms of hospital misbehavior. In some circumstances, not-for-profit hospitals may not have been fulfilling their charitable obligations, and their aggressive business-like behavior conflicted with the public's innate sense of how charitable institutions should conduct themselves.⁵⁴ Health care and union advocates directly accused the hospitals of wrongdoing.⁵⁵ Lawmakers

ILL. HOSP. ASS'N & METRO. CHI. HEALTHCARE COUNCIL, REPORT OF THE TASK FORCE ON CHARITY CARE AND COLLECTION PRACTICES FOR THE UNINSURED (2003).

⁵⁰ See, e.g., *Hearing on Hospital Billing and Collections*, *supra* note 28, at 89 (written statement of Kevin E. Lofton, Catholic Health Initiatives) (instructing debt collectors not to seek liens that would require sale or foreclosure of residence); *id.* at 102 (written statement of Herbert Pardes, New York Presbyterian Hospital) (stating that collectors should not seek foreclosure on residence or pursue income executions on patient's spouse); PATIENT FRIENDLY BILLING PROJECT, *supra* note 48, at 15; see also Liz Kowalczyk, *Hospital Softens Collection Tactics: State Agency Tells Baystate Some Policies Inappropriate*, BOSTON GLOBE, Jan. 27, 2005, at C1 (reporting on hospital's decision not to sue patients or place liens on homes except for largest unpaid bills).

⁵¹ See, e.g., JOHN KASPRAK, OFFICE OF LEGISLATIVE RESEARCH, CONN. GENERAL ASSEMBLY, HOSPITAL DEBT COLLECTION LAW (2004), available at <http://www.cga.ct.gov/2004/rpt/2004-R-0103.htm> (reporting that Yale-New Haven Hospital announced that it released ninety-five percent of its 2500 liens on area homes). It is possible that this is at least in part an admission that some of these patients should not have been liable for their bills in the first place because they were eligible for charity care or free bed funds.

⁵² See Tanya Albert, *Mississippi Hospital Agrees to Lower Charges for Uninsured Patients*, AM. MED. NEWS, Aug. 23, 2004, at 5; Ceci Connolly, *Tax-Exempt Hospitals' Practices Challenged: 46 Lawsuits Allege that Uninsured Pay the Most*, WASH. POST, Jan. 29, 2005, at A1 (explaining why settlement did not get finalized); Michele Molnar, *Discount Dilemma: Collecting from the Uninsured*, COLLECTIONS & CREDIT RISK, Oct. 2004, at 30.

⁵³ See, e.g., *Hearing on Hospital Billing and Collections*, *supra* note 28, at 83 (written statement of Anthony R. Tersigni, Ascension Health).

⁵⁴ See generally Thomas Kelley, *Rediscovering Vulgar Charity: A Historical Analysis of America's Tangled Nonprofit Law*, 73 FORDHAM L. REV. 2437 (2005) (exploring competing pressures on nonprofit institutions).

⁵⁵ See, e.g., CONN. CTR. FOR A NEW ECON., UNCHARITABLE CARE: YALE-NEW HAVEN HOSPITAL'S CHARITY CARE AND COLLECTIONS PRACTICES (2003), available at http://www.seiu.org/docUploads/Discriminatory_Pricing_yale_uncharitable_care.pdf; MED. BILLING TASK FORCE, CHAMPAIGN COUNTY HEALTH CARE CONSUMERS, MEDICAL DEBT REPORT: HOW MEDICAL DEBT AFFECTS CHAMPAIGN COUNTY CONSUMERS: A COMMUNITY REPORT ON MEDICAL DEBT-RELATED BANKRUPTCIES AND SMALL CLAIMS LAWSUITS (2002), available at http://www.prairienet.org/cchcc/Medical_Debt/med-dp2.htm. Some speculate that the unions took this position as leverage in a unionization fight. See, e.g., Washburn, *supra* note 23 (citing alderman saying union "is trying to muddy up

wanted to avoid intractable debates over the structural problems, such as covering the uninsured.⁵⁶ Changes in hospital pricing and practices could facilitate wider use of high deductible insurance plans in accordance with the goals of some patient advocates.⁵⁷ Recent attention on corporate responsibility and accountability may have increased the propensity to target hospital management as wrongdoers.⁵⁸

We believe that media portrayal of the issues also played a role.⁵⁹ In helping to shape public perceptions of problems,⁶⁰ the news media inevitably help frame the range of solutions considered.⁶¹ This possibility has led to research on the media's effect on the public's perceptions of the field of medicine, declining respect for health care professionals,⁶² and health care provider misdoings or failings.⁶³ For example, researchers have found that

the nuns in order to unionize their workers"); *Union Puts Heat on Hospital Group*, CHI. TRIB., June 15, 2004, at C3.

⁵⁶ See *Hearing on Hospital Billing and Collections*, supra note 28, at 4 (statement of Rep. Greenwood, Member, House Comm. on Energy & Commerce).

⁵⁷ See, e.g., Rhonda L. Rundle, *Activist for Uninsured Needles Hospitals—And Draws Blood*, WALL ST. J., June 10, 2003, at A1; Hospital Victims Project, <http://www.hospitalvictims.com> (last visited Dec. 6, 2005) (endorsing tax free health insurance certificate proposal for families to buy low cost insurance); Press Release, Florida Hospital Ass'n, *FHA Calls on K.B. Forbes to Cease Irresponsible Attack Ads and to Fully Disclose His Funding Sources and Insurance Ties* (Mar. 8, 2004), available at <http://news.banctec.com/clari/article.php?id=3&group=clari.biz.industry.insurance.releases>.

⁵⁸ See generally Thomas L. Greaney & Kathleen L. Boozang, *Mission, Margin, and Trust in the Non-Profit Health Enterprise*, 5 YALE J. HEALTH POL'Y L. & ETHICS 1 (2005).

⁵⁹ See, e.g., W. Lance Bennett, *Cracking the News Code: Some Rules that Journalists Live by*, in *DO THE MEDIA GOVERN?: POLITICIANS, VOTERS, AND REPORTERS IN AMERICA* 103 (Shanto Iyengar & Richard Reeves eds., 1997); Joel Best, "Road Warriors" on "Hair Trigger Highways": *Cultural Resources and the Media's Construction of the 1987 Freeway Shootings Problem*, 61 SOC. INQUIRY 327, 334-35 (1991); Neal R. Feigenson, *Accidents as Melodrama*, 43 N.Y.L. SCH. L. REV. 741, 742 (1999); Elayne Rapping, *Television, Melodrama, and the Rise of the Victims' Rights Movement*, 43 N.Y.L. SCH. L. REV. 665, 688-89 (1999). See generally RICHARD K. SHERWIN, *WHEN LAW GOES POP: THE VANISHING LINE BETWEEN LAW AND POPULAR CULTURE* 155-61 (2000).

⁶⁰ A significant thread of social science literature considers how the media shape or "frame" our conception of reality. See MICHAEL SCHUDSON, *THE SOCIOLOGY OF NEWS* 35 (2003) (defining framing as "principles of selection, emphasis, and presentation composed of little tacit theories about what exists, what happens, and what matters").

⁶¹ See generally Melissa B. Jacoby, *Negotiating Bankruptcy Legislation Through the News Media*, 41 HOUS. L. REV. 1091, 1107-15 (2004) (literature review).

⁶² See, e.g., Nazia Y. Ali et al., *Bad Press for Doctors: 21 Year Survey of Three National Newspapers*, 323 BRIT. MED. J. 782 (2001); Deborah Lupton & Jane McLean, *Representing Doctors: Discourses and Images in the Australian Press*, 46 SOC. SCI. MED. 947 (1998).

⁶³ See, e.g., Hannah Bradby et al., 'Sexy Docs' and 'Busty Blondes': *Press Coverage of Professional Misconduct Cases Brought Before the General Medical Council*, 17 SOC. HEALTH & ILLNESS 458, 470 (1995); Michael Calnan & Simon Williams, *Images of Scientific Medicine*, 14 SOC. HEALTH & ILLNESS 233 (1992); Jonathan Gabe et al., *Mediating Illness: Newspaper Coverage of Tranquilliser Dependence*, 13 SOC. HEALTH & ILLNESS 332, 344-45 (1991); Deborah Lupton, *Doctors in the News Media: Lay and Medical Audiences' Responses*, 34 J. SOC. 35 (1998); Huw Talfryn et al., *Public Trust and Accountability for Clinical Performance: Lessons from the National Press Reportage of the Bristol Hearing*, 5 J. EVALUATION CLINICAL PRAC. 335, 338 (1999) (finding hostile and emotive treatment of individual doctors and of the profession generally).

media coverage affects the likelihood and the nature of the government's response to allegations of problems with medications.⁶⁴ They also have explored how the media play a role in people's estimation of their risk of disease or their understanding of scientific findings.⁶⁵ These studies suggest the media have the power to frame, and might prefer to frame, the current debates in terms of hospital misbehavior—which would resonate with the public through its use of common and salient themes—rather than in terms of structural limitations.

In summary, a public problem characterized as hospital misbehavior has emerged. Whatever the reasons for such framing, the data we explore below suggest that the hospital misbehavior model is the wrong vehicle to prevent serious medical-related financial distress.

III. BEYOND HOSPITAL MISBEHAVIOR: AN EMPIRICAL INQUIRY

Several empirical projects cast doubt on the hospital misbehavior model by revealing the breadth of medical-related financial distress. We cite these sources throughout Part III, but in the text that follows, we focus principally on analyzing data collected from individuals who have filed for bankruptcy.

The federal bankruptcy system permits the collection of information on families in financial trouble. Under penalty of perjury, bankruptcy filers must file with federal courts substantial information about their financial circumstances.⁶⁶ They also must submit to an examination by a trustee and creditors.⁶⁷ Because the bankruptcy process is public, researchers can contact filers and ask them to complete questionnaires and follow-up interviews that substantially enrich the information in the courts' files. The opportunities to gather more data, combined with the extensive information already in the court records, make the bankruptcy system a particularly fruitful area for studying the origins of financial pressure—medical-related and otherwise—on households.⁶⁸

⁶⁴ See Jonathan Gabe & Michael Bury, *Halcion Nights: A Sociological Account of a Medical Controversy*, 30 SOC. 447, 459 (1996).

⁶⁵ See, e.g., Deena Blanchard et al., *Read All About It: The Over-Representation of Breast Cancer in Popular Magazines*, 35 PREVENTIVE MED. 343, 346–47 (2002) (finding a greater than 600% increase in number of breast cancer articles per year over a ten-year period compared with an increase of less than 50% for cardiovascular disease articles); Juanne N. Clarke, *Breast Cancer in Mass Circulating Magazines in the U.S.A. and Canada, 1974–1995*, 28 WOMEN & HEALTH 113, 114 (1999).

⁶⁶ Admin. Office of the U.S. Courts, Official Bankruptcy Form #1, Voluntary Petition, available at <http://www.uscourts.gov/bankform/b1-page2.pdf> (including signature and declaration under penalty of perjury that information provided in petition is true and correct); Admin. Office of the U.S. Courts, Official Bankruptcy Form #6, Declaration Concerning Debtor's Schedules, available at <http://www.uscourts.gov/bkforms/official/b6-decl.pdf>.

⁶⁷ See 11 U.S.C. § 341 (2000) (requiring meeting with trustee and creditors).

⁶⁸ For literature reviews, see Melissa B. Jacoby, Teresa A. Sullivan & Elizabeth Warren, *Rethinking the Debates over Health Care Financing: Evidence from the Bankruptcy Courts*, 76 N.Y.U. L. REV.

Bankruptcy filers as a group are not chronically disadvantaged, as distinguished from some of the individuals who were highlighted in the media's hospital misbehavior discussions and who come readily to mind in conversations about the uninsured or people struggling to pay medical bills.⁶⁹ The incomes of bankruptcy filers during the year before filing are low,⁷⁰ but their more enduring criteria—education, occupation, and homeownership—place many of them in the middle class.⁷¹ This characterization arguably makes the full set of data collected through the federal bankruptcy system even more relevant to testing the hospital misbehavior model because it makes clear that the scope of people at risk of medical-related financial failure is much broader than a hospital's charity care policy could address.⁷²

Commenced in 2001, Phase III of the Consumer Bankruptcy Project studies individuals who filed for bankruptcy in judicial districts in California, Texas, Illinois, Pennsylvania, and Tennessee.⁷³ The project has several

375, 378–82 (2001) [hereinafter Jacoby, Sullivan & Warren, *Rethinking the Debates*], and an updated supplement, Melissa B. Jacoby, *The Debtor-Patient: In Search of Non-Debt-Based Alternatives*, 69 BROOK. L. REV. 453, 454–61 (2004).

⁶⁹ See generally *Hearing on Hospital Billing and Collections*, *supra* note 28.

⁷⁰ In the year prior to filing for bankruptcy, the median income of medical bankruptcy filers was \$24,500, see David U. Himmelstein et al., *Market Watch: Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF., Feb. 2, 2005, at W5-63 exhibit 1, <http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.63/DC1>, which was less than half of the national median family income in 2000 (\$51,751), see CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, MONEY INCOME IN THE UNITED STATES: 2000, at 2 tbl.A (2001), available at <http://www.census.gov/prod/2001pubs/p60-213.pdf>, and almost 200% of the Federal Poverty Rate for a family of three that year (\$13,470), see JOSEPH DALAKER, U.S. CENSUS BUREAU, POVERTY IN THE UNITED STATES: 2000, at 5 (2001), available at <http://www.census.gov/prod/2001pubs/p60-214.pdf>.

⁷¹ See Elizabeth Warren, *The Economics of Race: When Making It to the Middle Is Not Enough*, 61 WASH. & LEE L. REV. 1777, 1782 (2004); Elizabeth Warren, *Financial Collapse and Class Status: Who Goes Bankrupt?*, 41 OSGOODE HALL L.J. 115 (2003) (reviewing socioeconomic status of 2001 bankruptcy sample). Overall, over ninety percent of the medical bankruptcy filers could be characterized as middle class on the criteria of college education, homeownership, or occupational prestige scores. The lists of codes for occupational prestige were developed by the National Organization for Research at the University of Chicago ("NORC"). See generally Robert W. Hodge, Paul M. Siegel & Peter H. Rossi, *Occupational Prestige in the United States, 1925–63*, 70 AM. J. SOC. 286 (1964); NORC, Summary of the Occupational Prestige Studies, <http://cloud9.norc.uchicago.edu/faqs/prestige.htm> (last visited Dec. 6, 2005).

⁷² For example, Kane and Wubbenhorst have found that even if all not-for-profit hospitals provided "care equal to the value of their tax exemptions," this would produce less than \$100 in new care per uninsured person per year. See Nancy M. Kane & William H. Wubbenhorst, *Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption*, 78 MILBANK Q. 185, 208 (2000).

⁷³ Phases I and II of the Consumer Bankruptcy Project ("CBP") were studies of individuals and families who filed for bankruptcy in 1981 and 1991 for which Professors Teresa Sullivan, Jay Westbrook, and Elizabeth Warren were the principal researchers. In 1999, Sullivan and Warren were joined by Melissa Jacoby to undertake a supplemental study of personal bankruptcy filers in eight judicial districts. What we now refer to as Phase III of the CBP is the study of individuals and families who filed for bankruptcy in 2001. Phase III relied on a diverse group of professors from research universities around the country to design and implement the study. In February 2001, the CBP started assembling a

components that together present an in-depth picture of medical problems and financial difficulty.⁷⁴ The filers represented in the project are a random sample of debtors who filled out written questionnaires prior to attending a meeting with the bankruptcy trustee and creditors.⁷⁵ The core sample is comprised of 1250 bankruptcy cases. A supplemental homeowner sample also was collected, bringing the total number of cases to 1771.

A subset of the filers participated in in-depth, follow-up telephone interviews, in which they discussed housing, self-employment, and medical problems and also offered detailed narrative accounts of their paths to the bankruptcy court.⁷⁶ Almost half (48%) of the debtors in the core sample completed a telephone questionnaire.⁷⁷ As part of the telephone survey, those debtors who specifically identified medical problems as a significant component of their financial distress responded to detailed inquiries regarding the circumstances that led to their bankruptcy filings.⁷⁸ In these surveys, respondents discussed issues such as diagnoses, time of illness or injury onset, source of health insurance coverage, responsibility for and amount of insurance premiums, employment status at illness onset, income sources during illness and reasons for loss of income during illness, types of medical debt, medical care utilization, and use of savings or credit products to make ends meet.⁷⁹

We had access to a third source of information about the debtors—court records⁸⁰—but we did not rely on this source for quantifying medical bills. In early studies, researchers examined claims filed with the court to estimate the impact of medical bills on bankruptcy filings.⁸¹ By 2001, how-

core random sample of 1250 debtors from five federal judicial districts in each of the states mentioned in the text. In each district, we first randomly selected Chapter 7 and 13 filers in the same proportion as the numbers of filers in that district. The CBP also created a supplemental sample of 521 homeowners from California, Illinois, and Pennsylvania, producing a sample of 1771 cases. All of the debtors are individuals, including individuals filing jointly. For a more detailed description of the selection of the districts and the sample, see ELIZABETH WARREN & AMELIA WARREN TYAGI, *THE TWO-INCOME TRAP: WHY MIDDLE-CLASS MOTHERS AND FATHERS ARE GOING BROKE* 181–88 (2003); Robert M. Lawless & Elizabeth Warren, *The Myth of the Disappearing Business Bankruptcy*, 93 CAL. L. REV. 743 (2005).

⁷⁴ See generally Himmelstein et al., *supra* note 70, at W5-63 (describing in detail medical-related aspects of the 2001 study).

⁷⁵ See Elizabeth Warren, *Bankrupt Children*, 86 MINN. L. REV. 1003, 1028–32 (2002) (reprinting questionnaire). The questionnaire was distributed at the meeting of creditors that takes place early in a bankruptcy case. See 11 U.S.C. § 341 (2000) (providing for meeting).

⁷⁶ See WARREN & TYAGI, *supra* note 73, at 181–88.

⁷⁷ In addition, debtors in the extended homeowner sample also completed telephone questionnaires for a total of 840 completed telephone surveys.

⁷⁸ See Himmelstein et al., *supra* note 70, at W5-65.

⁷⁹ See Consumer Bankruptcy Project Telephone Survey Coding Grid (on file with Northwestern University Law Review).

⁸⁰ WARREN & TYAGI, *supra* note 73, at 186.

⁸¹ See, e.g., TERESA A. SULLIVAN, ELIZABETH WARREN & JAY LAWRENCE WESTBROOK, *AS WE FORGIVE OUR DEBTORS: BANKRUPTCY AND CONSUMER CREDIT IN AMERICA* 168 (1989) (using 1981 data).

ever, people had changed substantially how they pay medical bills. Pharmacies, physicians, medical supply stores, physical therapists, home health care services, and a host of other health care providers routinely accept credit cards, which means that medical bills can take the form of general credit card debts and not medical debts in the court records. Even large and extraordinary outstanding debts, such as hospital bills or surgeon's fees, may not be identifiable. As we note later, some large medical obligations have been financed through second mortgages or home equity lines of credit. In other cases, the health care providers steered the debtors to a finance company to manage the credit end of the transaction. Because of these types of changes, we concluded that using court records to evaluate the impact of direct medical costs would result in a significant undercount.

In the section that follows, we explore data from the written questionnaires and from the telephone surveys, using what the debtors themselves told us about the medical and financial conditions that led to their bankruptcies. We then turn to data on specific types of medical-related financial distress that expose the severe limitations of the hospital misbehavior model.

A. *Filing for Bankruptcy in the Aftermath of Medical Problems*

Our research method relies heavily on self-reporting by debtors, and it is possible that debtors perceive the role of medical problems differently from an omniscient observer. Some might overstate the role of ill health because it seems to be a more acceptable explanation than, for example, overspending.⁸² Overstating is more difficult in the context of highly detailed questions over a period of time, as in the telephone surveys, but nonetheless is possible.⁸³ The role of medical problems may be understated as well. Some filers did not finish the written questionnaire and thus did not respond to the last question that asked them to indicate reasons for their bankruptcy filings; on the basis of the nonresponse, we count them as not having a medical reason for filing, which may or may not be correct.⁸⁴ In addition, some filers did not characterize their problems as medical-related even when health difficulties triggered their financial problems. For example, some said they filed for bankruptcy to save their homes from foreclosure; only later, in detailed questioning, would it emerge that the now-defaulted mortgage had been taken out to pay big medical bills. Others attributed financial downfall to large credit card debts or time off from work, obscuring what others might have considered medical reasons. In addition, debtors who participated in the telephone survey had a disincentive to re-

⁸² See Jacoby, Sullivan & Warren, *Rethinking the Debates*, *supra* note 68, at 384–85 (explaining over-attribution possibility).

⁸³ See Himmelstein et al., *supra* note 70, at W5-71.

⁸⁴ Of the 1250 in the core sample, 28 did not answer this last question, question twelve. Of the total sample of 1771 bankruptcy filings (core plus supplemental homeowner), 44 did not answer question twelve.

port medical-related financial problems. Respondents who said that medical problems did not play a role in their bankruptcies avoided another half an hour's worth of probing and sometimes embarrassing questions.⁸⁵

For these and other reasons, it is challenging to determine which debtors can be said to have “medical bankruptcies.”⁸⁶ We recognize that researchers might make different judgment calls about which debtors should be included and which should not in this category. To make the data as useful as possible, we offer a breakdown of the approaches in Figure 1 and the subsequent figures.

In the written survey, about 27% of the debtors from the core sample indicated illness or injury as a reason for filing bankruptcy, 7% identified the birth of a child as a reason for filing bankruptcy, and another 7% explained that a death in the family—which studies in the past have interpreted to have a medical component⁸⁷—precipitated their filings.⁸⁸ Among those from the core sample who took the telephone survey, about 35% of the debtors indicated illness or injury of self or family member, addition of a family member, or death of a family member as a reason for their bankruptcy filings.⁸⁹ When we combine responses from the written questionnaires and the telephone surveys, about 46% self-identified a medical reason (birth, death, illness, or injury) among their reasons for filing bankruptcy.⁹⁰

⁸⁵ Debtors were paid the same amount for their participation in the telephone survey (\$50) regardless of how many portions they completed. Some may have refused to respond to the medical portion to end the interview more quickly, whether or not their financial difficulties had a medical component. At the margins, this might have produced under-representation in the telephone surveys.

⁸⁶ See *supra* Part III.E and Figures 1–3.

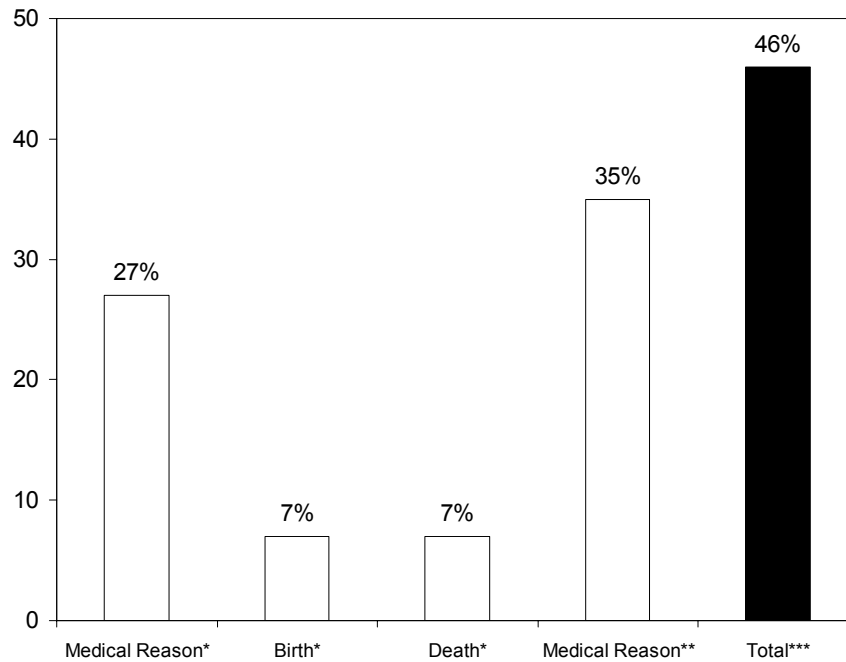
⁸⁷ See Jacoby, Sullivan & Warren, *Rethinking the Debates*, *supra* note 68, at 390.

⁸⁸ N = 1250.

⁸⁹ N = 602 (debtors with both telephone survey and written questionnaire).

⁹⁰ N = 602. Note that the N drops from the questionnaire data alone (1250 for the core sample) because the response rate on the follow-up telephone surveys was about half of all the core sample families that completed questionnaires. This means that any data that combine the paper questionnaires and telephone surveys can use only the smaller N from the telephone surveys. Because the “reasons” information is drawn from two sources instead of one, it is both different and more complete than the data reported in Himmelstein et al., *supra* note 70.

Figure 1: Debtors Identify Medical Reasons Behind Bankruptcy Filing



Source: 2001 Consumer Bankruptcy Project (*Written Questionnaire, N = 1250;
 Phone Survey, N = 602; *Phone/Written Combined, N = 602)

Our study collected other indications of medical-related financial distress whether or not the debtor self-identified medical reasons for filing. In the written questionnaire, about one in five debtors (21%) from the core sample indicated that they had lost at least two weeks' income because of a medical problem.⁹¹ In some situations, the primary wage earner was ill, and in others, the wage earner had to care for a child, spouse, or elderly relative. Either way, we surmised that the loss of at least two weeks' income constituted a hard financial blow for families of modest means.

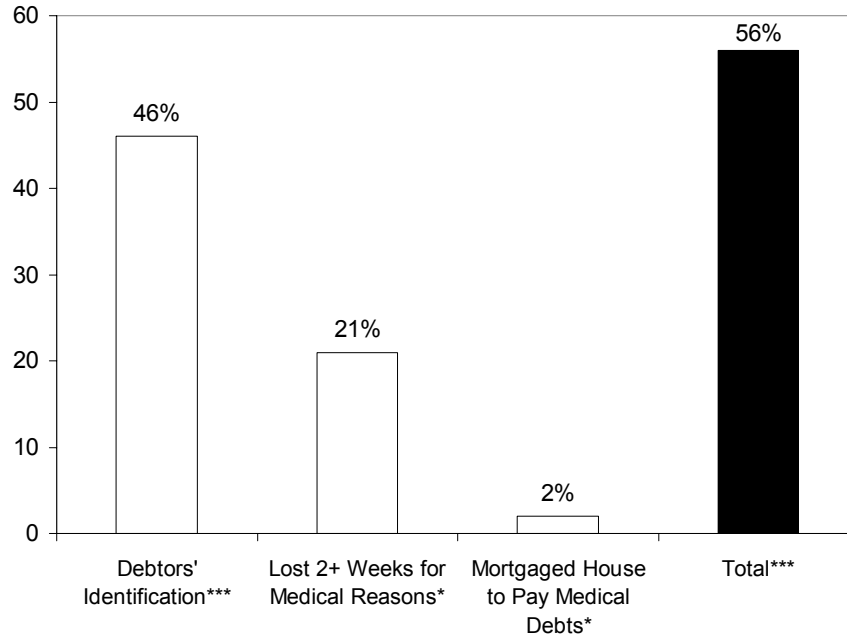
Some filers had mortgaged their homes in order to pay off medical debts. The numbers were modest—2% of the total sample, about 4% of the homeowners surveyed—but the impact on the family finances could be quite serious.⁹² Many but not all of those who mortgaged their homes or lost time from work had self-identified as filing for bankruptcy at least in part because of medical problems. Combining the data from self-

⁹¹ N = 1250.

⁹² N = 1250.

identifiers, as depicted in Figure 1, with these other filers increases the total percentage of medical-related filers to 56%.

Figure 2: Medical Reasons Plus Medical-Related Job Loss and Mortgages



Source: 2001 Consumer Bankruptcy Project
 (*Written Questionnaire, N = 1250; ***Phone/Written Combined, N = 602)

Other responses from filers also produce inferences of medical-related financial problems. For example, some researchers may want to include the 2% of the sample that identified alcohol and drug problems as a reason for filing.⁹³ For parents who explained that they had bankrupted themselves putting their teenaged children through substance abuse rehabilitation programs, this would seem to be an appropriate inclusion. Similarly, other researchers would want to include the 1% of the sample who identified a family member’s gambling problem as a reason for filing, recognizing that some families get left behind financially when a spouse or parent goes on a gambling binge, loses the house, and leaves everyone deep in debt.⁹⁴ In ad-

⁹³ N = 1250.

⁹⁴ Gambling is classified as a psychiatric disorder in the *Diagnostic and Statistical Manual of Mental Disorders*. See AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. text rev. 2000).

dition, about a quarter (26%) of the debtors in the core sample reported having medical bills in excess of \$1000 that were not covered by insurance in the two years before filing.⁹⁵

Not all researchers would agree that each of these three indicators, standing alone, should be characterized as a medical-related filing. To make the data as accessible as possible, we present our report both ways in Figure 3. If we exclude these three measures, the proportion of families filing for bankruptcy in the aftermath of a medical problem is 56%; if they are included, the number climbs to 63%.

By any analysis, this study finds a substantial number of families filing for bankruptcy in part to deal with the fallout from medical problems. If the proportions we observe in the 2001 Consumer Bankruptcy Project are representative of bankruptcy filers nationwide, this would mean that an estimated 668,000 to 915,000 families filed for bankruptcy in a single year, 2001, at least in part due to medical-related financial distress.⁹⁶ These numbers likely still pale in comparison with the number of debtors who avoid bankruptcy despite similar problems.⁹⁷ Yet, the experiences of bankruptcy filers are nonetheless relevant to evaluating the hospital misbehavior model.

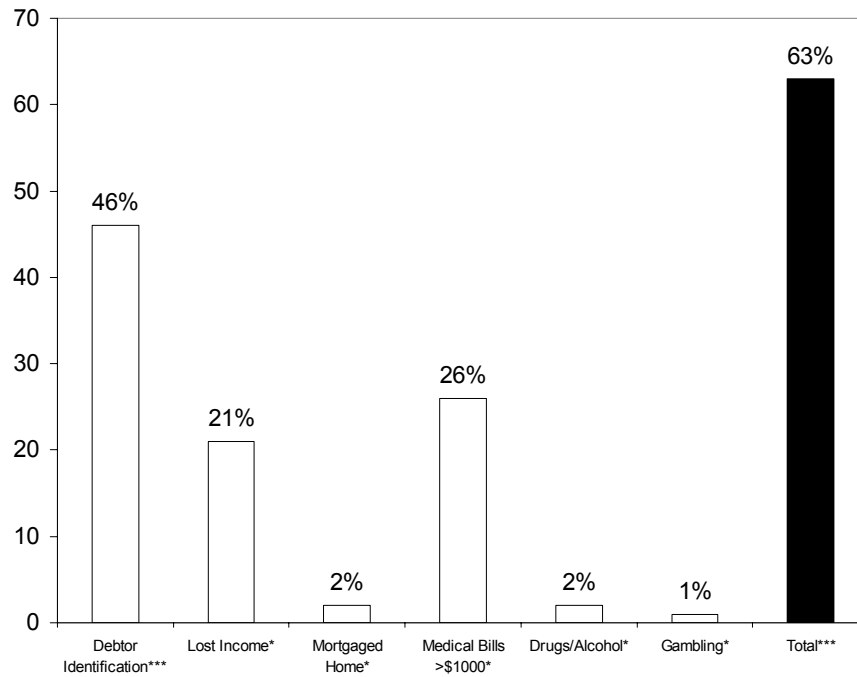
⁹⁵ N = 1250. The incomes for these households in the year before filing were quite modest. The median income was about \$25,000, and even at the 80th percentile, income was only slightly above \$40,000. Even an unpaid medical debt of \$1000 would likely cause a strain for many of these households. Of course, \$1000 is only the threshold number. The telephone surveys completed by a subset of the sample revealed medical debts at much higher amounts. See Himmelstein et al., *supra* note 70, at W5-70 (reporting mean out-of-pocket expenses of \$11,854) (N = 331).

⁹⁶ To estimate the number of families that will be affected, we use the data on bankruptcies from the Administrative Office of the United States (“AO”) courts. We follow the AO classification of cases into “business” and “non-business,” using the “non-business” classification as a proxy for the number of households filing for bankruptcy. In other work, the AO methods for distinguishing between business and non-business cases have been criticized because the count of “non-business bankruptcies” includes approximately 300,000 self-employed debtors, many of whom had small businesses that failed. See Lawless & Warren, *supra* note 73. In addition, the way in which the AO data are reported has changed over time, and this makes it difficult to evaluate trends in business and non-business filing rates from the mid-1980s. For the purposes of this work, however, the difficulties in distinguishing non-business filers from self-employed filers is less important. Whether they are wage earners or entrepreneurs, the non-business bankruptcies represent a household in financial trouble, and this is the appropriate unit of analysis here.

⁹⁷ See, e.g., USA TODAY, KAISER FAMILY FOUND. & HARVARD SCH. OF PUB. HEALTH, HEALTH CARE COST SURVEY: SUMMARY AND CHARTPACK 11 chart 3 (2005), available at <http://www.kff.org/newsmedia/upload/7371.pdf> [hereinafter HEALTH CARE COST SURVEY] (reporting that only a small percentage of sample who indicated medical-related financial distress filed bankruptcy); Michelle J. White, *Personal Bankruptcy Filing Under the 1978 Bankruptcy Code: An Economic Analysis*, 63 IND. L.J. 1, 50 (1987) (finding more households would benefit from bankruptcy than actually file); Press Release, Cambridge Consumer Credit Index, 83% of Americans with Medical Debts Say Those Debts Are Enough of a Burden to Prevent Them from Making Other Major Purchases (Feb. 7, 2004), available at http://www.cambridgeconsumerindex.com/index.asp?content=press_release (reporting that based on poll of over 800 adults, “83% of Americans say that debts they have incurred because of medical or dental procedures are burdensome enough to prevent them from buying large ticket items”); Amanda E. Dawsey & Lawrence M. Ausubel, *Informal Bankruptcy* (Apr. 12, 2004) (unpublished manuscript), available at <http://www.ausubel.com/creditcard-papers/informal-bankruptcy.pdf>.

As we explore below, the hospital misbehavior model does not capture the circumstances of these filers.

Figure 3: Medical-Related Bankruptcy - All Sources



Source: 2001 Consumer Bankruptcy Project

(*Written Questionnaire, N = 1250; ***Phone/Written Combined, N = 602)

B. Health Insurance and Medical-Related Indebtedness

Legislative, litigation, and voluntary hospital responses have targeted hospitals’ financial treatment of the low-income chronically uninsured, an approach that is consistent with the hospital misbehavior model.⁹⁸ Our study of bankruptcy filers, however, reveals that it is common for people with health insurance to develop medical-related financial problems.

⁹⁸ See, e.g., *Hearing on Hospital Billing and Collections*, *supra* note 28, at 283 (making clear that Ascension Health’s charity care policy is inapplicable to co-payments and deductibles of insured payments and providers of medical savings accounts).

Medical and nonmedical bankruptcy filers in the written questionnaire sample had similar health insurance rates at the time of the filing.⁹⁹ Almost seven out of ten (67.4%) medical filers said all family members had insurance at the time of the filing.¹⁰⁰ Among the telephone survey medical sample, more than three-quarters reported that the ill or injured person(s) had insurance at illness onset.¹⁰¹ More than eight out of ten (82.7%) of the ill or injured person(s) in the telephone survey medical sample were insured at the time of the telephone interview.¹⁰² Yet, medical debt caused financial difficulty for the insured. Indeed, those with private insurance at illness onset reported higher out-of-pocket costs on average (\$13,460) than those uninsured at illness onset (\$10,893).¹⁰³

These data are consistent with several other empirical studies of bankruptcy filers and of the general population. A study of individuals who filed for bankruptcy in 1999 reported a high rate of insurance coverage among bankruptcy filers who indicated that a medical problem contributed to their financial troubles.¹⁰⁴ Outside of the bankruptcy context, nationwide and local studies by groups such as the Commonwealth Fund, the Center for Studying Health System Change, the Kaiser Family Foundation, and the Access Project have observed significant financial vulnerability and medi-

⁹⁹ See Himmelstein et al., *supra* note 70, at W5-66 to -67 (measuring medical-related bankruptcy two ways and finding no statistically significant difference when comparing to debtors citing no medical cause).

¹⁰⁰ N = 1771 (core plus homeowner written questionnaire sample, weighted). *Id.* The figure for nonmedical filers was 65.5%, but the difference was not statistically significant.

¹⁰¹ See *id.* at W5-69.

¹⁰² N = 391 (core plus homeowner telephone survey sample, unweighted, measured by people instead of cases). Valid N = 329. The percentage calculated by cases rather than people results in a similar figure—82.83%. N = 331. Valid N = 297. *Id.*

¹⁰³ N = 331. See *id.* at W5-70 exhibit 5. These figures include those with no out-of-pocket costs. Possible explanations for lower costs for the uninsured include less health-seeking behavior and that some insured later lost coverage. Compare Wenke Hwang et al., *Out-of-Pocket Medical Spending for Care of Chronic Conditions*, 20 HEALTH AFF. 267, 272 (2001) (finding in a study of 1996 data that the mean out-of-pocket spending was higher for the uninsured than for the insured, although the uninsured were less likely to see a provider). These figures are significant when compared to the income levels of the written questionnaire sample. Himmelstein et al., *supra* note 70, at W5-66 exhibit 1 (median income \$24,500). It is also possible that these data reveal little about how much debt the insured and uninsured actually incur for medical treatment and simply identify the average point at which various people give up and file for bankruptcy. See generally *The Increase in Personal Bankruptcy and the Crisis in Consumer Credit: Hearing Before the Subcomm. on Admin. Oversight and the Courts of the S. Comm. on the Judiciary*, 105th Cong. 21 (1997) (prepared statement by Ian Domowitz, Professor, Northwestern University) (identifying unsecured medical debt as the single largest determinant of personal bankruptcy at the margin, explaining that medical debt in excess of two percent of income “results in a propensity to file which is 28 times that of the average household,” and noting that two percent of the general population had this much medical debt at the time of his study).

¹⁰⁴ See Jacoby, Sullivan & Warren, *Rethinking the Debates*, *supra* note 68, at 399–404 (finding about 80% of petitioners insured at time of filing, including about 80% of medical-related filers).

cal indebtedness even among the insured.¹⁰⁵ These findings come as no surprise to hospital executives and other commentators who observe that co-pays and deductibles among insured patients can be a significant part of a hospital's bad debt.¹⁰⁶

In addition to indicating medical-related indebtedness even for insured patients, the findings from the 2001 Consumer Bankruptcy Project also remind us that "insured" and "uninsured" are not stable categories. Among the telephone survey medical sample of bankruptcy filers, one-third of those with private coverage at illness onset reported that they lost coverage at some point during the course of their illness.¹⁰⁷ Assuming that our sample is

¹⁰⁵ See, e.g., SARA R. COLLINS ET AL., THE AFFORDABILITY CRISIS IN U.S. HEALTH CARE: FINDINGS FROM THE COMMONWEALTH FUND BIENNIAL HEALTH INSURANCE SURVEY xii, 17 (2004), available at http://www.cmf.org/usr_doc/collins_biennial2003_723.pdf (noting that two out of five adults had medical bill problems or accrued medical debt even though sixty-two percent had insurance); HEALTH CARE COST SURVEY, *supra* note 97, at 9 chart 1 (reporting that 61% of those having trouble paying medical bills were insured); JESSICA H. MAY & PETER J. CUNNINGHAM, CTR. FOR STUDYING HEALTH SYS. CHANGE, TOUGH TRADE-OFFS: MEDICAL BILLS, FAMILY FINANCES, AND ACCESS TO CARE 1 (2004), available at <http://www.hschange.org/CONTENT/689/689.pdf> (finding about 43 million people have medical debt problems even though about two-thirds have insurance); NAT'L PUB. RADIO, KAISER FAMILY FOUND. & HARVARD UNIV. KENNEDY SCH. OF GOV'T, SURVEY ON HEALTH CARE (2002), available at <http://www.kff.org/insurance/20020605a-index.cfm> (stating that over one fifth of families reported medical debt problems, including 15% of those with insurance); Cathy Schoen et al., *Insured but Not Protected: How Many Adults Are Underinsured?*, HEALTH AFF., June 14, 2005, at W5-289, W5-293, <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.289v1> (finding 12.3% of nonelderly adults underinsured); see also Deborah Gurewicz et al., *Medical Debt and Consumer Credit Counseling Services*, 15 J. HEALTH CARE POOR & UNDERSERVED 336, 340 (2004) (noting that about 75% of those with medical illnesses contributing to financial problems in Florida credit counseling sample reported having insurance at illness onset, and over half of insured reported having large medical debt); KAISER COMM'N ON MEDICAID & THE UNINSURED, KAISER FAMILY FOUND., CHALLENGES AND TRADEOFFS IN LOW-INCOME FAMILY BUDGETS: IMPLICATIONS FOR HEALTH COVERAGE (2004), available at <http://www.kff.org/medicaid/4147.cfm> (finding insured low income families with medical debt); CAROL PRYOR & DEBORAH GUREWICH, ACCESS PROJECT, GETTING CARE BUT PAYING THE PRICE: HOW MEDICAL DEBT LEAVES MANY IN MASSACHUSETTS FACING TOUGH CHOICES 6 (2004), available at <http://www.accessproject.org/downloads/MAreport.pdf> (reporting that over 40% in Massachusetts community health center user sample had medical debt problems, including almost 30% of those with insurance).

¹⁰⁶ See, e.g., Sharona Hoffman, *Unmanaged Care: Towards Moral Fairness in Health Care Coverage*, 78 IND. L.J. 659, 661 (2003); William D. White, *Market Forces, Competitive Strategies, and Health Care Regulation*, 2004 U. ILL. L. REV. 137, 162 ("[T]he net result of these cost sharing strategies is to expose employees to large out-of-pocket outlays in the event of serious illness."); Richard Haugh & Dagmara Scalise, *A Surge in Bad Debt: High Co-Pays and Deductibles Mean More Patients Can't Pay Hospital Bills in Full*, HOSP. & HEALTH NETWORKS, Dec. 2003, at 14; Reilly, *supra* note 29, at 7 (stating that increased cost-sharing is contributing to hospital bad debt).

¹⁰⁷ N = 331 (core plus supplemental homeowner telephone survey sample, weighted). The group that lost coverage amounts to nineteen percent of the telephone survey medical sample. For the debtors' reasons for losing coverage, see Himmelstein et al., *supra* note 70, at W5-67 exhibit 3. Gaps in coverage seem to correlate with greater out-of-pocket costs. In the written questionnaire sample, medical filers had a higher rate of reporting a gap in insurance than nonmedical filers. Over a third (38.4%) of medical bankruptcy filers in the written questionnaire sample reported at least one month lapse in insurance coverage for anyone in the household. When evaluating this finding, however, it is important to

even remotely representative of filers in other states, variable insurance status could complicate the application of Connecticut's new laws that calibrate the required financial treatment to insurance coverage and income.¹⁰⁸

Thus, one substantive limitation of the hospital misbehavior model is clear: the misbehavior model focuses on the chronically uninsured when medical-related indebtedness far transcends this group.¹⁰⁹ In addition, although policymakers may have good reasons to want to focus on those with no insurance, many people do not fit into hard and fast insurance categories.

C. *Non-Hospital Medical Care and Medical-Related Indebtedness*

The hospital misbehavior model focuses on the hospital as the provider of medical care and source of expenses. This results in solutions targeted directly to hospitals. As discussed below, some bankruptcy filers with significant medical debt identified hospital bills as their single largest expense, but even more struggled with bills from some other medical source.

Among a subset of the telephone survey medical sample who indicated that they incurred a significant medical debt, 42.5% identified hospital bills as the single biggest expense.¹¹⁰ Some might fit the profile of the patients featured in the news media. The role of hospital bills must be kept in perspective, however. If 42.5% of these filers identified hospital bills as their single biggest expense, that still leaves nearly 60% whose biggest expenses were something other than a hospital bill. For example, as shown in Figure 4 below, about one fifth (21%) identified prescription drugs as their biggest expense.¹¹¹ Another fifth (20%) identified doctor bills as their biggest expense.¹¹²

keep in mind that some of those who reported this gap may be uninsured at the time of filing. Among the telephone survey medical sample, ill or injured people with private coverage at illness onset, but who later lost it, reported an average of \$18,005 in out-of-pocket costs since onset as compared to those without any gap (\$9898). See Himmelstein et al., *supra* note 70, at W5-69 to -70 exhibit 5.

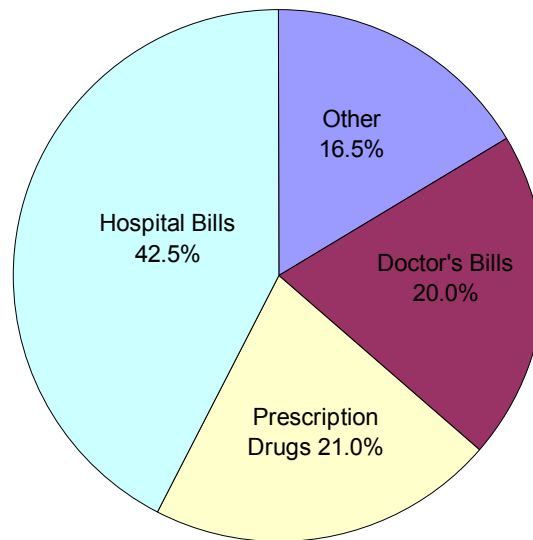
¹⁰⁸ See sources cited *supra* notes 34–38.

¹⁰⁹ See generally Jeffrey Prottas, *Costs, Charges, and Medical Debt: What is the Real Goal?*, 3 AM. HEART HOSP. J. 39, 41 (2005) (“[The] uninsured suffer the most, but the insured poor also carry a heavy burden of debt, and the problem is far from unusual among the middle class Focusing on the uninsured is a reasonable way to start, but it is clearly inadequate.”); *id.* at 42 (“Insurance failure is clearly contributing to the medical debt problem, perhaps on a scale comparable to the un-insurance problem.”).

¹¹⁰ See *supra* Figure 4; see also Himmelstein et al., *supra* note 70, at W5-69.

¹¹¹ See *id.* Among those filers eligible for Medicare and with psychiatric disorders, prescription drugs were the biggest expense for nearly all of them. See *id.* Compare Kenneth M. Langa et al., *Out-of-Pocket Health-Care Expenditures Among Older Americans with Cancer*, 7 VALUE HEALTH 186, 191 (2004) (finding that in a nationally representative study of older Americans, prescription drugs were the main source of increased out-of-pocket expenses among people undergoing cancer treatment). Whether or not the elderly will be aided by the Medicare prescription drug bill, see Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2469 (2003), those with trouble affording medications are not necessarily Medicare-eligible. See, e.g., Jae Kennedy & Christopher Erb, *Prescription Noncompliance Due to Cost Among Adults with Disabilities in the United States*,

**Figure 4: Largest Bills Not Covered by Insurance
Among Filers with Significant Medical Expenses**



Source: 2001 Consumer Bankruptcy Project (Phone Survey, Valid N = 196)

We were unable to determine through the debtors' bankruptcy court files whether hospitals were especially aggressive users of formal collection. The identity of the plaintiffs in lawsuits against debtors is often difficult to tell from bankruptcy records. We only can compare the percentage of medical-related and non-medical-related cases that identify a lawsuit. In doing so, we find no statistically significant difference between the two groups.¹¹³ We certainly cannot rule out the possibility that hospitals are

92 AM. J. PUB. HEALTH 1120, 1123 (2002) (stating that in the sample, twenty-seven percent of those with problems paying for drugs were eligible for Medicare).

¹¹² Himmelstein et al., *supra* note 70, at W5-69; *see also* Prottas, *supra* note 109, at 43 (observing that complaints about hospital collection practices may be applicable to other types of medical providers).

¹¹³ N = 1250 (core sample). Valid N = 1232. We compared the filers in the core sample who indicated on question twelve of the written questionnaire that illness or injury was a reason for filing to those who did not. Twenty percent of those filers had one or more lawsuits filed against them in the court records, as compared to 17.99% of those who did not indicate illness or injury on the written questionnaire. This difference was not statistically significant. The result does not change if we use a broader medical definition from Himmelstein et al., *supra* note 70, at W5-65, which includes those who indicated birth, death, lost work, or medical bills in excess of \$1000 within the two years prior to filing.

more aggressive collectors on the basis of this finding. Yet, it also adds no ammunition to the claim that hospitals require special regulation.

The fact that hospital bills are just one of many types of significant medical expense for individuals of modest means should not be surprising. For example, consumer out-of-pocket payments to hospitals are a tiny fraction of overall out-of-pocket payments in the United States.¹¹⁴ Doctor visits far exceed hospital visits.¹¹⁵ Studies in the medical literature have emphasized the role of nonhospital medical expenses when they evaluate cost-related underuse of health services and drugs.¹¹⁶ In one recent study, the overwhelming majority of older Americans in the study reported no out-of-pocket expenses for hospital or nursing home care, but most had other kinds of out-of-pocket medical expenses.¹¹⁷

Thus, the hospital misbehavior model hits another major limit. By focusing on the behavior of a single type of provider in the system, it omits consideration of many providers of health services and medications that contribute substantially to self-pay obligation, indebtedness, and sometimes bankruptcy.

D. Consumer Credit and Medical-Related Indebtedness

The hospital misbehavior model often assumes that hospitals remain creditors of their patients. As a result, many of the proposed interventions

¹¹⁴ U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES: 2004–2005, at 95 tbls.120–21 (2005) [hereinafter U.S. CENSUS BUREAU, STATISTICAL ABSTRACT] (reporting \$14.7 billion in out-of-pocket consumer payments to hospitals, and \$212.5 billion overall out-of-pocket payments in 2002). Payments to hospitals were less than those to physician and clinical services (\$34.2 billion), prescription drugs (\$48.6 billion), and nursing home care (\$25.9 billion). *Id.*

¹¹⁵ *Id.* at 109 tbl.154 (reporting 890 million physician office visits as compared to 110.2 million emergency department visits and 83.3 million outpatient department visits in 2002).

¹¹⁶ See, e.g., Jeffrey J. Ellis et al., *Suboptimal Statin Adherence and Discontinuation in Primary and Secondary Prevention Populations: Should We Target Patients with the Most to Gain?*, 19 J. GEN. INTERNAL MED. 638 (2004); Alex D. Federman, *Don't Ask, Don't Tell: The Status of Doctor-Patient Communication About Health Care Costs*, 164 ARCHIVES INTERNAL MED. 1723 (2004); Dana P. Goldman et al., *Pharmacy Benefits and the Use of Drugs by the Chronically Ill*, 291 J. AM. MED. ASS'N 2344 (2004); Haiden A. Huskamp et al., *The Effect of Incentive-Based Formularies on Prescription Drug Utilization and Spending*, 349 NEW ENG. J. MED. 2224 (2003); Kennedy & Erb, *supra* note 111; John D. Piette et al., *Problems Paying Out-of-Pocket Medication Costs Among Older Adults with Diabetes*, 27 DIABETES CARE 384 (2004) [hereinafter Piette et al., *Problems Paying Out-of-Pocket Medication Costs*]; John D. Piette et al., *Cost-Related Medication Underuse: Do Patients with Chronic Illnesses Tell Their Doctors?*, 164 ARCHIVES INTERNAL MED. 1749 (2004) [hereinafter Piette et al., *Cost-Related Medication Underuse*]; Michael A. Steinman et al., *Self-Restriction of Medications Due to Cost in Seniors Without Prescription Coverage*, 16 J. GEN. INTERNAL MED. 793 (2001); Robyn Tamblyn et al., *Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons*, 285 J. AM. MED. ASS'N 421 (2001); Rebecca Voelker, *When Cost Is an Adverse Drug Effect, Patients Cut Corners and Risk Health*, 292 J. AM. MED. ASS'N 2201 (2004) (summarizing recent studies); Dana G. Safran et al., *Prescription Drug Coverage and Seniors: How Well Are States Closing the Gap?*, HEALTH AFF., July 31, 2002, at W2-53.

¹¹⁷ See, e.g., Langa et al., *supra* note 111, at 190.

relate to restricting hospitals' debt collection activity. This approach inadequately takes into account the prominent and growing role that third-party credit plays in health care finance.

About three out of ten (29.3%) cases from the telephone survey medical sample reported use of credit cards for medical expenses.¹¹⁸ Although the data are not sufficiently detailed to determine whether the bills were big or small, paid off quickly or strung out over time,¹¹⁹ this percentage alone suggests that it is incorrect to simply assume that patients owe their medical bills directly to a hospital or other provider.

Going a significant step beyond unsecured credit, a small proportion of debtors mortgaged their homes to pay medical bills as we presented in Figure 2.¹²⁰ Among homeowners who had taken second or third mortgages on their homes, 15% had taken this step to finance their medical expenses.¹²¹ In the telephone survey medical sample, 13.8% of bankrupt homeowners with high cost mortgages cited a medical reason for the loan.¹²² They have taken a trip through bankruptcy and may owe nothing directly to a hospital, but these debtors will lose their homes if they do not repay this medical-related mortgage debt in full.

Bankruptcy filers are not alone in their use of consumer credit for medical expenses. Nationally representative studies have found families using personal loans, credit cards, and mortgages to finance medical bills.¹²³

¹¹⁸ N = 331 (core plus supplemental homeowner telephone survey sample, unweighted). This figure jumps to more than half (51.4%) if the filers with medical problems who charged basic necessities that may relate to health or general wellbeing are included.

¹¹⁹ The narrative accounts revealed some rather large amounts being financed through credit. For example, after insurance did not cover an emergency baby delivery, one new parent charged the entire \$17,000 bill to a credit card, starting a chain of financial problems. Consumer Bankruptcy Project Comment Index (on file with Northwestern University Law Review). A family used credit cards to finance monthly thousands of dollars of medications for a sick child because insurance would pay for blood transfusions but not drugs. A man used credit cards to buy supplies associated with a loved one's cancer treatments. Another filer reported that she regularly charged her health insurance premiums on a credit card. *Id.*

¹²⁰ See *supra* Figure 2 (core sample).

¹²¹ See Himmelstein et al., *supra* note 70, at W5-68 (core plus supplemental homeowners sample). In the written questionnaire sample, debtors with a thousand dollars or more in medical bills within the two years prior to filing were more likely than others to use a mortgage to finance medical bills (5% versus 0.8%). *Id.*

¹²² *Id.* A "high cost" mortgage refers here to one with an interest rate above twelve percent, or points plus fees of at least eight percent. *Id.*

¹²³ See, e.g., COLLINS ET AL., *supra* note 105, at 18 (reporting that one fifth of those with medical bill problems or medical debts charged large debts to credit cards or used home mortgage); HA T. TU, CTR. FOR STUDYING HEALTH SYS. CHANGE, RISING HEALTH COSTS, MEDICAL DEBT AND CHRONIC CONDITIONS 3 (2004), available at <http://www.hschange.org/CONTENT/706/706.pdf> (reporting that fifty percent of working-age adults with chronic conditions whose families had problems paying medical bills in past year had to borrow money to pay); Glenn B. Canner et al., *Recent Developments in Home Equity Lending*, 84 FED. RES. BULL. 241, 248 tbl.8 (1998) (reporting an increase in borrowers indicating medical expenses as use for home equity loans); Piette et al., *Problems Paying Out-of-Pocket Medication Costs*, *supra* note 116, at 387 (reporting that 14% of patients in sample, and 23% of those without

According to Visa, patients charged \$19.5 billion in health care services to Visa cards in 2001, which was made possible by the fact that most medical practices now accept credit cards.¹²⁴

In addition to the use of general purpose credit for medical care, medical providers may have unpublicized and informal relationships with lenders to provide credit to their patients to finance their care.¹²⁵ Furthermore, lenders offer medical-specific products. Examples of medical-specific credit products and receivables arrangements with providers include the Citi Health Card,¹²⁶ CareCredit (a division of GE Retail Sales Finance),¹²⁷ AccessOne,¹²⁸ MedCash,¹²⁹ Pxpert,¹³⁰ the King Thomason Group TotalCare Medical Accounts Receivable Credit Card Program,¹³¹ the HELPcard,¹³²

drug insurance coverage, increased credit card debt in order to afford prescription drugs). Other studies have reported the use of consumer credit in categories that have included medical debt. *See, e.g.*, HUD-TREASURY TASK FORCE ON PREDATORY LENDING, CURBING PREDATORY HOME MORTGAGE LENDING 31 (2000), available at <http://www.treas.gov/press/releases/reports/treasrpt.pdf> (citing a National Home Equity Mortgage Association survey finding that 30% of subprime home equity loans were used for covering medical, educational, and other expenses, as compared to 25% for home improvement and 45% for debt consolidation); Peter J. Brady et al., *The Effects of Recent Mortgage Refinancing*, 86 FED. RES. BULL. 441, 446 (2000) (reporting that 39% of 1998 and early 1999 refinancings were used for consumer expenditures, which includes medical expenses); JAVIER SILVA, A HOUSE OF CARDS: REFINANCING THE AMERICAN DREAM (2005), available at <http://www.demos-usa.org/pubs/AHouseofCards.pdf> (discussing Federal Reserve System Flow of Funds data from 2001–2002 showing that 25% of home equity fund were used for consumer expenditures, including medical expenses). *See generally* HEATHER C. MCGHEE & TAMARA DRAUT, RETIRING IN THE RED: THE GROWTH OF DEBT AMONG OLDER AMERICANS 6 (2004), available at http://www.demos-usa.org/pubs/Retiring_2ed.pdf (discussing the role of medical costs in increased credit card debt among older Americans).

¹²⁴ *See* Julie A. Jacob, *Credit to Your Practice: Letting Patients Pay with Plastic*, AM. MED. NEWS, July 29, 2002, at 13.

¹²⁵ *See, e.g.*, *Johnson v. Rutherford Hosp.*, 13 B.R. 185 (Bankr. M.D. Tenn. 1981) (involving hospital that arranged for credit). *See generally* Robert W. Seifert, *The Demand Side of Financial Exploitation: The Case of Medical Debt*, 15 HOUSING POL'Y DEBATE 785, 795 (2004).

¹²⁶ Citibank Health Card Program, http://www.citibank.com/us/cards/cardserv/healthcrd/cons_benefits.htm (last visited Nov. 14, 2005).

¹²⁷ *See* Tyler Chin, *Mastercard of Your Own Domain: Instant Pay, with No Paperwork*, AM. MED. NEWS, Jan. 12, 2004, at 16 (reporting that GE Sales Finance declined to discuss in detail but said it was targeting high-dollar specialty practices); Welcome to CareCredit, <http://www.carecredit.com> (last visited Nov. 14, 2005).

¹²⁸ *See* Daniel Costello, *Hospital Bills—But with Interest*, L.A. TIMES, Dec. 12, 2005, at F1 (noting that patients who are unable to pay can get credit cards specifically for medical expenses, but that interest rates can reach twenty-three percent); Mike Stobbe, *Credit Card Agency Cuts Hospitals' Losses*, CHARLOTTE OBSERVER, July 11, 2003, at 1D (discussing AccessOne program); Access One MedCard, <http://www.accessonemedcard.com> (last visited Nov. 14, 2005).

¹²⁹ *See* Michael Unger, *Just What the Doctor Ordered: Schein's One-Stop Service Ranges from Equipment to Personal Finance*, NEWSDAY, Dec. 30, 1996, at C7.

¹³⁰ *See* Chin, *supra* note 127 (stating PracticeXpert program will be targeting patients with poor credit histories); Press Release, King Thomason Group Inc., PracticeXpert Launches Pxpert Medical Credit Card Program (Aug. 4, 2003), available at <http://www.kgth.com/main/News-August42003.htm> (acquiring delinquent accounts from physician, transferring balance to credit card).

¹³¹ *See* Press Release, King Thomason Group Inc., King Thomason Group Enters into Agreement with Medical Capital Corporation to Market KTG's TotalCare Medical Accounts Receivable Credit

MediCredit,¹³³ and HealthEZ.¹³⁴ The Federal Trade Commission has noted the existence of a “well-established market” for medical-specific loans.¹³⁵

This discussion reinforces our concern that an account of medical-related financial distress that depends on the misbehavior of a specific type of provider is unproductive. Third-party lenders are a significant component of health care finance for individuals who are unable to pay the self-pay portion of medical bills out of current earnings or assets. Although some long-standing and new collection restrictions might apply to third-party lenders if applied literally, it is far from clear that lawmakers have contemplated how to implement their ideas in the context of multipurpose credit products.¹³⁶ From the vantage point of the debtor-creditor system, it makes little sense to impose more restrictive collection rights on one kind of creditor (hospitals) than on another (third-party lenders) when they are owed money from the same population and, at least originally, for the same services.¹³⁷

E. Income and Medical-Related Indebtedness

The hospital misbehavior model focuses on the medical-related financial distress that flows principally from the direct cost of care and, specifi-

Card Program (Apr. 23, 2004), available at <http://www.kgth.com/main/News-April232004.htm> (citing ninety-five percent approval rate for private pay patients). KTG also offers a structured payment plan as an alternative to credit cards.

¹³² The HELPCard, <http://www.helpcard.com/consumer/helpisprovided.html> (last visited Nov. 14, 2005).

¹³³ This credit product is used by patients of the Inova Health System, to be distinguished from the financier of cosmetic surgery with the same name.

¹³⁴ Larry Werner, *War Stories About Start-Up Funding Leave 'Em Laughing*, MINN. STAR TRIB., July 2, 2003, at 1D; HealthEZ Home Page, <http://www.healthEZ.com> (last visited Nov. 14, 2005) (encouraging employers to supplement health plans by adding HealthEZ).

¹³⁵ See FTC, COMMENTS ON PROPOSED RULE PART 717, FAIR CREDIT REPORTING—MEDICAL INFORMATION 4 (2004), available at <http://www.ftc.gov/os/2004/05/040528factacomments.pdf>.

¹³⁶ The existing statutes that restrict medical debt collection are, in some instances, ambiguous in their intent to cover third-party lenders. See *supra* notes 33–47 and accompanying text; *infra* notes 183–185 and accompanying text. Yet, applying these restrictions to general purpose lenders will be very difficult. For example, open-end consumer credit may be used for medical purposes as well as other expenses and thus will raise a host of tracing problems. In addition, property exemptions generally restrict unsecured creditors that become judgment creditors but not creditors that receive consensual security interests. Thus, it is unlikely that the restrictions would affect the entitlements of mortgage lenders.

¹³⁷ See, e.g., Jacoby, Sullivan & Warren, *Rethinking the Debates*, *supra* note 68, at 411 (questioning whether it is appropriate for consumer credit industry to seek better bankruptcy protection for itself than for medical providers). We recognize that others may see principled reasons to support hospital-based restrictions stemming from duties associated with religious or not-for-profit status. In addition, hospital misbehavior may be contributing to the use of third-party credit if hospitals encourage low-income patients to finance their obligations rather than screen them for charity care. See, e.g., *Hearing on Hospital Billing and Collections*, *supra* note 28, at 3 (statement of Rep. Greenwood, Member, House Comm. on Energy & Commerce); Protas, *supra* note 109, at 41 (observing from a small study of hospital billing that the hospital billing process starts with requests for payments, with consideration of discounts possibly arising later).

cally, from hospitals' inappropriate handling of patient accounts. In this section, we explore the important role of income loss, which so often is omitted from accounts of medical-related financial distress.

The bankruptcy data contain several indicia that medical-related indebtedness is not just a consequence of direct medical bills. For example, bankruptcy filers sometimes indicate illness or injury as a reason for filing even if they do not indicate personal liability for large medical bills.¹³⁸ As noted earlier, about one in five debtors (21%) from the core sample indicated that they had lost at least two weeks' income because of a medical problem.¹³⁹

Among those who had identified a medical reason for filing in the telephone survey sample, four out of ten (40.1%) said that medical debt was *not a factor at all* in their decision to file.¹⁴⁰ Half (50.8%) said that prescription drug costs were not a factor at all.¹⁴¹ But slightly more than seven out of ten (71.6%) reported that income loss due to health problems contributed "very much" to their bankruptcies and another 8.6% said income loss contributed "somewhat" to their bankruptcies.¹⁴²

The long-term diagnoses of the filers reinforce the role that income loss may continue to play in their financial outlook. Slightly over half (51.7%) of the medical problems identified in the telephone survey sample involved ongoing chronic illnesses, some of which may continue to complicate earning capacity.¹⁴³ Although we cannot prove that the filers' health conditions made them disabled in accordance with applicable definitions,

¹³⁸ In the 2001 written survey sample, more than a quarter of all filers in the written questionnaire sample identified illness or injury as a reason for filing, whether or not they owed large medical debts. See Himmelstein et al., *supra* note 70, at W5-67 exhibit 2 (N = 1771). See generally Jacoby, Sullivan & Warren, *Rethinking the Debates*, *supra* note 68, at 388 (stating that 54.9% of those who said illness or injury was a reason for filing for bankruptcy did not identify a current debt to a medical provider).

¹³⁹ See *supra* Figure 2. N = 1250 (core sample). The rate is nearly identical (21.3%) if the homeowner sample is added and weighted into the analysis as well. See Himmelstein et al., *supra* note 70, at W5-67 exhibit 2.

¹⁴⁰ N = 331 (core plus supplemental homeowner telephone survey sample, unweighted).

¹⁴¹ N = 331.

¹⁴² N = 331. The filers' narrative accounts, even if not representative, also illustrate the range of circumstances in which income loss follows both longer-term and acute problems. For example, open-heart surgery and its aftermath led to loss of temporary work and a resulting loss of income for one filer. See Consumer Bankruptcy Project Phase III Comment Index (on file with Northwestern University Law Review). Others told interviewers they had missed too much work due to chronic illness or hospitalizations and either could not work out an arrangement with employers or were advised by doctors to take different types of jobs. Doctors ordered bed rest for pregnant women who had been in car accidents or who had developed gestational diabetes; one consumed all her allotted family leave before the baby was born and soon after was fired. A number of others explained that they had difficulty receiving their workers' compensation benefits or were receiving benefits at levels far below their prior incomes. *Id.*

¹⁴³ Himmelstein et al., *supra* note 70, at W5-69. For example, more than a quarter (26.6%) reported cardiovascular problems as a primary or secondary diagnosis. Nearly a third had trauma, orthopedic, or back and spine problems. Almost one out of ten (9.5%) reported cancer. Approximately 10% reported diabetes. *Id.*

only 21.2% of the ill people employed at the time of illness onset in the telephone survey medical sample reported that their employer had offered them long-term disability insurance coverage,¹⁴⁴ and only about 15% of that same sample reported actually having some form of long-term disability insurance coverage.¹⁴⁵

Complicating the role of income loss is the fact that the bankruptcy filers often were not themselves ill or injured but lost income while taking care of sick relatives.¹⁴⁶ Of the bankruptcy filers who had curtailed paid employment as a result of a medical problem, more than half (52.8%) did so to take care of someone else.¹⁴⁷ In 13.3% of the medical bankruptcy cases involved in the follow-up telephone survey, primary earners were trying to take care of a sick child.¹⁴⁸ The filers tell stories of premature births and chronically ill or disabled children with constant care needs. Among those in the sample were parents who reported missing months of work when a child with spinal bifida required repeated operations, when a baby was born with heart defects, or when an infant with sickle cell anemia needed special care.¹⁴⁹ A parent faced substantial work disruptions because of an autistic child, and yet another lost income to deal with an epileptic child.¹⁵⁰ A child with severe bipolar and anxiety disorder required twenty-four hour monitoring, leading first to significant leaves of absence and eventually to job loss for the child's mother.¹⁵¹ After being told by doctors that their son with kidney problems would die, one set of parents moved the entire family to a different state with hopes of better treatment and a different prognosis.¹⁵²

¹⁴⁴ N = 391 (core plus supplemental homeowner telephone survey sample, unweighted, measured by people instead of cases). Valid N = 332.

¹⁴⁵ In 15.48% percent of the cases, the ill or injured person reported having disability insurance. N = 391 (core plus supplemental homeowner telephone survey sample, unweighted, measured by people instead of cases). Valid N = 241. Respondents were asked this question only if the ill or injured person at issue was employed part-time or full-time by a third party at the time of the illness or injury. Even if some ultimately could prove entitlement to disability payments under one of the Social Security programs, the level of income replacement would be low and thus would not necessarily forestall major financial trouble. See generally TERESA A. SULLIVAN, ELIZABETH WARREN & JAY LAWRENCE WESTBROOK, *THE FRAGILE MIDDLE CLASS: AMERICANS IN DEBT* 158-63 (2000).

¹⁴⁶ See generally B.F. Hughes et al., *Pediatric Femur Fractures: Effects of Spica Cast Treatment on Family and Community*, 15 J. PEDIATRIC ORTHOPEDICS 457 (1995) (discussing costs of casting for femur fractures, including average of three weeks of lost work for parent in families with two working parents); Carol E. Smith et al., *Efficiency of Families Managing Home Health Care*, 73 ANNALS OPERATIONS RES. 157 (1997).

¹⁴⁷ See Himmelstein et al., *supra* note 70, at W5-69.

¹⁴⁸ See *id.*

¹⁴⁹ See Consumer Bankruptcy Project Phase III Comment Index (on file with Northwestern University Law Review).

¹⁵⁰ *Id.*

¹⁵¹ *Id.*

¹⁵² *Id.*

Some bankruptcy filers reported caring for the children of their seriously ill siblings.¹⁵³

Other filers reported losing income to care for spouses, aging parents, or other relatives. One man cared for his wife while she battled lung cancer, while another went back to work only after his wife had three operations in six months and finally was able to walk down the hallway of their home without his help.¹⁵⁴ An adult daughter struggled to help with her mother's medical bills not covered by Medicare and eventually took unpaid family leave so she could take her mother for medical treatments.¹⁵⁵ Adult children temporarily or permanently moved in with parents to help them cope with the effects of chronic or terminal illnesses.¹⁵⁶ One man cared for an uncle with cancer while trying to raise a toddler grandson and assist his son with college.¹⁵⁷

The statistics and stories suggest again that structural limitations of health care finance—not the misbehavior of any one provider—is the real story of medical-related financial distress. By focusing on the provider, the hospital misbehavior model ignores significant indirect costs of illness or injury for both the ill person and her extended family.

F. Summary

In Part III, we have used data from bankruptcy filings, supplemented by other studies, to present a broader picture of the components of medical-related financial distress. Allegations of misbehavior should not be ignored. Yet, a behavioral explanation for a largely structural problem has limited utility in the long run. In Part IV, we put allegations of hospital misbehavior within the context of debtor-creditor law.

IV. A LEGAL PERSPECTIVE ON HOSPITAL MISBEHAVIOR

The hospital misbehavior model contains three components relating to hospital treatment of low-income uninsured patients: pricing,¹⁵⁸ charity care and discounts,¹⁵⁹ and debt collection tactics.¹⁶⁰ The media stories and fol-

¹⁵³ *Id.*

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

¹⁵⁸ See generally ROBERT J. HOBBS ET AL., NAT'L CONSUMER LAW CTR., FAIR DEBT COLLECTION 588–90 (2004) (describing legal challenges to list prices paid by uninsured patients as meeting with “mixed success”).

¹⁵⁹ *Id.* at 590. This point is bolstered by allegations that hospitals receive millions of dollars in state funds to subsidize patients who cannot afford to pay. See, e.g., Ahmad v. Yale-New Haven Hosp., No. (X02)CV040183725S, 2004 WL 2361781 (Conn. Super. Ct. Sept. 29, 2004) (seeking class action and alleging that hospital failed to notify patients of eligibility for funds that would have entitled them to free care instead of liability and debt collection); Elisabeth Benjamin & Kat Gabriesheski, *The Case for Reform: How New York State's Secret Hospital Charity Care Pool Funds Fail to Help Uninsured and*

low-up legal interventions have involved unprecedented scrutiny of hospitals' efforts to collect their bills.¹⁶¹ We focus here principally on debt collection tactics, both because this is our area of study and because the indebtedness that triggers collection will persist for many patients even if hospitals stop misbehaving in other respects.¹⁶²

Again, we do not purport to speak to the tax-related issues surrounding not-for-profit providers. From a debtor-creditor perspective, however, the very idea that hospitals misbehave when they engage in formal collection activity for legally valid debts conflicts with the existing framework. No matter how distasteful, many of the challenged hospital collection practices are legal, common, and even encouraged. If the practices are beyond what our society can tolerate or are thought to be inefficient, then the practices should be changed or banned more broadly.¹⁶³

Section A looks briefly at how medical providers are encouraged to pursue collection through special legal rights. Section B explains the basis for legal liability for medical bills that triggers collection, even in the absence of special legal rights.

Underinsured New Yorkers, 8 N.Y.U. J. LEGIS. & PUB. POL'Y 5 (2005); ELISABETH BENJAMIN ET AL., LEGAL AID SOC'Y, STATE SECRET: HOW GOVERNMENT FAILS TO ENSURE THAT UNINSURED AND UNDERINSURED PATIENTS HAVE ACCESS TO STATE CHARITY FUNDS (2003), available at <http://www.legal-aid.org/Uploads/BDCCReport.pdf>.

¹⁶⁰ See, e.g., *Gibson v. Yale-New Haven Hosp.*, No. CV980414230S, 2003 WL 22079573 (Conn. Super. Ct. Aug. 18, 2003) (alleging that hospital's collection attempts ran afoul of unfair trade practice laws because care was rendered in connection with workers' compensation claim); CONN. CTR. FOR A NEW ECONOMY, YALE, DON'T LIEN ON ME: THE ATTACK ON HOMEOWNERSHIP BY THE YALE-NEW HAVEN HEALTH SYSTEM AND YALE SCHOOL OF MEDICINE (2003), available at <http://www.ctneweconomy.org/publications.html>.

¹⁶¹ See, e.g., Lagnado, *supra* note 15; Lagnado, *Twenty Years—And He Isn't Paying Any More*, *supra* note 27.

¹⁶² See, e.g., Prottas, *supra* note 109, at 41 (“[G]iving the uninsured the same discounts as hospitals give insurance companies will remove an injustice without doing justice. . . . A 30% decrease in an unpayable bill will generally result in a smaller unpayable bill, but the credit implications of an unpaid bill are largely independent of its size.”). Prottas also notes that giving a self-pay patient the same discount as Blue Cross/Blue Shield may “still leave an individual family with a bill that leaves them permanently in debt with ruined credit and without a hope of ever buying a home. It is irrelevant to a low-income person with health insurance, whose deductible and co-payments leave them in the same situation.” *Id.* at 43; see also Singer, *supra* note 21, at 627 (“[EMTALA is] essentially an unfunded mandate, requiring hospitals to act but not necessarily compensating them to do so, unless the patient has insurance. As such, it indirectly imposes costs on all of us, at a time when resources might be better deployed toward developing a comprehensive system of care.”).

¹⁶³ See generally DAVID CAPLOVITZ, CONSUMERS IN TROUBLE: A STUDY OF DEBTORS IN DEFAULT 288 (1974); WINTON E. WILLIAMS, GAMES CREDITORS PLAY: COLLECTING FROM OVEREXTENDED CONSUMERS (1998); Richard M. Hynes, *Why (Consumer) Bankruptcy?*, 56 ALA. L. REV. 121, 140–43 (2004) (discussing proposals to limit or prohibit formal collection of unsecured debts as a replacement for bankruptcy discharge); Arthur Leff, *Injury, Ignorance and Spite—The Dynamics of Coercive Collection*, 80 YALE L.J. 1 (1970); Robert E. Scott, *Rethinking the Regulation of Coercive Creditor Remedies*, 89 COLUM. L. REV. 730 (1989); William C. Whitford, *A Critique of the Consumer Credit Collection System*, 1979 WIS. L. REV. 1047.

A. Medical-Specific Entitlements and Restrictions

The idea that hospital debt collection is inappropriate is in tension with state laws that give medical providers special debt collection rights.¹⁶⁴ The most common form of preference for medical providers comes in the form of in rem rights in patients' personal injury lawsuits, settlements, or insurance proceeds.¹⁶⁵ Hospital lien laws come in a staggering array of options not only in terms of the requirements and limits on lien enforcement, but with respect to the range of providers that benefit. For example, although a few states grant these statutory liens to only a subset of hospitals,¹⁶⁶ many others grant these liens to a wider range of providers, such as ambulance services, physicians, nursing homes, nurses, chiropractors, and dentists.¹⁶⁷ Hospital liens generally have been honored and preserved in patients' bankruptcy cases as long as the providers have complied with applicable state statutory requirements.¹⁶⁸

¹⁶⁴ Although a public choice analysis of these laws is beyond the scope of this Article, we cannot rule out the possibility that the hospitals overreached in their advocacy for increased protection.

¹⁶⁵ See, e.g., *Trevino v. HHL Fin. Servs., Inc.*, 945 P.2d 1345 (Colo. 1997); *Maynard v. Parker*, 369 N.E.2d 352 (Ill. App. Ct. 1977); *Martinez v. St. Joseph Healthcare Sys.*, 871 P.2d 1363 (N.M. 1994); *Hillcrest Med. Ctr. v. Fleming*, 643 P.2d 868 (Okla. Civ. App. 1982); *Bashara v. Baptist Mem'l Hosp. Sys.*, 685 S.W.2d 307 (Tex. 1985). See generally Erik V. Larson & Diana L. Panian, *Successfully Discharging Medical Liens in Personal Injury Cases*, 32 CUMB. L. REV. 349 (2002); Karen L. Neal, *Ten Basic Facts to Know—The Texas Hospital Lien Statute*, 61 TEX. B.J. 428 (1998); Michael J. Adrian, Comment, *The Nation's Medical Quandary Concerning Hospital and Physician Liens: Who Should Pick up the Check?*, 23 ST. LOUIS U. PUB. L. REV. 427 (2004); Jay M. Zitter, Annotation, *Physicians' and Surgeons' Liens*, 39 A.L.R.5th 787, 797–98 (1996).

¹⁶⁶ See, e.g., DEL. CODE ANN. tit. 25, § 4301 (2005) (charitable only); N.Y. LIEN LAW § 189 (McKinney 2005) (charitable and public); N.D. CENT. CODE § 35-18-01 (2003) (charitable only); WIS. STAT. ANN. § 779.80 (West 2005) (charitable only).

¹⁶⁷ See, e.g., ARK. CODE ANN. § 18-46-104 (West 2005) (hospitals, nurses, physicians, and ambulance services); MO. REV. STAT. § 430.225 (2005) (doctors, therapists, chiropractors, hospitals, nurses, psychologists, ambulatory surgical facilities, social workers, and professional counselors); N.J. STAT. ANN. § 2A:44-36 (West 2005) (hospitals, nursing homes, physicians, and dentists); WASH. REV. CODE § 60.44.010 (2005) (hospitals, nurses, physicians, and ambulance services).

¹⁶⁸ See, e.g., *Rafool v. Associated Anesthesiologists, S.C. (In re Cagle)*, No. 00-82350, 2002 WL 750835 (Bankr. C.D. Ill. Mar. 5, 2002) (holding that trustee cannot avoid hospital statutory lien); *Barber v. Trinity Med. Ctr. (In re Stotler)*, No. 99-82013, 2001 WL 1851241 (Bankr. C.D. Ill. July 6, 2001) (holding that provider's lien was valid under section 545 of Bankruptcy Code); *St. John Med. Ctr. v. Innis (In re Innis)*, 181 B.R. 548 (Bankr. N.D. Okla. 1995) (upholding hospital lien securing claim of over \$230,000); *In re Pohrman*, 146 B.R. 570 (Bankr. D. Or. 1992) (upholding three hospital liens); *Benjamin v. Bd. of Regents (In re Benjamin)*, No. 92-60183, 1992 WL 12004439 (Bankr. S.D. Ga. Aug. 20, 1992); *Medcenter One, Inc. v. Dueis (In re Dueis)*, 130 B.R. 83 (Bankr. D.N.D. 1991) (upholding hospital lien); *St. Mary's Med. Ctr. v. Nelson (In re Nelson)*, 92 B.R. 837 (Bankr. D. Minn. 1988); *Janssen v. Wash. Hosp. Ctr. (In re Janssen)*, 42 B.R. 294 (Bankr. E.D. Va. 1984) (holding that a hospital lien held for longer than ninety days before bankruptcy not avoidable as a preference); *In re Shahan*, 40 B.R. 608 (Bankr. N.D. Tex. 1984) (holding that lien of hospital district cannot be avoided as preferential transfer, but doctor's lien might be vulnerable); *Howard v. Wash. Hosp. Ctr. (In re Howard)*, 43 B.R. 135 (Bankr. D. Md. 1983) (holding lien not avoidable as preferential transfer). But see *Oglesby v. S.E. Neurologic Assocs. P.C. (In re Oglesby)*, Nos. 99-30214, 99-03011A, 2000 WL 33943203 (Bankr. S.D. Ga. Sept. 27, 2000) (holding doctor's nonstatutory lien avoidable); *Malloy v. St. John Med. Ctr. (In re Wood-*

Sometimes state laws give providers or the government statutory liens on other kinds of personal property or on real property due to the receipt of medical care. In Idaho, for example, if a patient applies for financial assistance with her hospital bill, this triggers the attachment of an automatic lien to any real and personal property and insurance benefits.¹⁶⁹ In South Dakota, a county gets a statutory lien on real or personal property, then owned or thereafter acquired, of a former patient, if the county reimbursed the hospital for the patient's care.¹⁷⁰ Similarly, in New Mexico, a government payment to a hospital or health provider on behalf of an indigent patient creates a lien against "all real property or interest in real property vested in or later acquired by the indigent patient or any person legally responsible for his debts"¹⁷¹ New Jersey imposes a lien on "any goods, rights, credits, chattels, moneys or effects" owned or held by the patient who receives medical care and hospitalization that is compensated by a county.¹⁷² In North Carolina, city- or county-owned or supported ambulance services have a special right to attach real property.¹⁷³ In Oregon, ambulance operators have a lien on insurance proceeds even if the ambulance ride was not precipitated by an accident.¹⁷⁴

Other states permit hospitals to engage in certain kinds of standard debt collection, even when those practices are prohibited for other creditors. For example, in North Carolina, public hospitals (and city- or county-owned ambulance services) are one of the few kinds of creditors permitted to garnish wages, although the privilege is conditioned on a number of factors.¹⁷⁵ Even some of the bills introduced in state legislatures in the wake of the re-

ward), 234 B.R. 519 (Bankr. N.D. Okla. 1999) (avoiding liens of hospitals and doctor due to state law procedural defects); *In re Stoner*, No. 96-82060, 1997 WL 33475059 (Bankr. C.D. Ill. Feb. 20, 1997) (avoiding hospital lien using different logic); *In re Harris*, 50 B.R. 157 (Bankr. E.D. Wis. 1985) (holding that exemption for personal injury proceeds trumps statutory lien); *In re Thorogood*, 22 B.R. 725 (Bankr. E.D.N.Y. 1982) (assigning smaller amount to hospital lien in settlement with bankrupt patient).

¹⁶⁹ See IDAHO CODE ANN. § 31-3504 (West 2005). Idaho law also provides that the county board may require the medically indigent to work, presumably to pay off their hospital bills. *Id.* § 3510A(6). See generally *Mechling v. Bonner County Office of Assistance* (*In re Mechling*), 284 B.R. 127 (Bankr. D. Idaho 2002) (holding that statutory lien could not attach to property acquired by the debtor after declaration of bankruptcy); *IHC Hosps., Inc. v. Teton County*, 75 P.3d 1198 (Idaho 2003) (reviewing procedures); KEVIN BORDEN ET AL., DON'T LIEN ON ME: WHY THE STATE'S MEDICAL INDIGENCY CARE PROGRAM IS UNHEALTHY FOR IDAHOANS (2001), available at <http://www.accessproject.org/downloads/IdahoLienR.pdf>.

¹⁷⁰ See S.D. CODIFIED LAWS § 34-8-14 (2005) (emergency and nonemergency hospitalization of indigent patient); *id.* § 25-14-5 (lien right generally); *In re Hanson*, 164 B.R. 632 (Bankr. D.S.D. 1994); *Claussen v. Brookings County* (*In re Claussen*), 118 B.R. 1009 (Bankr. D.S.D. 1990) (reviewing South Dakota lien law and comparing it to other states' lien laws).

¹⁷¹ N.M. STAT. ANN. § 27-5-14 (West 2005).

¹⁷² N.J. STAT. ANN. §§ 44:5-19.1, -19.6 (West 2005).

¹⁷³ See N.C. GEN. STAT. §§ 44-51.1, -51.5 (2005).

¹⁷⁴ See OR. REV. STAT. § 87.607 (2003).

¹⁷⁵ See, e.g., N.C. GEN. STAT. §§ 131E-48 to -51 (2005) (public hospitals); *id.* § 44-51.4 (county or city ambulance service).

cent hospital billing and collection scandals would permit hospitals to continue garnishing wages and attaching bank accounts as long as the hospital board so approved.¹⁷⁶

It would be incorrect to interpret the aforementioned special rights as a sign that state legislators expect hospitals to refrain from other collection activities. Some have expressly made clear that the lien laws do not preclude ordinary creditor entitlements. For example, Illinois's health services lien act provides:

Nothing in this Act shall be construed as limiting the right of a health care professional or health care provider, or attorney, to pursue collection, through all available means, of its reasonable charges for the services it furnishes to an injured person. Notwithstanding any other provision of law, a lien holder may seek payment of the amount of its reasonable charges that remain not paid after the satisfaction of its lien under this Act.¹⁷⁷

Nevada's laws go further to direct the hospitals to engage in collection activity: "Whenever hospital care is furnished to a person on account of an injury suffered by the person in a motor vehicle accident, the hospital shall use reasonable diligence to collect the amount of the charges for that care from the patient or any other person responsible for his support."¹⁷⁸

Some state laws also facilitate the collection of medical debts by widening the circle of people who are liable for the debt. For example, the doctrine of necessities imposes liability on spouses of patients for medical care.¹⁷⁹ Some state courts have abrogated or abolished the doctrine on constitutional grounds.¹⁸⁰ Elsewhere, however, it lives on—principally, some

¹⁷⁶ See, e.g., A.O. 2521, 2005-06 Leg., Reg. Sess. (N.Y. 2005).

¹⁷⁷ 770 ILL. COMP. STAT. ANN. 23/45 (West 2005).

¹⁷⁸ NEV. REV. STAT. § 428.215 (2004).

¹⁷⁹ See, e.g., *Sprouse v. City Credits Co.*, 126 F. Supp. 2d 1083 (S.D. Ohio 2000) (suing patient and spouse for \$4200 bill); *Yale-New Haven Hosp. v. Turcotte*, No. CV000434944, 2001 WL 1668993 (Conn. Super. Ct. Dec. 7, 2001) (suing patient's spouse on basis of necessities statute); *Queen's Med. Ctr. v. Kagawa*, 967 P.2d 686 (Haw. Ct. App. 1998) (suing almost-divorced spouse for \$150,000); *MRI Coop. v. Berlin*, No. 92-T-4712, 1993 WL 257078 (Ohio Ct. App. June 30, 1993) (suing for unpaid \$103 portion of MRI bill); *Trident Reg'l Med. Ctr. v. Evans*, 454 S.E.2d 343 (S.C. Ct. App. 1995); *Faulk County Mem'l Hosp. v. Neilan*, 269 N.W.2d 121 (S.D. 1978); *Outpatient Diagnostic Ctr. v. Christian*, No. 01A01-9510-CV-00467, 1997 WL 210842 (Tenn. Ct. App. Apr. 30, 1997) (suing husband, who did not agree to be liable, for wife's care). *But see* *Cheshire Med. Ctr. v. Holbrook*, 663 A.2d 1344 (N.H. 1995) (holding that hospital first must attempt collection from patient before pursuing spouse); *Fulton County Health Ctr. v. Underwood*, 654 N.E.2d 354 (Ohio Ct. App. 1995) (holding that hospital first must evaluate patient's ability to pay before pursuing spouse).

¹⁸⁰ See, e.g., *N. Ottawa Cmty. Hosp. v. Kieft*, 578 N.W.2d 267, 273 (Mich. 1998) (holding that doctrine of necessities no longer part of Michigan's common law); *Schilling v. Bedford County Mem'l Hosp., Inc.*, 303 S.E.2d 905 (Va. 1983) (abolishing doctrine); *Med. Ctr. Hosp. of Vt. v. Lorrain*, 675 A.2d 1326 (Vt. 1996) (abolishing doctrine). For a complete list, see HOBBS ET AL., *supra* note 158, at 141.

commentators say, as a basis for collecting medical debt.¹⁸¹ States also may have statutes under other names that require family members to help compensate hospitals or government agencies for the cost of an indigent person's hospital care.¹⁸²

Because states offer a laboratory for ways in which to deal with similar problems, we also find some state laws that try to protect patients from debt collection when they have faced a medical calamity. For example, several states alter individual debtors' homestead exemptions in the event of illness.¹⁸³ Kansas law limits wage garnishment if a debtor is sick and the illness prevents the debtor from working.¹⁸⁴ The most recent entrant into

¹⁸¹ See, e.g., *Med. Ctr. Hosp. of Vt.*, 675 A.2d at 1329 ("Virtually all of the necessities cases concern hospitals or clinics . . ."); Shawn M. Willson, Comment, *Abrogating the Doctrine of Necessaries in Florida: The Future of Spousal Liability for Necessary Expenses After Connor v. Southwest Florida Regional Medical Center, Inc.*, 24 FLA. ST. U. L. REV. 1031, 1043 (1997) ("In the last fifty years, all of the Florida cases in which a party invoked the doctrine involved unpaid medical expenses. In case after case, hospitals sought to trap an unwilling spouse into making payment . . .").

¹⁸² See, e.g., N.J. STAT. ANN. § 44:5-19.9 (West 2005).

¹⁸³ West Virginia provides a slightly larger homestead exemption (\$7500 instead of \$5000) in the event of judgments for debts resulting from "catastrophic illness or injury." See W. VA. CODE § 38-9-3(b) (2005) (applying to "all debts and liabilities for hospital or medical expenses incurred from a catastrophic illness or injury"). West Virginia law contains a lengthy and detailed definition of catastrophic illness or injury, and the exemption expires upon the death of the debtor. *Id.* Louisiana law protects the full value of a home (instead of \$25,000) with respect to a debt that arises from "a catastrophic or terminal illness or injury." See LA. REV. STAT. ANN. § 20:1 (West 2004). It defines "catastrophic or terminal illness or injury" in terms of both the debt to health providers (more than \$10,000) and the percentage of the debtor's adjusted gross income. *Id.* at § 20:1(A)(3). A few states prohibit foreclosure of primary residences during the debtor's lifetime for judgments arising from "health care services and supplies," similar to Medicaid's approach. See, e.g., NEV. REV. STAT. § 21.095 (2004) ("The primary dwelling, including a mobile or manufactured home, of a judgment debtor is exempt from execution upon a judgment for a medical bill . . ."); OHIO REV. CODE § 2329.66A(1)(a) (2005) (applying to "judgment or order regarding money owed for health care services rendered or health care supplies provided" under certain circumstances). Ohio law specifically provides, however, that the exemption does not apply to consensual mortgages arising from similar circumstances. See *id.* § 2329.661; see also *Wickliffe Country Place v. Kovacs*, 765 N.E.2d 975 (Ohio Ct. App. 2001) (involving lien filed by a nursing home against patient's real property); *Meadow Wind Health Care Ctr., Inc. v. McInnes*, No. 1999CA00338, 2000 WL 1055938, at *3 (Ohio Ct. App. July 24, 2000) (holding that debtor is entitled to the exemption "if any health care services were rendered or any health care supplies were provided"). In California, it appears that county hospitals may not take liens on real property of patients who are recipients of public assistance. See CAL. WELF. & INST. CODE §§ 11007, 14112 (West 2005). In Maine, a hospital may not take a lien on a home of a person in a twelve-month period during which the person is eligible for financial assistance under the state's catastrophic illness program. See ME. REV. STAT. ANN. tit. 10, § 3411 (2005). And, most recently, Connecticut increased its homestead exemption from \$75,000 to \$150,000 for judgments due to hospitals services under some circumstances. See CONN. GEN. STAT. ANN. § 52-352b(t) (West Supp. 2005).

¹⁸⁴ See KAN. STAT. ANN. § 60-2310(c) (West 2004) ("If any debtor is prevented from working at the debtor's regular trade, profession, or calling for any period greater than two weeks because of illness of the debtor or any member of the family of the debtor, and this fact is shown by the affidavit of the debtor, the provisions of this section shall not be invoked against any such debtor until after the expiration of two months after recovery from such illness."). Ohio briefly limited medical bill garnishment, but then quickly repealed it. See OHIO REV. CODE § 2716.021 (repealed 1995). See generally Hugh F.

patient protection is Connecticut, a state whose laws were explored in Part II.¹⁸⁵ We cannot find evidence in case law or the published literature that individuals who live in these states know about and take advantage of these protections, although these sources are not dispositive. More importantly, however, these patient-protection laws often co-exist with laws that give health providers strong creditor status in other respects.

Although somewhat beyond the scope of this discussion of debt collection laws, we note that federal Medicare-related laws and regulations may encourage hospitals to engage in debt collection against not only Medicare patients, but against uninsured patients.¹⁸⁶ The federal government has strenuously denied that laws, regulations, or government representatives helped create the current pattern of hospital billing and collection practices.¹⁸⁷ Yet, this response is not entirely credible. The complex system of Medicare-related laws and regulations undoubtedly has helped structure hospital-patient financial relationships and must have played some role in encouraging or discouraging certain hospital activities. In any event, we are unaware of efforts by the federal government to change these laws or regulations to reduce such effects. Even now, hospitals trying to improve their charity care policies must overcome multiple regulatory hurdles in order to put those policies into place.¹⁸⁸ Likewise, as mentioned in Part II, some state lawmakers have proposed adding collection restrictions applicable to medical providers, but to our knowledge none has called for widespread re-

“Trey” Daly III et al., *Into the Red to Stay in the Pink: The Hidden Cost of Being Uninsured*, 12 HEALTH MATRIX 39, 49–51 (2002) (reporting on court challenges to legislation and repeal).

¹⁸⁵ As noted earlier, in the wake of the media attention over the past several years, lawmakers in a few states have proposed legislation that would impose more restrictions on hospitals attempting to collect, but most of these bills are unlikely to be enacted. For example, the Mississippi senate considered a bill that would increase property exemptions if the judgments arise from hospital services, but the bill received an unfavorable report from the state senate finance committee. S.B. 2506, 2005 Leg., Reg. Sess. (Miss. 2005). Several state lawmakers introduced bills that would prohibit hospitals from foreclosing on the primary residence of a patient. See, e.g., H.B. 0715, 2004 Leg., Reg. Sess. (Fla. 2004); A.O. 2521, 2005-06 Leg., Reg. Sess. (N.Y. 2005). The Florida bill died in committee.

¹⁸⁶ See, e.g., *Hearing on Hospital Billing and Collections*, supra note 28, at 136 (statement of Lewis Morris, Chief Counsel to the Inspector General, Dept. of Health and Human Services) (arguing OIG’s legal authorities have limited applicability to uninsured patients and explaining how anti-kickback laws and excessive charges exclusion affect uninsured); CAROL PRYOR ET AL., THE COMMONWEALTH FUND, UNINTENDED CONSEQUENCES: HOW FEDERAL REGULATIONS AND HOSPITAL POLICIES CAN LEAVE PATIENTS IN DEBT (2003), available at <http://www.accessproject.org/downloads/unintended.pdf>. The Emergency Medical Treatment and Labor Act is part of this statutory and regulatory picture as well. See 42 U.S.C. § 1395dd (Supp. 2003).

¹⁸⁷ See *Hearing on Hospital Billing and Collections*, supra note 28, at 271–80 (Health and Human Services’ response to Committee’s request for information); U.S. DEPT. OF HEALTH & HUMAN SERVICES, HOSPITAL DISCOUNTS OFFERED TO PATIENTS WHO CANNOT AFFORD TO PAY THEIR HOSPITAL BILLS (2004), available at <http://oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA021904hospitaldiscounts.pdf>.

¹⁸⁸ See, e.g., *Hearing on Hospital Billing and Collections*, supra note 28, at 95 (written statement of Jack Bovender, Hosp. Corp. of Am.) (reporting proposed discount proposal had to go through CMS as well as five fiscal intermediaries before implementation).

consideration of the special collection treatment already embedded in the law.¹⁸⁹

B. General Liability and Debt Collection

1. *Liability.*—Special rules aside, the legal system often treats medical debt like any other contract claim. Many patients and providers find themselves in standard debtor-creditor relationships.¹⁹⁰ Often this relationship develops from an express contract between the patient and the hospital.¹⁹¹ Contract law does not require actual negotiation of the terms of a contract, and it generally enforces standard forms drafted by one party.¹⁹² The fact that the terms are not extensively disclosed ordinarily will not defeat enforceability.¹⁹³

¹⁸⁹ Arizona revised its hospital lien law to limit its reach. See ARIZ. REV. STAT. ANN. § 33-931 (West Supp. 2005); see also Elbert David, *Hospitals Accused of Misuse of Lien Law*, DES MOINES REG., July 15, 2004, at D1 (reporting on lawsuit alleging hospitals use lien law to overcharge accident victims).

¹⁹⁰ This characterization often arises in subrogation disputes. See, e.g., Trevino v. HHL Fin. Servs., Inc., 945 P.2d 1345, 1348 (Colo. 1997) (describing hospital as patient's creditor); Maynard v. Parker, 369 N.E.2d 352, 355 (Ill. App. Ct. 1977) (stating that hospital recovery involves "ordinary debtor-creditor relationship"); Bashara v. Baptist Mem'l Hosp. Sys., 685 S.W.2d 307, 310 (Tex. 1985) (describing hospital-patient relationship as debtor-creditor); Lynch v. Deaconess Med. Ctr., 776 P.2d 681, 684 (Wash. 1989); Porter v. McPherson, 479 S.E.2d 668, 673, 675 (W. Va. 1996).

¹⁹¹ See, e.g., Crawford v. Credit Collection Servs., 898 F. Supp. 699, 701 (D.S.D. 1995) (holding that patient authorization agreement is a contract for purposes of Fair Debt Collection Practices Act); Milford Hosp. v. Champeau, No. CV00069269S, 2001 WL 497110 (Conn. Super. Ct. Apr. 27, 2001) (finding, on summary judgment, that plaintiff failed to prove duress regarding authorization form obligating patient to pay charges, collection costs, and attorneys' fees); Sholkoff v. Boca Raton Cmty. Hosp., Inc., 693 So. 2d 1114 (Fla. Dist. Ct. App. 1997) (involving admission form imposing highest interest rate permitted by law if patient did not pay within forty-five days); Mercy Hosp., Inc. v. Carr, 297 So. 2d 598 (Fla. Dist. Ct. App. 1974) (involving form requiring payment of unpaid balance and seven percent interest); Albany Med. Ctr. Hosp. v. Armlin, 536 N.Y.S.2d 272 (App. Div. 1989) (holding that guarantee of payment for eye surgery imposed liability, notwithstanding belief that study would cover expenses); McCarthy v. Weaver, 472 N.Y.S.2d 64, 65 (App. Div. 1984) (involving form obligating patient "to pay all costs, charges and expenses of the hospital of every kind and description"); Healthline v. Sturdevant, 779 P.2d 624, 625 (Or. Ct. App. 1989) (involving express promise to pay for son's care "in accordance with the rates and terms of the hospital"). But see Bondanza v. Peninsula Hosp. & Med. Ctr., 590 P.2d 22 (Cal. 1979) (holding that form requiring payment of all reasonable attorney fees and collection costs did not entitle hospital to include collection costs amounting to thirty-three percent of bill); Payne v. Humana Hosp. Orange Park, 661 So. 2d 1239 (Fla. Dist. Ct. App. 1995) (holding express contract enforceable but compensation may be limited because amount of charges not addressed within four corners of document). For attempts to use duress and related defenses to a breach of contract claim on a hospital bill, see HOBBS ET AL., *supra* note 158, at 138.

¹⁹² See, e.g., Robert A. Hillman & Jeffrey J. Rachlinski, *Standard-Form Contracting in the Electronic Age*, 77 N.Y.U. L. REV. 429, 435-36 (2002); Stephen J. Ware, *Arbitration Clauses, Jury-Waiver Clauses, and Other Contractual Waivers of Constitutional Rights*, 67 LAW & CONTEMP. PROBS. 167, 172 (2004) ("[The] norm in contract law is consent to the unknown.").

¹⁹³ Most of the few courts and commentators that have dealt with this issue seem to conclude that these agreements are not subject to truth-in-lending disclosure laws. See Finnegan v. Univ. of Rochester Med. Ctr., 21 F. Supp. 2d 223 (W.D.N.Y. 1998) (holding Fair Credit Billing Act not applicable); Bright

Even if a court later concludes that a hospital admissions form is an insufficient basis to establish contractual liability to pay a particular price, patients likely owe money to providers. For example, the Tennessee Supreme Court found that a hospital admission form that inadequately defines the charges cannot form the basis of patient liability for hospitals' list prices.¹⁹⁴ Yet the court still found the patient personally liable for reasonable charges under theories of quasi-contract or unjust enrichment.¹⁹⁵ "Reasonable charges" were to be determined by considering a hospital's internal cost factors and the charges of other hospitals in the community.¹⁹⁶ Other circumstances that might defeat express contract enforceability, such as the complete absence of a signature on a hospital admission form, might nonetheless result in liability for a patient on the grounds of unjust enrichment if she received health care for which she did not pay.¹⁹⁷ Even in the absence of express contract or an unjust enrichment claim, patients may be liable in

v. Ball Mem'l Hosp. Ass'n, Inc., 463 F. Supp. 152 (S.D. Ind. 1979), *aff'd*, 616 F.2d 328 (7th Cir. 1980) (holding that late charge did not extend credit, and thus was not in violation of Regulation Z); Defendant's Reply to Plaintiff's Memorandum in Opposition to Defendant's Motion for Partial Judgment on the Pleadings, *Finck v. Fairfield Med. Ctr.* (S.D. Ohio Jan. 9, 2004) (C-2-03-884) (arguing that defendant was not a creditor under truth-in-lending laws, and that a handling charge was not a finance charge); Linda Galler, Note, *Subjecting Hospitals to Truth in Lending Disclosure Requirements: Bright v. Ball Memorial Hospital*, 8 AM. J.L. & MED. 69 (1982) (advocating change so that hospitals comply with truth-in-lending laws); Thomas S. Lucksinger & Kemp W. Gorthy, *Perils and Prerogatives of Collection Laws, Part 2: Collecting Indebtedness*, HEALTHCARE FIN. MGMT., Mar. 1979, at 18; *cf.* Hahn v. Hank's Ambulance Serv., Inc., 787 F.2d 543 (11th Cir. 1986) (holding that ambulance company late charge was not an extension of credit subject to truth-in-lending laws); *Johnson v. Rutherford Hosp. (In re Johnson)*, 13 B.R. 185 (Bankr. M.D. Tenn. 1981) (involving a hospital conceding that it violated truth-in-lending laws after arranging for bank to make loan to patient without making proper disclosures); Richard M. Alderman, *The Business of Medicine—Health Care Providers, Physicians, and the Deceptive Trade Practices Act*, 26 HOUS. L. REV. 109, 138 (1989) (discussing application of Texas deceptive trade law to medical bills); James H. Backman, *Consumer Credit and the Learned Professions of Law and Medicine*, 1976 BYU L. REV. 783.

¹⁹⁴ See *Doe v. HCA Health Servs. of Tenn., Inc.*, 46 S.W.3d 191 (Tenn. 2001) (affirming appeals court's holding that indefinite agreement in hospital form to pay "charges" did not establish contract to pay hospital's secret list prices).

¹⁹⁵ *Id.* at 198.

¹⁹⁶ *Id.* at 198–99. See generally HOBBS ET AL., *supra* note 158, at 139.

¹⁹⁷ See, e.g., *Cardiology Assocs. of Fairfield County, P.C. v. Sussman*, No. CV970162007, 2000 WL 872492 (Conn. Super. Ct. June 16, 2000); *Bingham Mem'l Hosp. c. Boyd (In re Boyd)*, 8 P.3d 664 (Idaho Ct. App. 2000) (holding that hospital could collect unjust enrichment from deceased patient's estate); *Galloway v. Methodist Hosps., Inc.*, 658 N.E.2d 611 (Ind. Ct. App. 1995) (permitting recovery in quantum meruit after patient's husband failed to sign financial liability statement during emergency premature delivery); *Credit Bureau Enters., Inc. v. Pelo*, 608 N.W.2d 20 (Iowa 2000) (permitting recovery in quantum meruit after patient hospitalized for emergency mental condition refused to sign insurance release); *Heartland Health Sys., Inc. v. Chamberlin*, 871 S.W.2d 8 (Mo. Ct. App. 1993) (allowing hospital to collect from patient in unjust enrichment after he was brought to hospital unconscious, and from patient's mother on express contract theory); *Layton Physical Therapy Co. v. Palozzi*, 777 N.E.2d 306 (Ohio Ct. App. 2002); *Dallas County Hosp. Dist. v. Wiley*, No. 05-01-01031, 2002 WL 1286515 (Tex. App. Jan. 12, 2002) (remanding for consideration of quantum meruit after holding hospital lien does not attach to uninsured motorist insurance proceeds). See generally HOBBS ET AL., *supra* note 158, at 138.

implied contract.¹⁹⁸ An unsigned form, or a form signed by a patient who cannot read and understand it, also might lead to a finding of an implied promise to pay for care.¹⁹⁹

Of course, not all patient-provider relationships devolve into longer-term debtor-creditor relationships.²⁰⁰ Nonetheless, it remains the case that

¹⁹⁸ See, e.g., W. VA. CODE § 16-4C-11 (2005); see also *infra* note 199 and sources cited therein.

¹⁹⁹ See, e.g., *Shellnut v. Randolph County Hosp.*, 469 So. 2d 632 (Ala. Civ. App. 1985) (implying that hospital was entitled to reasonable and customary fees for services even absent express contract); *Yale-New Haven Hosp., Inc. v. Gargiulo*, No. CV980419980, 1999 WL 989422 (Conn. Super. Ct. Oct. 18, 1999) (finding, on motion to strike defenses, implied agreement between hospital and patient (assuming that bill of hospital was reasonable and customary), and observing that issue of hospital's mitigation of damages through Hill-Burton or other financial aid opportunities may arise later); *Sherman Hosp. v. Wingren*, 523 N.E.2d 220 (Ill. App. Ct. 1988) (implying that contract theory entitles hospital to reasonable and customary charges); *Cuyahoga County Hosps. v. Price*, 581 N.E.2d 1125 (Ohio Ct. App. 1989) (holding patient who could not read or understand form liable under implied contract theory because he reasonably knew hospital expected payment for provided care); *Porter v. McPherson*, 479 S.E.2d 668, 673-74 (W. Va. 1996) (permitting hospital to collect based on express or implied contract for reasonable value of services).

²⁰⁰ Some states' versions of Medicaid or a true HMO sharply limit patients' personal liability. See *Yale-New Haven Hosp. v. Vignola*, No. CV000444787S, 2002 WL 377675 (Conn. Super. Ct. Feb. 15, 2002) (holding that hospital has duty to determine applicability of insurance coverage to hospital procedure). See generally Gail B. Agrawal, *Chicago Hope Meets the Chicago School*, 96 MICH. L. REV. 1793, 1796 (1998) (reviewing MARK A. HALL, *MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS* (1997)) (explaining that managed care eliminates patient's responsibility for coinsurance and deductibles for covered treatments). A patient found eligible for a full account write-off under a hospital's own charity care policy should not owe any money, although providers sometimes have insufficient information to determine charity care eligibility until later in the collection process. See, e.g., Ray B. Lefton, *Developing Organizational Charity-Care Policies and Procedures*, HEALTH CARE FIN. MGMT., Apr. 2002, at 52, 54-55; PATIENT FRIENDLY BILLING PROJECT, *supra* note 48, at 15 (noting possibility of collection agencies returning accounts that turn out to qualify for charity care). Medical providers may attempt to run a cash-only business or to collect the sum before the patient receives care or leaves the building, quickly terminating the debtor-creditor aspect of the relationship. See, e.g., Robert Geer, *Improving Collections in the ED*, PATIENT ACCTS., Oct. 2003, at 1; Mary Chris Jaklevic, *All Cash, All the Time*, MOD. HEALTHCARE, Jun 23, 2003, at 40; Mike Norbut, *Money Woes Solved with Cash-Only Practice*, AM. MED. NEWS, Feb. 10, 2003, at 19. Like any other creditor, providers sometimes discourage patients from challenging bills in the hopes of receiving prompt payment. See, e.g., Kimberly Elsbach, Robert I. Sutton, & Kristine E. Principe, *Averting Expected Challenges Through Anticipatory Impression Management: A Study of Hospital Billing*, 9 ORG. SCIENCE 68, 79-80 (1998) (noting that bureaucratic barriers, threats of outside debt collectors, and suggestions that audits could lead to higher bills discourage bill challenges). "Patient-friendly billing" projects are underway to limit disputes and to encourage quick bill satisfaction. See PATIENT FRIENDLY BILLING PROJECT, HEALTHCARE FIN. MGMT. ASS'N, PATIENT FRIENDLY BILLING: MAKING PATIENT BILLS CLEAR, CONCISE, CORRECT, AND PATIENT FRIENDLY 4-6 (2003), available at <http://www.patientfriendlybilling.org/pdf/BrochureJune03.pdf>; Donell Cohen & Paul Hoffman, *When Putting Patients First Fits the Bill: One Hospital Shows How a Change in Billing Format Can Reduce Costs and Improve Patient Satisfaction*, HEALTHCARE FIN. MGMT., Sept. 2003, at 90; Robert Lowes, *When You Ask for Payment, Do it Right!*, MED. ECON., Jan. 10, 2003, at 58; Terry Allison Rappuhn, *The Revenue Cycle from the Patient's Perspective: Improve Your Revenue Cycle by Tailoring Patient Financial Communications to Meet Patient Needs*, HEALTHCARE FIN. MGMT., Sept. 2003, at 64; see also Mary Chris Jaklevic, *Billing Question?: Point and Click; Mich. System Among Few Offering Online Account Access*, MOD. HEALTHCARE, July 22, 2002, at 23.

patients often bear personal liability for some of their direct medical costs.²⁰¹ Indeed, some currently popular health care finance approaches are based on the belief that liability is desirable to prevent medical care overuse and to promote cost containment.²⁰² Liability means legal enforceability, and enforceability has collection-related consequences regardless of the creditor's identity.²⁰³

2. *General Debt Collection Entitlements.*—In the absence of special privileges or restrictions, debtor-creditor law gives creditors (including medical providers) basic rights to enforce legal obligations. They have collection rights whether or not they are in the business of extending credit and whether or not they are not-for-profit institutions.

In attempting to collect overdue bills, creditors' procedures often start with informal attempts to collect before resorting to formal legal action.²⁰⁴ For example, outside debt collectors coax repayment through telephone and written contact.²⁰⁵ The laws generally prohibit excessive harassment but leave even third-party collectors wide latitude as they pursue nonpaying debtors.²⁰⁶ This includes calling up until 9 p.m., making contact on holidays, talking to debtors' children who might pick up the phone in the late afternoon, and threatening a wide range of consequences for nonpayment.²⁰⁷

²⁰¹ See U.S. CENSUS BUREAU, STATISTICAL ABSTRACT, *supra* note 114, at 93 tbl. 115 (reporting that of \$819.7 billion in health services and supply expenditures, \$212.5 billion was out-of-pocket payments).

²⁰² See, e.g., *First Hearing in a Series on Tax Exemption: Pricing Practices of Hospitals Before the Subcomm. on Oversight of the House Comm. on Ways & Means*, 108th Cong. 53 (2004) (statement of Regina Herzlinger, Harvard Business Sch.), available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_house_hearings&docid=f:99670.pdf; Robert Kaestner, *Publicly Provided Health Insurance for the Nonelderly Poor: Can We Save Money Safely?*, 2004 U. ILL. L. REV. 91, 97–98, 102–103.

²⁰³ Thus, the National Consumer Law Center advises that a “very effective method to deal with medical debt is to find someone else to pay for it.” HOBBS ET AL., *supra* note 158, at 576.

²⁰⁴ See, e.g., WILLIAMS, *supra* note 163, at 40 (“There is ample evidence that creditors believe that the informal or non-judicial collection process is their most cost-effective remedy. Virtually no institutional lender is without its collection department and independent collection agencies supplement the work of these departments and serve the needs of smaller creditors.”).

²⁰⁵ See, e.g., Ronald Paul Hill, *Bill Collectors and Consumers: A Troublesome Exchange Relationship*, 13 J. PUB. POL’Y & MKTG. 20, 21 (1994); Anat Rafaeli & Robert I. Sutton, *Emotional Contrast Strategies as Means of Social Influence: Lessons from Criminal Interrogators and Bill Collectors*, 34 ACAD. MGMT. J. 749, 755 (1991) (“[D]ata from one month suggested that collectors obtained substantial payments from 60% of debtors who were 35 to 64 days late and from 25% of debtors who were 155 to 184 days late.”).

²⁰⁶ See generally Rafaeli & Sutton, *supra* note 205. In addition to the Fair Debt Collection Practices Act, state debt collection laws, unfair or deceptive trade practices, and other laws may apply. *Id.* at 581–82.

²⁰⁷ See, e.g., ELIZABETH WARREN & AMELIA WARREN TYAGI, ALL YOUR WORTH: THE ULTIMATE LIFETIME MONEY PLAN 251–52 (2005) (discussing debt collection tactics, including communication with children).

Like other creditors, health care providers long have used debt collectors.²⁰⁸ Both collections experts and provider management experts have written frequently about how to decrease bad medical debt,²⁰⁹ how to decide between in-house collection and outsourcing,²¹⁰ how and when to deploy secondary collection agencies after primary placements have failed,²¹¹ and how to increase revenues through the outright sale of patient accounts to third parties.²¹² Although patients sometimes challenge the billing and col-

²⁰⁸ See, e.g., Bobette Gustafson, *The Collector Inspector: Self-pay Trends Necessitate More Effective RFPs*, HEALTHCARE FIN. MGMT., Dec. 2003, at 46 (2003) (“[A]bout 80 percent of ACA International’s 3,125 member agencies provide some level of collection services to the healthcare industry.”). For examples in cases, see *Smith v. Computer Credit, Inc.*, 167 F.3d 1052, 1053 (6th Cir. 1999) (debt collection by letters); *Lockard v. Equifax, Inc.*, 163 F.3d 1259, 1262 (11th Cir. 1998) (use of collection agencies); *Bryant v. Bonded Accounts Service/Check Recovery*, No. Civ. 00-1072 RHKJMM, 2000 WL 34494806 (D. Minn. Nov. 21, 2000) (medical debt collection letter); *Sprouse v. City Credits Co.*, 126 F. Supp. 2d 1093 (S.D. Ohio 2000) (same); *Lara v. Kern County Board. of Supervisors*, 130 Cal. Rptr. 668, 670 (Ct. App. 1976) (describing longstanding practice of counties in California to have agreements with debt collectors for patient hospital debts); *Georgia Public Service Commission v. Charles H. Turner, Inc.*, 407 S.E.2d 113 (Ga. Ct. App. 1991) (permitting medical debt collector to use automatic dialing service with recorded messages); *Forsyth Memorial Hospital, Inc. v. Contreras*, 421 S.E.2d 167 (N.C. Ct. App. 1992) (medical debt collection letter); *Weiss v. Collection Center, Inc.*, 667 N.W.2d 567, 569–70 (N.D. 2003) (describing medical debt collector’s practice). See also Opinion Letter from Fed’l Trade Comm’n Bureau of Consumer Protection to Thomas Isgrigg (November 10, 1992) (advising business that has collected delinquent hospital bills in Los Angeles County for twelve years), available at <http://www.ftc.gov/os/statutes/fdcpa/letters/isgrigg1.htm>.

²⁰⁹ See, e.g., Lynn Degrote, *Lowering Bad Debt in Health Care: The Cure is Easier than You Think*, CLINICAL LEADERSHIP & MGMT. REV., Mar.–Apr. 2002, at 59 (advocating Internet services to reduce bad debt); Tom Jainy, *The What, Why and When of Collecting Patient Balances*, MED. PRACTICE MGMT., July–Aug. 2003, at 33; Robert Kazel, *Getting Patients to Pay: Gentle Ways to Get the Check*, AM. MED. NEWS, Sept. 22, 2003, at 14; Scott W. Sankary & Nick H. Kupferle III, *Make Collections Your Goal: Summit Healthcare Case Studies*, MGMA CONNEXION, Jan. 2003, at 40; see also Opinion Letter from Fed’l Trade Comm’n Bureau of Consumer Protection to J. Russell Gibson, III (February 21, 1990) (discussing application of Fair Debt Collection Practices Act to medical “pre-collection” activities), available at <http://www.ftc.gov/os/statutes/fdcpa/letters/gibson90.htm>.

²¹⁰ See, e.g., J. Mantone, *Letting Someone Else Do It Better: Outsourcing Business Functions Can Mean Higher Revenue, but Not Costs*, MOD. HEALTHCARE, Nov. 24, 2004, at S10; Maria H. Seman & Elizabeth M. Guyton, *Three Steps for Optimizing Self-Pay Outsourcing*, HEALTHCARE FIN. MGMT., Oct. 2004, at 42; William C. Sturm & Gregory J. Naples, *Hospital-Owned Collection Agencies: Concerns and Considerations*, HEALTHCARE FIN. MGMT., Dec. 1986, at 34.

²¹¹ See, e.g., Robert M. Frohlich, *Effective Reassignment of Accounts Can Decrease Bad Debt*, HEALTHCARE FIN. MGMT., July 1994, at 36, 37.

²¹² See, e.g., HEALTHCARE FIN. MGMT. ASS’N, *BAD DEBT RISING: WHEN TO SELL YOUR ACCOUNTS RECEIVABLE* (2004), available at http://www.hfma.org/FeaturedTopic/resource/bad_debt.pdf; Gustafson, *supra* note 208. Health services researchers and advocacy groups now study and track use of collection agencies for patient accounts. See, e.g., MAY & CUNNINGHAM, *supra* note 105 (stating that in nationally representative study, more than sixty percent of families with medical bill problems reported being contacted by collection agencies); PRYOR & GUREWICH, *supra* note 105, at 7 (stating that almost two-thirds of those with medical debt in study reported being contacted by collection agency); TU, *supra* note 123 (stating that sixty-four percent of those with chronic conditions reported being contacted by collection agency); S. Felt-Lisk, M. McHugh, & E. Howell, *Monitoring Local Safety-Net Providers: Do They Have Adequate Capacity?*, 21 HEALTH AFF. 277, 279 (Sept. 2002) (tracking collection activities used against uninsured patients in survey of safety net providers in five cities); Thomas P.

lection practices of hospitals under consumer laws, we have found few cases when such challenges have been successful.²¹³

Although some kinds of creditors have found informal collection to be efficient and effective, creditors have the right to file a lawsuit when informal techniques are unavailing. Indeed, it is the possibility of legal action that encourages voluntary payment of most obligations. Thus, medical providers who are owed money from their patients act within their basic legal rights when they sue.²¹⁴ Generally, it is not very difficult for a provider to show that the patient received care, was liable for care, and failed to pay.²¹⁵

State laws have extensive judgment collection procedures precisely for the purpose of giving a creditor options for satisfying an obligation once a

O'Toole et al., *Medical Debt and Aggressive Debt Restitution Practices: Predatory Billing Among the Urban Poor*, 19 J. GEN. INTERNAL MED. 772, 774 (2004) (noting that nearly forty percent of sample reported being referred to debt collection agency for medical debt even though average annual income of sample was less than \$8000).

²¹³ See, e.g., *Edwards v. McCormick*, 136 F. Supp. 2d 795 (S.D. Ohio 2000) (rejecting class certification for action against debt collector for medical debt collection practices, including threat of foreclosure on judgment lien); *Yale-New Haven Hosp. v. DeMatteo*, No. CV 970407311S, 1998 WL 563817 (Conn. Super. Ct. Aug. 12, 1998) (striking patient's counterclaim that hospital violated the state's Creditor's Collection Practices Act); *Franklin Collection Serv., Inc. v. Stewart*, 863 So. 2d 925 (Miss. 2003) (dismissing with prejudice debtors' fraud on the court and abuse of process actions against collection agency that pursued open medical accounts); *Witherwax v. Transcare, Inc.*, No. 114065/03, 2005 WL 1458061 (N.Y. Sup. Ct. Apr. 22, 2005) (dismissing action brought by patient on FDCPA grounds as trial court found and appellate court affirmed that defendant was a creditor, not a debt collector); *Forsyth Mem'l Hosp., Inc. v. Contreras*, 421 S.E.2d 167 (N.C. Ct. App. 1992) (holding that summary judgment was properly granted in favor of hospital where patient alleged violation of debt collection laws stemming from collection letters patient claimed were misleading). *But see Bryant v. Bonded Accounts Service/Check Recovery*, No. Civ. 00-1072 RHKJMM, 2000 WL 34494806, (D. Minn. Nov. 21, 2000) (finding that an unsophisticated consumer could reasonably interpret the collection letters defendant sent as denying credit and thus medical care); *Bondanza v. Peninsula Hosp. & Med. Ctr.*, 590 P.2d 22 (Cal. 1979) (forcing patient to pay collection agency's commission of one-third the balance constituted unlawful and unfair business practice); *Bundren v. Superior Court*, 193 Cal. Rptr. 671, 676 (Ct. App. 1983) (observing that there was a "serious question as to whether hospital's method of seeking payment" was reasonable since the patient was still in the hospital and recovering from surgery at the time the hospital sought payment); *Summa Health Sys. v. Viningre*, 749 N.E.2d 344 (Ohio Ct. App. 2000) (holding that even though transactions between doctors and patients are exempted from the Consumer Sales Practices Act, transactions between a medical service provider, like a hospital, and a patient are not clearly exempted). The recent round of lawsuits that make slightly different allegations, namely profiteering due to the amount of the charges, have so far been unsuccessful as well. See generally STAITI, HURLEY & CUNNINGHAM, *supra* note 48 (reporting on lack of success of class action lawsuits).

²¹⁴ See *supra* notes 183–192 and accompanying text (setting forth examples of theories of liability in lawsuits against patients); see also MED. BILLING TASK FORCE, *supra* note 55.

²¹⁵ See, e.g., *Wash. County Mem'l Hosp. v. Hattabaugh*, 717 N.E.2d 929 (Ind. Ct. App. 1999) (finding statement of charges for hospital or other health care expenses constitutes prima facie evidence that charges are reasonable and remanding to charge prejudgment interest of eight percent). A factual dispute on the reasonableness of the charge may preclude summary judgment, however. See, e.g., *Yale-New Haven Hosp. v. Turcotte*, No. CV000434944, 2001 WL 1668993 (Conn. Super. Ct. Dec. 7, 2001). For strategies used to challenge amount of liability, see, for example, HOBBS ET AL., *supra* note 158, at 587.

judgment has been rendered.²¹⁶ A combination of state and federal laws protect some property and future income from the reach of judgment creditors, as the prior discussion of medical-specific laws suggested.²¹⁷ But judgment creditors are otherwise legally entitled to obtain liens on patients' homes or cars,²¹⁸ garnish patients' wages,²¹⁹ and attach patients' bank accounts.²²⁰ In most instances, collection law is the same whether the debt was incurred for a trip to the Bahamas or to the emergency room of the local hospital. If a debtor files for bankruptcy, she may be able to remove ju-

²¹⁶ See generally William J. Woodward Jr., *Enforcements of Money Judgments: Objectives and Restrictions*, in 9 DEBTOR-CREDITOR LAW 37-24 (Theodore Eisenberg ed., 1990).

²¹⁷ *Id.* Nothing precludes debtors from voluntarily parting with property, leaving room for creditors to encourage debtors to sell property voluntarily to pay bills. See, e.g., *Ellis Hosp. v. Little*, 409 N.Y.S.2d 459 (App. Div. 1978).

²¹⁸ See, e.g., *Edwards v. McCormick*, 136 F. Supp. 2d 795, 798 (S.D. Ohio 2000) (involving a debt collector who filed a judgment lien which created a lien on patient's real property); *Wickliffe Country Place v. Kovacs*, 765 N.E.2d 975, 977 (Ohio Ct. App. 2001) (involving a nursing home that filed judgment lien against nursing home resident's real property and filed a complaint to foreclose on the lien); *Meadow Wind Health Care Ctr., Inc. v. McInnes*, No. 1999CA00338, 2000 WL 1055938, at *1 (Ohio Ct. App. July 24, 2000) (involving a health care center which filed a complaint for foreclosure of patient's real property); *Landmark Med. Ctr. v. Gauthier*, 635 A.2d 1145, 1146-47 (R.I. 1994) (involving a medical center that obtained default judgment against patient and issued an execution against patient's real estate).

²¹⁹ See *Van Wert Co. Hosp. v. French (In re Cummings)*, 266 B.R. 138, 140 (Bankr. N.D. Ohio 2001) (wages garnished to pay hospital bills); *Williams v. Baptist Health Sys., Inc.*, 857 So. 2d 149, 150 (Ala. Civ. App. 2003) (involving a hospital's attempt to garnish patient's mother's wages after obtaining default judgment against patient and patient's mother); *Yale-New Haven Hosp., Inc. v. Richardson*, No. CV000439636S, 2001 WL 984731, at *1 (Conn. Super. Ct. July 26, 2001) (wages garnished to pay hospital bills); *Christian v. M & R Collection Adjustment, Inc.*, 307 S.E.2d 523, 523-24 (Ga. Ct. App. 1983) (same); *A.C. White Transfer & Storage Co., Inc. v. Grady Mem'l Hosp.*, 261 S.E.2d 476, 477 (Ga. Ct. App. 1979) (same); *Saint Elizabeth Cmty. Health Ctr. v. Penrod*, No. A-02-789, 2004 WL 1091926, at *1-2 (Neb. App. May 18, 2004) (defendant's wages garnished to pay hospital bills of father of defendant's children); *Blake v. Charleston Area Med. Ctr., Inc.*, 498 S.E.2d 41 (W.Va. 1997) (wages garnished to pay hospital bills); *Kenosha Hosp. & Med. Ctr. v. Garcia*, 683 N.W.2d 425, 427 (Wis. 2004) (involving hospital's motion for a judgment against patient's employer for full amount of patient's debt after employer failed to respond to notice of garnishment of patient's wages); see also CONN. CTR. FOR A NEW ECONOMY, *supra* note 160; Susan D. Kovac, *Judgment-Proof Debtors in Bankruptcy*, 65 AM. BANKR. L.J. 675 (1991) (showing that in study of Tennessee debtors in 1980s, over one-fifth of those with medical debt were subject to garnishments); Sidney D. Watson, *Commercialization of Medicaid*, 45 ST. LOUIS U. L.J. 53, 61 (2001) ("Welfare medicine breaks down when . . . the hospital, which runs the clinic and receives over seventeen million dollars a year for indigent care, garnishes the minimum wage salary of a young mother who forgot, in the midst of a nighttime medical crisis, to bring her two year old son's Medicaid card with her to the emergency room."). See generally Woodward, *supra* note 216.

²²⁰ See, e.g., *Harris v. Bailey*, 574 F. Supp. 966 (W.D. Va. 1983) (involving garnishment of a patient's bank account which was solely comprised of Social Security benefits); *Hosp. of St. Raphael v. New Haven Sav. Bank*, 534 A.2d 1189 (Conn. 1987) (involving hospital's attempt to garnish bank accounts of debtor even though debtor had closed those accounts and received teller's checks for them); *Morristown Mem'l Hosp. v. Caldwell*, 775 A.2d 34 (N.J. Super. Ct. App. Div. 2001) (involving hospital's motion for turnover of patient's assets in bank account); *Grant Hosp. v. O'Neil*, No. 96APE06-793, 1997 WL 101657 (Ohio Ct. App. Mar. 4, 1997) (involving garnishment of joint bank accounts to satisfy hospital debts); *Ingram v. Hocking Valley Bank*, 708 N.E.2d 232 (Ohio Ct. App. 1997) (same).

dicial liens from homes²²¹ or free wages from garnishment.²²² But this relief is available only if the circumstances satisfy the technical statutory standards in the Bankruptcy Code, not because the provider or creditor engaged in wrongdoing.²²³

The creditor will have even greater collection rights if the debtor has given a creditor a consensual security interest in property, whether to secure a medical-related obligation or for some entirely different purpose.²²⁴ Creditors with security interests in personal property, such as cars, may be able to seize and privately sell the collateral without any court proceedings or intervention.²²⁵ The process for real property varies by state and likely will be a bit more complex, but the mortgage lender generally will not be hindered by property exemptions.²²⁶

Whether or not it pursues formal collection for a debt, a creditor may be inclined to participate in the credit reporting system. The credit reporting system, governed largely by the Fair Credit Reporting Act, alerts other creditors, insurers, landlords, and even employers to unpaid debts and related collection activity.²²⁷ The available data suggest that some medical

²²¹ See 11 U.S.C. § 522(f) (2000) (allowing avoidance of judicial liens to the extent they impair property exemptions); see also *Hughes v. Marshall Mem'l Hosp.* (*In re Hughes*), No. EO-98-086, 1999 WL 232672 (B.A.P. 10th Cir. Apr. 15, 1999) (reversing and remanding denial of debtor's motion to avoid hospital's judicial lien); *In re Schwartz*, No. 92-32725-S-7, 1993 WL 405010 (N.D. Ohio June 18, 1993) (involving hospital lien already avoided); *In re Patterson*, 275 B.R. 578 (Bankr. D. Colo. 2002) (involving hospital lien for over \$16,000); *In re Freeman*, 259 B.R. 104 (Bankr. D.S.C. 2001) (involving hospital lien securing debt of over \$28,000, but with interest, exceeding \$47,000); *In re Groff*, 223 B.R. 697 (Bankr. S.D. Ill. 1998) (involving lien for over \$13,000); *In re Cardwell*, 128 B.R. 427 (Bankr. S.D. Ohio 1991) (seeking to avoid hospital and doctor liens); *McCullough v. IRS* (*In re McCullough*), 122 B.R. 251 (Bankr. W.D. Pa. 1990) (involving hospital judicial lien avoided); *In re Owens*, 67 B.R. 418, 420 (Bankr. E.D. Pa. 1987) (same); *In re Wolf*, 58 B.R. 354 (Bankr. N.D. Ohio 1986) (involving four liens, including two hospital liens with twenty percent interest); *In re Marino*, 27 B.R. 282 (Bankr. N.D. Ind. 1983) (involving ten liens, including two hospital liens). But see *Anderson v. Blair* (*In re Blair*), No. 99-08835-W, 2000 WL 33710889 (Bankr. D.S.C. June 27, 2000) (involving hospital lien already paid at time of sale); *Barzee v. Trammel* (*In re Trammel*), 63 B.R. 878 (Bankr. E.D. Va. 1986) (trying unsuccessfully to avoid hospital's judicial lien on property the filer no longer owned).

²²² See, e.g., *In re Vasquez*, 205 B.R. 136 (Bankr. N.D. Ill. 1997); *In re Rodriguez*, 140 B.R. 562 (Bankr. D. Kan. 1992); *Stoffer v. St. Mary's Hosp. Sisters* (*In re Stoffer*), 103 B.R. 1008 (Bankr. C.D. Ill. 1986). But see *Johnston Mem'l Hosp. v. Hess*, 44 B.R. 598 (W.D. Va. 1984) (honoring hospital's judgment lien even though debtor did not own property at time of writ).

²²³ See, e.g., 11 U.S.C. § 522(f) (2000).

²²⁴ See generally JAMES J. WHITE & ROBERT S. SUMMERS, UNIFORM COMMERCIAL CODE: SECURED TRANSACTIONS (5th ed. 2000).

²²⁵ U.C.C. § 9-609 (2001) (permitting secured creditor to take possession of collateral after default); *id.* § 9-610 (permitting disposition of collateral through commercially reasonable private sale).

²²⁶ See, e.g., WIS. STAT. § 815.20 (2005) (providing that homestead exemption does not apply to mortgages).

²²⁷ See Fair Credit Reporting Act, 15 U.S.C. § 1681b (2000) (including employment among permissible purposes for furnishing of credit reports); *id.* § 1681k (listing requirements relating to public record information for employment-related inquiries); *id.* § 1681c (specifying length of time for reporting notation); see also *Spence v. TRW, Inc.*, 92 F.3d 380 (6th Cir. 1996) (credit reporting challenge). Congress

providers regularly participate in this system,²²⁸ although their participation surely pales in comparison with the submission of delinquency information by consumer lenders.²²⁹ Some observers have speculated that medical debt owed to providers has a lesser credit rating impact than ordinary consumer loans.²³⁰ Even so, the notations relating to medical debts may affect a substantial number of credit scores,²³¹ although again, not nearly to the extent of late payments or defaults on ordinary consumer credit.

Overall, the debtor-creditor system contemplates that creditors—which is what hospitals are considered under our health care system—will engage in informal collection (including frequent phone calls), formal collection (including lawsuits and liens), credit reporting participation when their debtors fail to pay, or any combination of these tactics.

C. Summary

This brief tour through liability and debt collection offers a framework for evaluating the claim that hospitals misbehave when they collect the debts owed to them. Medical debt collection is the consequence of the structure of our health care finance and debtor-creditor systems, not simply

recently reauthorized the Fair Credit Reporting Act. See Fair and Accurate Credit Transactions Act of 2003, Pub. L. No. 108-159, 117 Stat 1952.

²²⁸ Federal Reserve economists estimate that medical bills account for 18.2% of court judgments on credit reports, and 52.2% of collection agency actions reported to credit bureaus. See Robert B. Avery et al., *An Overview of Consumer Data and Credit Reporting*, 89 FED. RES. BULL. 47, 67, 69 (2003); see also COLLINS ET AL., *supra* note 105, at 17–19 (reporting on percentage of adults being contacted by collection agencies or having other medical bill problems).

²²⁹ Most of the components of a credit score and credit report relate to trade lines of credit, the holders of which regularly report loan, repayment, and delinquency information to credit bureaus. See MyFico, What's in Your Credit Report, <http://www.myfico.com/CreditEducation/InYourReport.aspx?fire=5> (last visited Jan. 2, 2006). According to Fair Isaac, the credit scoring firm, the average consumer has thirteen credit obligations on a credit report, including various types of credit and charge cards and installment loans reported by lenders. See MyFico, Average Credit Statistics, <http://www.myfico.com/CreditEducation/AverageStats.aspx> (last visited Jan. 2, 2006).

²³⁰ See, e.g., *Hearing on Hospital Billing and Collections*, *supra* note 28, at 111 (written statement of Jack Bovender, Hospital Corp. of America) (“I have been told by people who do credit scoring and are in this type of business that hospital debt is not viewed at the same level as mortgages and car payments.”).

²³¹ Federal Reserve economists estimate that medical-related collection agency actions affect the credit scores of 15% of the general population and 51.6% of the low credit score population. Among those for whom eliminating the impact of medical debt collections raised the score, the average increase was 11.2 points for the general population, 8 points for the low-credit-score population, and 16.6 points for the high-credit-score population. Among those for whom eliminating the impact of medical debt collections decreased the score, the average decrease was 5.9 points for the general population, 2.7 points for the low-credit-score population, and 6.8 points for the high-credit-score population. See Robert B. Avery, Paul S. Calem & Glenn B. Canner, *Credit Report Accuracy and Access to Credit*, 90 FED. RES. BULL. 297, 314 tbl.3, 316 tbl.4 (2004). The credit score is “not only a respected estimate of a credit report’s implied creditworthiness, it is the implied creditworthiness for some purposes.” David K. Musto, *What Happens When Information Leaves a Market?: Evidence from Postbankruptcy Consumers*, 77 J. BUS. 725, 730 (2004).

the manifestation of a provider's misbehavior. Most patients bear some self-pay liability, and this will be the case even if hospitals properly implement reasonably generous charity care and discount policies. By and large, hospitals are engaging in activities and practices recognized as part of our system of contract and related liability enforcement. If those practices are shocking, inefficient, or otherwise inappropriate, they should be banned regardless of whether they are undertaken by Citibank or City Hospital.

To sustain the claim that hospitals should be singled out among consumer creditors for their collection activities, it is necessary to show that there is something special about what hospitals do. There is no doubt that they may have overreached in certain instances, in much the same way as other kinds of creditors have done from time to time.²³² But current debtor-creditor law is reasonably lenient with respect to the creation of legally binding obligations and the use of informal and formal mechanisms to collect those amounts. Our system tolerates relatively aggressive attempts to pressure individual debtors to pay. Medical debt collection has the potential to exacerbate the trouble for people already struggling with illness or injury, but this issue is distinct from whether hospitals misbehave when they engage in standard forms of collection available to all creditors.

It would be possible to develop additional arguments that hospitals are using their debt collection powers differently than other providers and creditors, but such arguments would require more empirical support. For

²³² For example, we have concerns about the use of body attachments, bench warrants, or courts' contempt power as a debt collection practice. See source cited *supra* note 17. Formally, imprisonment in these contexts is for failure to abide by a court order (such as an order to appear in court) because imprisonment for debt has long been prohibited in most contexts. See William J. Woodward, Jr., *New Judgment Liens on Personal Property: Does "Efficient" Mean "Better"?*, 27 HARV. J. ON LEGIS. 1, 42–43 (1990) (“[T]he legal system seldom imposes criminal sanctions on debtors.”); Becky A. Vogt, Note, *State v. Allison: Imprisonment for Debt in South Dakota*, 46 S.D. L. REV. 334, 347 (2001) (reviewing federal and state abolition of imprisonment for indebtedness). Functionally, this approach wields the tremendous leverage of restricting personal freedom in order to collect debts. See 1 Edward C. Dolan, *Collection of Contract Debts*, in PRACTICE MANUAL FOR THE MARYLAND LAWYER S-35, S-36 (3d ed. 2002) (“[B]ody attachments are usually rather effective, as most debtors do not like to be imprisoned and suddenly find funds.”); Karen I. Englehardt, *Guide to Collection Procedures in Federal Court*, 16 CHIC. BAR ASS'N REC. 34, 36–37 (2002) (“If the witness does not attend that hearing, you should ask the court to enter a body attachment, the process where the U.S. Marshal's Service will arrest and bring the witness to the Judge.”). Some hospital executives testified under oath that they now prohibit their debt collectors from using bench warrants. See *Hearing on Hospital Billing and Collections*, *supra* note 28, at 89 (written statement of Kevin Lofton, Catholic Health Initiatives) (stating that new contracts with collectors prohibit bench warrants); *id.* at 293 (stating that Ascension Health's new policy prohibits bench warrants). Individual hospitals may have attempted to overreach in other related and distinct ways, but this is not limited to the last few years. See, e.g., *Cnty. Hosp. of Roanoke Valley, Inc. v. Musser (In re Musser)*, 24 B.R. 913 (W.D. Va. 1982) (involving a hospital forcing family to sign (unenforceable) waiver of homestead exemption following serious accident); *County of Santa Clara v. Vargas*, 139 Cal. Rptr. 537 (Ct. App. 1977) (permitting continuation of lawsuit against deceased patient's spouse due to statute of limitations waiver); *Turnboo v. County of Santa Clara*, 301 P.2d 992 (Cal. Dist. Ct. App. 1956) (upholding waiver of statute of limitations); *Bedard v. Notre Dame Hosp.*, 151 A.2d 690 (R.I. 1959) (involving plaintiff's allegation that hospital refused to release two-year-old son).

example, perhaps systematic research would uncover that hospitals are categorically more aggressive in collection than other kinds of creditors. Or perhaps studies would find that hospitals direct their collection efforts toward debtors who are much less likely to be able to pay for the sole purpose of deterring their attempts to get health care at all. These would be important research questions for both health policy and debtor-creditor policy and are questions we hope to pursue in future years. Depending on the findings, such research potentially could help justify the misbehavior label and the pursuit of a more targeted response. At this point, however, the evidence has not been presented.

Others may argue that not-for-profit or religious hospitals have special obligations to refrain from engaging in collection activities even in the absence of this kind of data.²³³ We would be surprised by a broad claim that debt collection is off limits for all entities with tax-exempt status—including credit unions, universities, and most of the nation’s hospitals.²³⁴ If anything, we suspect some of them have a rather strong need to try to collect what they are owed.²³⁵ Nonetheless, if the goal is to preclude not-for-profit or religious hospitals from engaging in debt collection, then it may make sense to reconsider debt collection entitlements more broadly. Those who have studied the debtor-creditor system have long worried about the impact of indebtedness and debt collection.²³⁶ If the motivating concern is protection of individuals—as opposed to promoting a more palatable conception of “charitable” institutions—then the analysis is more effective if it is shifted to a patient/debtor-centered or tactic-based approach to the problem rather than focusing on the identity and “wrongdoing” of particular types of creditors. We return to this issue in Part V.

V. IMPLICATIONS, PROPOSALS, AND CONCLUSIONS

News media reports, the work of advocate groups, and the responses of lawmakers have made the public more aware that medical problems can financially devastate people of modest means and that aggressive debt collection exacerbates the impact of our chosen health care finance system. We applaud those who have surfaced this issue. Without them, the stories would remain largely in the shadows. But the responses to these revelations are heading in the wrong direction. They take the form of proposals nar-

²³³ See, e.g., Benjamin & Gabriesheski, *supra* note 159.

²³⁴ See U.S. CENSUS BUREAU, STATISTICAL ABSTRACT, *supra* note 114, at 111 tbl.157; Greaney & Boozang, *supra* note 58, at 3.

²³⁵ See generally Greaney & Boozang, *supra* note 58, at 39 (discussing application of corporate duties and law to nonprofits, and noting that fiduciaries in nonprofit setting have special duty to protect assets); Kelley, *supra* note 54.

²³⁶ See, e.g., DAVID CAPLOVITZ, CONSUMERS IN TROUBLE: A STUDY OF DEBTORS IN DEFAULT 288 (1974) (concluding that “the current system of resolving disputes between creditors and debtors is far too costly both to the debtors and to society at large”). See generally Melissa B. Jacoby, *Does Indebtedness Influence Health?: A Preliminary Inquiry*, 30 J.L. MED. & ETHICS 560, 564–67 (2002).

rowly targeted toward making hospitals behave differently rather than taking a critical look at the structure of the health care finance system that makes it inevitable that this activity will occur. In this Part, we briefly identify some implications of our analysis.

Judging by the advocacy groups' interest in the hospital misbehavior model, we assume they believe that some low-income uninsured people will benefit from this approach in the short term.²³⁷ In a world in which little progress is made to solve health care finance problems, the possibility of some advancement for this group may seem attractive. But hospitals have limited capacity to provide enduring answers. They cannot finance the health care of the uninsured even if they spend every dollar of the value of their tax exemptions.²³⁸ They already collect far less than the full amount from self-pay patients.²³⁹ Expecting hospitals to absorb the cost of treating uninsured patients may contribute to a reduction of the number of services available to all patients, which of course would be counterproductive.²⁴⁰

²³⁷ See, e.g., *Hearing on Hospital Billing and Collections*, *supra* note 28, at 33–37 (written statement of Mark Rukavina, The Access Project); PATIENT FRIENDLY BILLING PROJECT, *supra* note 48, at 14 (explaining types of payment plans that surveyed hospitals are implementing).

²³⁸ See Noble et al., *supra* note 30 (charity hospitals); Elizabeth K. Keating et al., *Assessing Financial Vulnerability in the Nonprofit Sector* (John F. Kennedy Sch. of Gov't, Faculty Research Working Paper No. RWP05-002, 2005) (nonprofit hospitals).

²³⁹ See, e.g., Prottas, *supra* note 109 (“Hospitals’ bad debt collections are very low—estimates generally range from 7% to 10% Charging the uninsured more than the insured gains hospitals . . . virtually no revenue.”); *Hearing on Hospital Billing and Collections*, *supra* note 28, at 94 (written statement of Jack Bovender, Hospital Corp. of America) (reporting that HCA treated one million uninsured patients in the previous year, that they contributed less than one percent to HCA’s net revenues, and that HCA lost half a billion dollars in unreimbursed costs); *id.* at 100 (June 24, 2004) (written statement of Herbert Pardes, New York Presbyterian Hospital) (reporting that the hospital collects twelve to thirteen percent of the charges for services from self-pay patients, with write-offs approaching \$70 million per year).

²⁴⁰ See Jill R. Horwitz, *Why We Need the Independent Sector: The Behavior, Law, and Ethics of Not-For-Profit Hospitals*, 50 UCLA L. REV. 1345, 1405–07 (2003); Noble et al., *supra* note 30. *But see* Greaney & Boozang, *supra* note 58, at 6 (noting competing evidence on whether not-for-profit hospitals provide benefits justifying special treatment). *See also* *Hearing on Hospital Billing and Collections*, *supra* note 28, at 94 (written statement of Jack Bovender, Hospital Corp. of America) (reporting on how full service facilities are left caring for uninsured while physician-owned limited care hospitals take profitable services for low risk patients); SCHUMACHER GROUP, 2004 HOSPITAL EMERGENCY DEPARTMENT ADMINISTRATION SURVEY (2004) (on file with authors) (using 2003 data and reporting that 33% of respondents who lost specialty coverage reported that uncompensated care discouraged specialists from providing coverage, 20% reported reimbursement for services as the top concern or priority facing the department in the next twelve months, 77% reported that their emergency department was a major provider of primary care for the indigent or uninsured in the community, 39% reported that patients sometimes have to wait more than two hours to receive care, and 9% reported patients often had to wait more than two hours). Hospitals have raised the question of whether the pressure to provide larger write-offs will restrict the services that employers and insurers are willing to cover. PATIENT FRIENDLY BILLING PROJECT, *supra* note 48, at 6–7. Although their point may be self-serving, their question accurately reflects the impossibility of hospitals solving even hospital-specific problems on their own. A wider range of parties must tackle the structural factors.

In addition, even if lawmakers implement misbehavior-driven responses with full hospital compliance, the type of problems that received front-page treatment will not subside because their structural determinants will continue to exist; the problems will simply receive less attention. Families will lose homes due to foreclosure of mortgages incurred to finance major health expenses. Insured families will be dunned by hospitals or credit card lenders for big co-pays and deductibles. Middle-aged couples will drain assets intended to fund retirement in order to keep their short-term finances together after a major health crisis. Medical problems will hinder the ability of people to work. Parents will struggle to take care of seriously ill children, and adult children will struggle to take care of aging parents. To curb costs, some patients may underuse prescribed medication or deny themselves needed medical care.²⁴¹ In the meantime, worrying about medical-related financial distress may exacerbate health problems.²⁴² Hospitals can neither bear all the blame nor shoulder the entire burden.

In an ideal world, policymakers would identify the full range of financial problems faced by individuals and their families in the aftermath of serious illness or injury and would undertake a comprehensive study of the aspects of our health care finance system—broadly construed—that contribute to these problems. Medical and public health researchers are searching for mechanisms to measure the full economic impact of sickness on households around the world.²⁴³ Studies of health care issues in other na-

²⁴¹ See, e.g., *Hearing on Hospital Billing and Collections*, *supra* note 28, at 53 chart 16 (written statement of Sara Collins, The Commonwealth Fund) (reporting on health care deprivations based on insurance status); Himmelstein et al., *supra* note 70, at W5-68 exhibit 4 (reporting privations experienced by medical-related bankruptcy filers prior to filing); O'Toole et al., *supra* note 212, at 774 tbl.2 (reporting that 67.4% of low-income patients surveyed reported medical debt or collection activity affected subsequent care, including delay in seeking care or use of emergency room); see also Adrienne S. Kapel et al., *Increasing Up-Front Collections*, HEALTHCARE FIN. MGMT., Mar. 2004, at 82 (reporting that patients cancel appointments when doctors change payment policies).

²⁴² See J.H.J. Bankroft et al., *The Reasons People Give for Taking Overdoses*, 128 BRITISH J. PSYCHIATRY 538 (1968); Patricia Drentea, *Age, Debt and Anxiety*, 41 J. HEALTH & SOC. BEHAV. 437 (2000); Patricia Drentea & Paul J. Lavrakas, *Over the Limit: The Association Among Health, Race and Debt*, 50 SOC. SCI. & MED. 517 (2000); Simon Hatcher, *Debt and Deliberate Self Poisoning*, 164 BRITISH J. PSYCHIATRY 111 (1994); Sarah Nettleton & Roger Burrows, *When a Capital Investment Becomes an Emotional Loss: The Health Consequences of the Experience of Mortgage Possession in England*, 15 HOUSING STUDS. 463 (2000). For a literature review, see Jacoby, *supra* note 236. But see Angela C. Lyons & Tansel Yilmazer, *Health and Financial Strain: Evidence from the Survey of Consumer Finances*, 71 S. ECON. J. 873 (finding that large financial burdens are unlikely to accelerate a decline in financial status).

²⁴³ See, e.g., Wenke Hwang et al., *Out-of-Pocket Medical Spending for Care of Chronic Conditions*, 20 HEALTH AFF. 267 (2001); Ke Xu et al., *Household Catastrophic Health Expenditure: A Multicountry Analysis*, 362 LANCET 111 (2003); Steven Russell, *The Economic Burden of Illness for Households in Developing Countries: A Review of Studies Focusing on Malaria, Tuberculosis, and Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome*, 7 AM. J. TROPICAL MED. HYGIENE 147 (2004) (showing indirect costs of illness as percentage of household income, and advocating for more complete measure of economic effects at household level); R. Sauerborn et al., *Household Strategies to Cope with the Economic Costs of Illness*, 43 SOC. SCI. & MED. 291 (1996); Eric J. Sherman et al., *The Collection of*

tions with very different economic and health profiles can prompt a rethinking of the boundaries of health care finance in the United States.²⁴⁴

Assuming, as we must, that legislators and policymakers inevitably prefer more incremental and narrowly targeted proposals, our empirical findings in Part III and legal discussion in Part IV nonetheless should shape the contours of such proposals. For example, if legislators decide they can tackle no more than providing better protection for the chronically uninsured from large hospital bills, the proposals must revisit existing state laws that give hospitals special collection rights against low-income patients. They also should find a way to extend any proposed restrictions on hospitals to third-party financers of medical bills; otherwise hospitals will have strong incentives to essentially require patients to incur third-party credit.²⁴⁵

We hope that our exploration of this issue invites a debate on debtor-creditor policy as well. The hospital misbehavior model, properly contextualized, raises the question whether debtor-creditor laws strike the right balance between enforcement of legal obligations and the protection of individuals. For a long time, the law not only has given liberal recognition to the creation of legally binding debts, and given all types of creditors wide latitude in coaxing “voluntary” payments; it has required that taxpayers subsidize debt collection activities against individuals and families of modest means.²⁴⁶ Stories of embarrassing and value-reducing debt collection activities rarely enter into the public discourse. The media’s hospital misbehavior stories have thrown standard debt collection practices into

Indirect and Nonmedical Direct Costs (COIN) Form: A New Tool for Collecting the Invisible Costs of Androgen Independent Prostate Carcinoma, 91 *CANCER* 841 (2000); Hugh R. Waters et al., *Measuring Financial Protection in Health in the United States*, 69 *HEALTH POL’Y* 339 (2004).

²⁴⁴ See, e.g., Jane Falkingham, *Poverty, Out-of-Pocket Payments and Access to Health Care: Evidence from Tajikistan*, 58 *SOC. SCI. & MED.* 247 (2003); Paul Gertler & Jonathan Gruber, *Insuring Consumption Against Illness*, 92 *AM. ECON. REV.* 51 (2002) (Indonesia); Michael Kent Ranson, *Reduction of Catastrophic Health Care Expenditures by a Community-Based Health Insurance Scheme in Gujarat, India: Current Experiences and Challenges*, 80 *BULL. WORLD HEALTH ORG.* 613, 615 (2002) (studying impact of community insurance schemes on medical debt); Steven Russell, *Ability to Pay for Health Care: Concepts and Evidence*, 11 *HEALTH POL’Y & PLANNING* 219 (1996); Sauerborn et al., *supra* note 243 (seeking greater emphasis on time costs of caring and intrahousehold transfers); M. Segal et al., *Economic Transition Should Come with a Health Warning: The Case of Vietnam*, 56 *J. EPIDEMIOLOGICAL COMMUNITY HEALTH* 497 (2002); Wim Van Damme et al., *Out-of-Pocket Health Expenditures and Debt in Poor Households: Evidence from Cambodia*, 9 *TROPICAL MED. & INT’L HEALTH* 273 (2004); Oxford Health Alliance Working Group, *The Economic Consequences of Health Shocks* (World Bank Dev. Research Group, Working Paper No. 3644, 2005), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=757386 (Vietnam).

²⁴⁵ Including private lenders in medical debt collection restrictions admittedly is a much more complex and controversial undertaking. Particularly with respect to multipurpose revolving credit, debt incurred for a hospital stay quickly becomes entangled with credit extended for food, clothing, and other expenditures, not to mention compounding interest and fees. Studies of the purpose of home equity loans show that medical expenses are often lumped together with other household needs.

²⁴⁶ See Whitford, *supra* note 163.

sharp relief, and possibly have set the stage for reexamination of the long-accepted status quo.

The hospital misbehavior model may offer some short-term benefits for the low-income uninsured, and it has shamed some hospitals into reexamining certain aggressive practices. The focus on behavior, though, only superficially captures the entanglement between the health care system and the debtor-creditor system. To make meaningful inroads into the pervasive problem of medical-related financial distress, a much broader structural inquiry is in order.