



## Medical Debt: What States Are Doing to Protect Consumers

Paying for health care is becoming increasingly difficult for American families. Fewer workers are receiving health coverage through their jobs, and those who do have job-based coverage face rising out-of-pocket costs. Not surprisingly, more families are going into debt trying to pay for the health care they need.

The health reform proposals that are currently before Congress would prevent millions of families from accruing medical debt by making insurance affordable for people who are now uninsured, capping out-of-pocket costs for those with insurance, and making sure that people with low incomes have lower out-of-pocket costs. Some provisions in these bills will go further by helping people who are struggling with medical debt.<sup>1</sup>

While these bills will help families and individuals avoid getting into medical debt, they don't address every aspect of this complex problem. That's where states come in. Some states have already taken action to ensure that low-income, uninsured or underinsured Americans are charged fair prices for their care, do not face high interest charges when they cannot afford to pay their medical bills immediately, and are protected from aggressive debt collection practices.<sup>2</sup> This brief looks at four kinds of state protections:

1. **Hospital Billing and Financial Assistance Laws:** A handful of states have passed fairly comprehensive laws that establish requirements for charity care and that restrict hospitals' billing and collection practices. (Charity care is care that is provided to low-income patients by hospitals at reduced prices or for free.)
2. **Legal Agreements with Hospitals about Fair Prices and Debt Collection:** Some states have formal legal agreements with certain hospitals or hospital systems about their charity care and billing policies.
3. **Protections against Balance Billing:** A few states protect insured patients from the large bills that can come when they have to use out-of-network providers. Out-of-network providers generally bill patients the difference between their own charges and what the patient's health plan reimburses; this balance is often far greater than the copayments or co-insurance a patient would pay for seeing in-network providers. This practice is called "balance billing."
4. **Protections from Certain Collection Practices for People with Medical Debt:** Several states provide special exemptions to people with medical debt to protect more of their incomes from collection, or to prevent them from losing their homes.

This brief provides many state-specific examples of these four types of protections, although we do not have information on every state's medical debt laws.

## 1. Hospital Billing and Financial Assistance Laws

In order to help prevent patients from accruing medical debt in the first place, some states have implemented comprehensive laws that inform consumers about their payment options, as well as laws that protect and assist consumers. These laws do the following:

- require that patients be notified about financial assistance or charity care programs,
- set income thresholds at which patients will be offered further financial assistance or charity care,
- limit the amounts that uninsured patients and insured patients with low and modest incomes can be charged,
- limit the amounts that can be collected from patients in a year relative to their income,
- limit the amount of interest that can be charged on patients' delinquent hospital bills, and
- require hospitals to go through certain steps before initiating lawsuits against patients.

For a full listing of state free care laws, see Community Catalyst's Web-based [Free Care Compendium](#).

The table below summarizes the provisions in each state's laws, followed by a closer look at those states and the steps they have taken to protect consumers.

Summary of Consumer Protections that Are Required by Law, by State

	Establishes Income Thresholds For Hospital Charity Care	Hospitals Required to Notify Patients of Charity Care	Limits on Hospital Charges	Limits on Interest for Hospital Bills	Limits on Lawsuits Brought By Hospitals and Debt Collectors	Annual Limits on Collection
California	◆	◆	◆	◆	◆	
Connecticut		◆	◆	◆	◆	
Illinois		◆	◆	◆	◆	◆
Maryland	◆	◆	◆	◆		
New Jersey	◆	◆	◆			
New York	◆	◆	◆	◆	◆	

## ■ California

In 2006, California passed AB 774 (California Health and Safety Code 127400-127446), a law that addresses hospital billing and fair pricing policies, as well as certain debt collection practices. This law requires the following major reforms:

- Hospitals must write up their charity care policies, and notices of these policies must be provided in multiple languages and must be posted in locations around the hospital. Hospitals must also provide patients with notice of their consumer rights and financial options, including information on their right to apply for public health coverage, charity or discounted care, and other forms of assistance. (The law doesn't specify how much charity care hospitals have to provide.)
- Hospitals must make reasonable efforts to see if insurance will cover patient charges, and they must inform patients about public coverage programs for which they may be eligible, such as Medicaid and the Children's Health Insurance Program (CHIP), as well as how to apply for these programs.
- Hospitals may not charge uninsured families with incomes that are less than 350 percent of the federal poverty level (\$64,085 for a family of three in 2009) and that have few assets (see the law for details on asset limits) more than the public price that is set by California's Medicaid program (Medi-Cal), Medicare, or another government-sponsored health care program in which the hospital participates, whichever is greatest.
- Uninsured and underinsured<sup>3</sup> patients who meet the above guidelines are also eligible for hospital charity care. (Generally, patients are considered underinsured if they have high out-of-pocket medical costs – usually above 10 percent of their income.) Rural hospitals can set lower income limits if necessary to maintain their financial integrity.
- When hospitals work out payment plans with low-income uninsured or underinsured patients, they cannot charge interest.
- Hospitals must provide uninsured and underinsured families with a 150-day period during which they can negotiate their hospital payments before their medical bills are sent to collections agencies.
- If a hospital bill goes to collection, the debt collector is not allowed to garnish a patient's wages except by court order. If a collector seeks such a court order, the court must consider the patient's ability to pay, including the patient's likely future medical expenses, before allowing garnishment of wages. Further, the hospital or collector cannot force the sale of the patient's primary residence to pay a medical debt during the patient or spouse's lifetime or while a dependent child is living in the home.

California has other laws that protect insured consumers from receiving bills when a public or private insurer should have paid for medical care (see “California: No Balance Billing for Emergency and Stabilization Care, Rules on Reimbursing Out-of-Network Providers” on page 12).

### ■ Connecticut

In 2003, Connecticut passed Public Act 03-266, An Act Concerning Hospital Billing Practices (Connecticut General Statutes, Sections 19a-509b; 19a-673a, b, and c; 37-3a; and 42-356d). This act strengthened previous state laws that require hospitals to notify patients about the availability of free and discounted care. Public Act 03-266 ensures the following:

- Hospitals must inform patients about their policies regarding free and discounted care. Hospitals must provide a one-page summary in English and Spanish that explains how to apply for free or reduced-cost care. All hospital billing and collection agents, whether internal or external to the particular hospital, have to include notice of the available charity programs in every collection notice that is sent to patients.
- Hospitals must assess indebted patients to determine whether they are eligible for charity care assistance. These assessments must be conducted before the hospital can sue the patient for the debt. If a collector learns that a current or former patient may qualify for charity care, the collector must cease collection activities, even if a lawsuit is in progress or the collector has won a lawsuit.
- Hospitals cannot bill uninsured patients with incomes below 250 percent of poverty (\$45,775 for a family of three in 2009) more than the actual cost of providing the service.
- Medical debt is recognized as involuntary debt and is not subject to the same kind of punitive debt collection tactics that Connecticut allows regarding other kinds of debt.
- Special hearings are held before wage garnishment or bank execution is permitted (bank execution is when a hospital or collection agency takes money out of a patient’s bank account to recover medical bill charges).
- The interest rates that hospitals are allowed to charge patients are capped. The maximum monetary judgment interest on hospital debt is now set at 5 percent. For other kinds of debt, the maximum judgment can be 10 percent. (Until this law was passed, hospitals were able to collect 10 percent interest.)
- Up to \$125,000 of the value of the patient’s home is exempt from collection for a hospital debt. Furthermore, if a person has agreed through a court order to pay a hospital bill in installments, the hospital or collection agency cannot seize or sell the person’s property or garnish their wages or bank account – as long as the consumer is making the required payments.

## ■ Illinois

Illinois passed two laws in recent years that are designed to protect residents from accruing hospital debt. The Fair Patient Billing Act (210 Illinois Compiled Statutes 88/1 to 88/999) went into effect in 2007, and the Hospital Uninsured Patient Discount Act went into effect in 2008 (210 Illinois Compiled Statutes 89/5 to 89/20). These laws ensure that Illinois patients, both uninsured and insured, are protected from unfair hospital billing and collection practices at all licensed hospitals. They also limit hospital charges for uninsured patients. Other general statutes limit interest on debt, including medical debt. Taken together, these laws require the following:

- Hospitals must post notices regarding the availability of any financial assistance they offer in the admission and registration areas of the hospital (the law doesn't specify any income guidelines for such assistance programs). This information must be posted in languages other than English if such languages are spoken in the community. Hospitals must also publicize information on their financial assistance programs through brochures and on patient bills. If a hospital has a Web site, it must also post information about financial assistance and an application for assistance on its site.
- Hospitals must provide patients with timely, clear, and accessible information regarding their bills and how to inquire about or dispute bills.
- Before bills are sent to collection, patients must be given the right to dispute a bill, apply for financial assistance or charity care, or enter into a reasonable payment plan.
- Hospital boards must adopt fair billing and collection policies, and any external collection agencies that are used by a hospital must also abide by its policies. These boards are also expected to approve any post-judgment collection actions, for example, wage garnishment or liens on property.
- In addition to any charity care programs they have established, hospitals must discount what they charge to uninsured patients who meet income and asset guidelines, and the law specifies the income guidelines for these discounts.<sup>4</sup>
- Hospitals can collect a maximum of 25 percent of a family's income in a year from an uninsured patient who is eligible for discounted care.
- Unless the debtor has agreed to a different amount of interest in writing, interest on all types of bills in Illinois is generally limited to 5 percent per year before judgment and 9 percent per year if the debtor is taken to court and there is a judgment against him or her. However, no legal action may be taken against uninsured patients for uncollected hospital bills if patients have demonstrated that they cannot meet their financial obligations because of insufficient income and assets.

## ■ Maryland

On May 7, 2009, Governor Martin O'Malley approved Senate Bill 776 (Health General §§19-214.2 and 19-214.3), which strengthens hospital financial assistance programs and better protects consumers from hospital debt. The new law requires the following:

- Hospitals must establish policies for providing free and reduced-cost care, and they must post notices about these policies in areas that are easily accessible to patients.
- Hospitals must have uniform applications for financial assistance, and they must give these applications to all uninsured patients.
- Hospitals must send an easy-to-read information sheet along with hospital bills that explains who to contact about the bill, how to apply for financial assistance, how to apply for Medicaid or other programs that might help, the patient's rights with respect to the bill, and that they will receive separate bills for physician services.
- When a hospital sends a bill to a debt collector who attempts to collect on behalf of the hospital, the hospital must actively oversee the debt collector's practices.
- Hospitals cannot sell bills to debt collectors. Selling bills to debt collectors has been a way for hospitals to get partial payment while letting go of collection responsibilities. This practice has resulted in aggressive, and sometimes abusive, collection tactics.
- Hospital financial assistance programs must provide medically necessary care for free to patients with family incomes at or below 150 percent of poverty (\$27,465 for a family of three in 2009), and for a reduced cost to patients with family incomes above 150 percent of poverty. Hospitals have discretion to set the upper income limits for their assistance programs "in accordance with the mission and service area of the hospital."
- Hospitals cannot charge interest on bills incurred by self-pay patients before a court judgment is obtained.

Current Maryland law still allows liens to be placed on patients' homes to collect medical debt, and the liens can result in foreclosure. However, Senate Bill 776 requires the Maryland Health Services Cost Review Commission to convene a new workgroup on patient financial assistance and debt collection to evaluate the use of liens and to consider further reforms in hospital debt collection practices.

A separate Maryland law (Health General §19-710) prohibits providers from collecting from a patient any money owed by a health maintenance organization (HMO) for a covered service (see "Maryland: No Balance Billing for Emergency or Other Authorized Services" on page 14).

## ■ New Jersey

Since 1992, New Jersey has required hospitals to provide charity care to low-income, uninsured patients, as well as to patients whose insurance covers only part of the bill, through its Hospital Care Payment Assistance Program. This law, as it has been amended over the years, also mandates uniform hospital guidelines and accounting practices (Public Law 1997 Chapter 263 and N. J. A. C. 10:52-11-13). To help hospitals provide this care, New Jersey maintains a health care subsidy fund that pays hospitals based on the extent of the charity care they provide. In 2008, New Jersey enacted a law to limit hospital charges for uninsured patients (Public Law 2008, c.60 (C.26:2H-1 et seq.)). Taken together, these two laws do the following:

- Require hospitals to notify patients about the availability of charity care at the time of service or when they first receive a bill. Hospitals must also post notices about their charity care programs throughout the hospital in English, Spanish, and other languages that are widely spoken by patients.
- Prohibit hospitals from charging uninsured patients whose gross income is below 500 percent of poverty (\$54,150 for an individual in 2009) more than 15 percent above the applicable Medicare rate.
- Require hospitals to provide charity care to people with incomes up to 300 percent of poverty through New Jersey's Hospital Care Payment Assistance Program. To be eligible for charity care, people must also meet an asset test: Assets cannot exceed \$7,500 for individuals and \$15,000 for families.
  - People with incomes below 200 percent of poverty (below \$21,660 for an individual in 2009) get free care.
  - People with incomes between 200 and 300 percent of poverty (\$21,660 to \$32,490 for an individual in 2009) receive care that is discounted on a sliding scale.
- People who are eligible for free care may not be billed or be subject to collection procedures.<sup>5</sup> For those people who are eligible for sliding scale charity care, the hospital may not bill or begin collection procedures on the portion of the bill that is supposed to be covered by charity care (the difference between the full amount and the discounted amount).

## ■ New York

In April 2006, New York passed bipartisan legislation that enhances the state's hospital charity care policies.<sup>6</sup> The law, which amends New York State Public Health Law, Section 2807-K, went into effect on January 1, 2007. The law applies to all New York general hospitals and requires the following:

- Hospitals must notify patients about their financial assistance policies upon admission, on their bills, and in notices posted around the hospital. Hospitals must also make this information available in multiple languages.
- Hospitals must reduce their charges for low-income patients who are uninsured or who have exhausted their health insurance benefits and who can demonstrate an inability to pay the hospital's full charge. The hospital can still charge these patients, but only up to the rate paid by the hospital's highest-volume health insurer for the same services. Hospitals may also choose to reduce or discount the copayments or deductibles that they collect from insured patients who can demonstrate an inability to pay.
- Hospitals must implement a sliding-scale payment system for uninsured, low-income patients. All uninsured patients with incomes below 300 percent of poverty (\$32,490 for an individual or \$54,930 for a family of three in 2009) are deemed "presumptively eligible" for one of the following payment reductions:
  - For uninsured individuals with incomes at or below the federal poverty level, hospitals may charge only a nominal hospital fee (to be determined by the Commissioner for Health). This hospital fee is the only charge.
  - For uninsured patients with incomes between 101 and 150 percent of poverty (\$10,830 to \$16,245 for an individual in 2009), hospitals may charge a sliding-scale fee where the maximum charge is no more than 20 percent of what the hospital would have been paid by its highest-volume payer, Medicare, or Medicaid – whichever is greatest.
  - For uninsured patients with incomes between 151 and 250 percent of poverty (\$16,245 to \$27,075 for an individual in 2009), hospitals may charge sliding-scale fees of between 20 and 100 percent of what the hospital would have been paid by its highest-volume payer, Medicare, or Medicaid – whichever is greatest.
  - For uninsured patients with incomes between 251 and 300 percent of poverty (\$27,075 to \$32,490 for an individual in 2009), hospitals may charge no more than what the hospital would have been paid by its highest-volume payer, Medicare, or Medicaid – whichever is greatest.
- Hospitals must allow patients to pay in installments, and they may charge only a limited amount of interest on outstanding balances.<sup>7</sup> Hospitals and debt collectors also cannot raise the interest rate on debt when someone misses a payment.
- Hospitals and their collectors cannot foreclose on a patient's home or force the sale of a home in order to collect on a bill.
- No collection is permitted against people who are eligible for Medicaid at the time of service.



- Collection agencies must obtain the hospital's written consent prior to commencing legal action.
- Hospitals must file reports with the state about the financial assistance they provide to patients.

### Nevada Law Helps Consumers Negotiate Payment Agreements

Nevada takes a narrower approach through a law that requires "major hospitals" to provide discounts of at least 30 percent on hospital bills to patients who are uninsured, who are ineligible for a government program that would pay the bill, and who make reasonable arrangements to pay their bills within 30 days of being discharged. The Bureau for Hospital Patients in the Governor's office hears, mediates, arbitrates, and resolves disputes between patients and hospitals about charges and whether these payment arrangements are reasonable. (Nevada Revised Statutes 223.575 and 439B.260)

## 2. Legal Agreements with Hospitals about Fair Prices and Debt Collection

A few states have crafted formal legal agreements with certain hospitals or hospital systems about their charity care and billing policies. The following are examples of such agreements:

### ■ Minnesota:

#### Agreements on Discounted Hospital Care and Hospital Debt Collection Practices

In 2005, the Minnesota Attorney General's office forged an agreement with more than 125 hospitals across the state regarding their debt collection practices for the uninsured. The hospitals agreed to charge a fair price for care and to be less aggressive in their debt collection practices. In 2007, the Attorney General and hospitals extended the agreement for five more years.<sup>8</sup>

Under the agreement, uninsured patients who make less than \$125,000 a year receive the same discounts that insurance companies have negotiated with the hospitals. This can mean a 40 to 60 percent price reduction for services. This agreement also changed hospital debt collection practices in the following ways:

- Before filing lawsuits against patients, hospital administrators must screen patient records to ensure that insurance companies have been billed and that payment plans, as well as any free or discounted care, have been offered to eligible patients.
- A clear process must be developed for patients to dispute or challenge bills from hospitals or clinics, and no judgments may be made against patients until they are given time to respond.

- Hospitals are not allowed to withdraw any money from patients' bank accounts without a legal judgment authorizing them to do so.
- A "zero tolerance" policy was implemented to prevent debt collectors from engaging in abusive collection practices. Hospital boards must review their debt collection practices frequently.

In 2009, the Minnesota Attorney General reached a settlement with another nonprofit hospital and clinic system regarding the interest they charge on medical bills. Prior to the lawsuit, Allina Hospitals and Clinics had offered to finance patients' medical debt through a service called MedCredit that charged patients 18 percent interest. Attorney General Lori Swanson sued, citing a Minnesota law that sets the allowable interest rate under this type of arrangement at 8 percent. Allina agreed to cap the interest it charged for future bills at 8 percent and to reimburse patients who had been charged higher interest during the two years before the lawsuit (January 22, 2007 to January 31, 2009).<sup>9</sup>

#### ■ Wisconsin:

##### Agreements on Discounted Care and Other Charity Care

In 2005, state Attorney General Peg Lautenschlager filed complaints (No. 05C52, 05C53) before the Department of Agriculture and the Department of Trade and Consumer Protection against the nonprofit hospital system Wheaton Franciscan Health Care. These complaints stated that two of its hospitals, the St. Joseph Medical Center and the Wisconsin Heart Hospital, overcharged uninsured patients. In response, Wheaton Franciscan Health Care revised what it charged uninsured ("self-pay") patients and revised its voluntary charity care policies for low-income, self-pay patients. Subsequently, Ms. Lautenschlager dismissed the complaints.

Under the revised billing system, Wheaton Franciscan Health Care agreed to provide self-pay patients with discounts equal to the average percent discount that is offered to the three largest managed care providers. In the Milwaukee area, this discount is estimated to be about 45 percent.

In addition to these discounts, other significant changes were made to Wheaton Franciscan Health Care's charity care policy. Patients with financial need may qualify for charity care discounts in addition to the discounts that apply to all self-pay patients. To qualify for charity care, patients must meet the following requirements:

- Their income must be at or below 400 percent of poverty (\$43,320 for an individual in 2009). Previously, only patients with incomes below 300 percent of poverty were eligible for charitable care discounts. Patients with incomes at or below 200 percent of poverty (\$21,660 for an individual in 2009) receive free care.

- Their assets must not exceed \$50,000 (the previous limit was \$20,000). Assets are defined as savings, checking accounts, CDs, stocks, bonds, IRAs, 401(k)s, 403(b)s, and property that generates rental income.
- Their home equity must not exceed \$150,000 (the previous limit was \$100,000).<sup>10</sup>

All patients who receive charitable care do not have to pay any out-of-pocket expenses once their total out-of-pocket costs have reached 15 percent of their gross income.

In December 2006, a similar agreement was reached with Mercy Health System Corporation, another nonprofit hospital system in Wisconsin. Under that agreement, Mercy Health will provide an automatic discount to uninsured patients equal to the average percent discount that is offered to insured patients.<sup>11</sup>

### 3. Protections against Balance Billing

Insured patients often face a different problem in regards to medical debt: In some situations, they do not have control over which providers they use, and they face very high charges when they use out-of-network providers. In particular, consumers may not be able to avoid using out-of-network providers in an emergency. Furthermore, when patients are admitted to a hospital that is within their plan's network, they are often treated by specialists and ancillary providers, such as anesthesiologists, who are not in their network. The patients usually do not realize that they are seeing out-of-network providers until they get a bill. In both of these situations, the out-of-network providers generally bill patients the difference between their own charges and what the health plan reimburses; this balance is often far greater than the copayments or co-insurance a patient would pay for seeing in-network providers. This practice is called "balance billing."

Most health plans will provide some coverage for out-of-network emergency services without prior authorization. However, most states have not addressed the issue of whether patients can still be billed the balance between the out-of-network provider's charges for these services and what their plan reimburses.

A few states have tried to address these problems for patients in health maintenance organizations (HMOs), and a very few states have also addressed problems for patients in preferred provider organizations (PPOs). Laws in these states require plans to pay for certain out-of-network services and prohibit providers from billing patients for more than their copayments and co-insurance. Some state laws go on to explain how the plans should determine the rates they pay the out-of-network providers.

The following are examples of laws that some states have passed to protect consumers from balance billing:

## ■ California:

### No Balance Billing for Emergency and Stabilization Care, Rules on Reimbursing Out-of-Network Providers

California's managed care law requires health plans to pay for emergency stabilization care without prior authorization. If a person has received such care out of network, the plan must either make arrangements to transfer the patient to an in-network facility for any further necessary care once the patient is stabilized, or it must agree to continue paying for post-stabilization care at the out-of-network facility. (California Health and Safety Code § 1371.4.)

In addition, unless the patient has refused an offer of safe transfer to a network hospital for post-stabilization care, California generally prohibits hospitals from billing patients any more than their plan's copayments, deductibles, and co-insurance for emergency care or for post-stabilization care. (California Health and Safety Code §1262.8.) And, if there is a dispute between a plan and a contracting provider about payment, the contracting provider cannot attempt to collect from the patient any money that is owed by the plan. (California Health and Safety Code § 1379.)

The California Department of Managed Care has issued rules about how much a health plan must reimburse out-of-network providers: The plan must pay a "reasonable and customary value," taking into account the provider's experience and qualifications, the provider's usual fees, rates charged by other providers in the area, and other relevant factors and circumstances. (Cal. Code Regs., tit. 28, § 1300.71, subd. (a)(3)(B))<sup>12</sup>

Even after enactment of these laws and regulations, there have still been disputes about how they apply to emergency room doctors who are out of a patient's network and who do not have a written contract with the patient's HMO. However, the issue was recently addressed in the legal case *Prospect Medical Group Inc. v. Northridge Emergency Medical Group* (California Supreme Court Opinion No. S142209, January 8, 2009). The court found that these laws and regulations prohibit emergency room physicians who practice in in-network facilities from balance billing patients, even if the emergency room physicians themselves are not part of a patient's network.

#### Patients with Medicaid May Not Be Billed

Under federal law, Medicaid providers are required to accept Medicaid as payment in full and can bill Medicaid patients for copayments only. Despite this law, Medicaid patients throughout the country often receive bills when providers have difficulty collecting Medicaid reimbursement. California law clarifies that patients should not be tangled in these payment disputes:

"Any provider of health care services who obtains a label or copy from the Medi-Cal card or other proof of eligibility pursuant to this chapter shall not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the eligible applicant or recipient . . . ." (California Welfare and Institutions Code §14019.4.)

## ■ Colorado:

### **No Balance Billing by Out-of-Network Providers Who Practice in Network Facilities**

In 2006, Colorado passed a law to protect consumers who receive care from out-of-network providers when they go to in-network facilities. The statute was enacted to reinforce a determination by the Colorado Division of Insurance that mandates that insurers must hold consumers harmless for any additional charges from out-of-network providers for care that is provided in network facilities (meaning that patients don't have to pay those charges). The law requires that if a consumer who is covered in either an HMO or PPO uses a network facility and is not aware that assisting providers are out of his or her network, the "covered services or treatment rendered at a network facility, including ancillary services or treatment rendered by an out-of-network provider performing the services or treatment at a network facility, shall be covered at no greater cost to the covered person than if the services or treatment were obtained from an in-network provider." However, the law does not set a payment formula for out-of-network services. (Colorado Revised Statutes 10-16-704 (3).)

Because the measure was somewhat controversial when the legislature was considering it, the law was scheduled to sunset in July 2010. However, before the repeal takes effect, the law specifies that the Division of Insurance must evaluate the impact of the law on consumers. That evaluation is currently underway and will help advise further legislative action.<sup>13</sup>

## ■ Delaware:

### **No Balance Billing for Emergency Services or for Special Dental Services**

Delaware prohibits out-of-network providers from billing insured patients for emergency care. This care includes screening examinations, stabilization services, and, if they have been authorized by the insurer, post-stabilization services. Instead of billing patients, the law requires all individual and group health insurance plans to make payments for out-of-network emergency care at negotiated rates. If the provider and plan cannot agree on a rate, the Insurance Commission provides an arbitration process for settling the dispute. (Delaware Code 18-3565)

Under a new law that will go into effect in July 2010, Delaware will also protect families of children with severe disabilities who use out-of-network dental providers that offer specialized treatment and support. Individual and group health plans must reimburse these out-of-network providers at the insurers' reasonable and customary rate for similar services in the area, and the providers cannot balance bill the families. (Delaware Code 18-3571C and 18-3558)

**■ Florida:****No Balance Billing for Emergency Services**

Florida's managed care law prohibits HMOs from collecting or attempting to collect from the patient, or from reporting the patient to a credit bureau, when the HMO is liable for payment. HMOs (not patients) are liable for payment of fees for emergency services that are provided, even if the provider is out of the patient's network. (Florida Statutes 641.3154) Furthermore, the law requires HMOs to reimburse out-of-network emergency providers the lesser of the following: the provider's charges, the usual and customary charges for similar services in the community, or a rate agreed to by the HMO and the provider. If the patient is a Medicaid recipient, the Medicaid rate is also considered. (Florida Statutes 641.513)

**■ Maryland:****No Balance Billing for Emergency or Other Authorized Services**

Maryland law prohibits providers from collecting from an enrollee any money that is owed by an HMO for a covered service. The law also sets rates that plans must pay to out-of-network providers either in an emergency or when use of an out-of-network provider has been preauthorized by the plan. This payment formula was recently modified, and effective January 2010, out-of-network providers will be paid as follows (Health General §19-710):

- Hospitals will be paid an amount that has been approved by Maryland's Health Services Cost Review Commission;
- Trauma physicians will receive either 140 percent of the Medicare rate for the service or the rate the HMO paid for the service in that geographic area in 2001, whichever is greater;
- Other physicians that provide evaluation and management services will receive either 140 percent of the Medicare rate for the service<sup>14</sup> or 125 percent of the average rate the HMO paid its contracting providers for the service the previous year, whichever is greater;
- Providers of other services will receive 125 percent of the average rate that the HMO paid its contracting providers for the services the previous year.

### ■ West Virginia: No Balance Billing for Covered Services

West Virginia protects HMO enrollees from liability for bills from providers for covered services as long as the provider is aware that the person is enrolled in an HMO. If an enrollee receives emergency care out of network, the HMO must pay the “provider’s normal charges for those health care services, exclusive of any deductibles or copayments.” (West Virginia Code 33-25A-7a)

For a more in-depth discussion of balance billing protections, see Jack Hoadley, Kevin Lucia, and Sonya Schwartz, [\*Unexpected Charges: What States Are Doing about Balance Billing\*](#) (Oakland: California Healthcare Foundation, 2009).

## 4. Protections from Certain Collection Practices for People with Medical Debt

Unless states have mandated specific protections for people with medical debt, these consumers may face a host of serious problems. If they do not reach a payment agreement with their health care provider, the provider may take them to court or sell the debt to a collection agency who takes them to court. All but a minimal amount of their wages may be garnished to pay their bills, their bank accounts may be seized, and, in many states, their homes may be put up for sale. Furthermore, the debt may linger for many years. People who are initially exempt from debt collection because they have a low income and few assets may find that, years later, when their earnings increase, the debt collectors are back at their door or have already seized their wages.

The federal Consumer Credit Protection Act helps protect workers from having all of their wages garnished to pay a debt: Generally, for any workweek, the most that can be garnished is 25 percent of the person’s disposable earnings *or* the amount of earnings that exceeds 30 times the hourly federal minimum wage (\$217.50 per week in 2009), whichever is less. (Disposable earnings are earnings that remain after legally required deductions for taxes, Social Security, unemployment, etc.) Federal law also protects some benefits, such as Social Security income, from garnishment.

The following are examples of states that have tried to protect more income or assets from collection for people with medical debt, or that have established other protections for more specific circumstances. (This is not a comprehensive list, and some of these protections are better than others. Also, some additional states that are not listed here protect more income or assets for all types of debtors.)

**■ Arkansas:****Limit on How Long Medical Debt Lasts**

According to Arkansas state law, “No action shall be brought to recover charges for medical services performed or provided . . . by a physician or other medical service provider after the expiration of a period of two (2) years from the date the services were performed or provided or from the date of the most recent partial payment for the services, whichever is later.” (A.C.A. §16-56-106(2))

**■ Kansas:****No Wage Garnishment during Illness**

If a debtor has not been able to work for two or more weeks because of personal illness or an illness in the family, his or her wages cannot be garnished until two months after recovery from the illness. (KSA 60-2310)

**■ Louisiana:****Cannot Foreclose on Homes of Patients with Catastrophic or Terminal Illnesses**

The full value of the person’s home is exempt from seizure or sale when the owner has medical debts from a catastrophic or terminal illness or injury. In other cases, only \$25,000 of the value of the home is exempt. (LA Revised Statutes 20:1)

**■ North Carolina:****Public Hospitals Cannot Garnish Wages in Certain Cases**

Public hospitals cannot seek wage garnishment of patients whose family income is 200 percent of poverty or less (\$36,320 for a family of three or \$21,660 for an individual in 2009). For patients with higher incomes, a public hospital cannot move for garnishment unless it has made reasonable efforts to collect the bill from third party payers (such as insurers) and has waited at least 120 days after sending the patient the bill. Furthermore, the court cannot order garnishment if the debtor is paying at least 10 percent of his or her monthly income toward the debt, or if the debtor is still pursuing payment for the debt from a third party. (N.C Statutes, Section 131E-49)

**■ Nevada and Ohio:****Cannot Foreclose on a Home that Is Occupied**

Homes cannot be seized or sold for medical debt while the debtor and/or the debtor’s dependents still live in the residence. (NRS 21.095 and OH Revised Code 2329.55)

**■ Ohio:****Responsibility in Case of Divorce**

In cases where a family court has ordered someone to provide an ex-spouse or child with health insurance and that person has failed to do so, a medical provider or collection agency can collect only from the person so ordered and not from the ex-spouse or child. (OH Revised Code 1349, 01)



### ■ Texas:

#### **No Collection if Provider Failed to Bill in a Timely Manner**

If a medical provider did not bill an insurer in a timely manner, the medical provider cannot recover the amount from the patient that should have been billed to the insurer. (TX Civil Practice Code 146.002)

### ■ Virginia:

#### **No Collection While Certain Claims Are Pending**

If a patient has made claims for medical treatment through worker's compensation or crime victims' compensation, providers cannot collect debts for those health care services or refer those debts to collection until worker's compensation or crime victims' compensation has determined what they will pay and made payment. (Code of VA 65.2-601,1 and 10.2-368.5:2)

## Conclusion

Many people cannot avoid medical debt: They can't afford to buy insurance, they are rejected for coverage due to their pre-existing conditions, or they have insurance that does not fully cover the medical care they need. When they cannot afford to pay for their care, they may be burdened for years with interest payments on their medical debt, garnishments, or bad credit, or they may even face home foreclosures.

A few states have begun to address these problems. They have required hospitals to establish mandatory charity care programs, and they have prohibited hospitals from charging more to uninsured, low-income patients than they do to patients with insurance. A few limit interest rates on hospital bills so that people have a better chance of making a dent in their debt through making monthly payments. A few states have also clamped down on other abusive debt collection practices. For patients who have insurance but who are surprised by bills from out-of-network providers, some states require health plans to pay instead of holding patients accountable. Finally, some states have recognized that consumers need special protections when they face medical debt. In response, states have lengthened the time that people have to pay medical debt before consequences escalate, or they have exempted people with medical debt from certain types of collection activity.

The health reform bills that Congress is considering will extend health coverage to millions of people and will limit their out-of-pocket costs for medical care. These critical provisions will decrease the chance that American families will incur large debts when they get sick. However, both state and federal governments have a role to play in addressing the financial needs of consumers who have medical expenses that are not covered by insurance and protecting those consumers from harmful collection practices.

## How Do I Find Out about Laws in My State?

The following published sources are good starting points:

- Community Catalyst's [Free Care Compendium](#).
- Jack Hoadley, Kevin Lucia, and Sonya Schwartz, [Unexpected Charges: What States Are Doing about Balance Billing](#) (Oakland: California Healthcare Foundation, 2009).
- Chapter 10 of the National Consumer Law Center's [Collection Action Manual](#) (2008 and 2009 supplement).

Other places to seek current information include the following:

- State Attorney General offices, consumer protection unit – Attorneys General have brought lawsuits to enforce fair debt collection and charity care statutes.
- [Legal services programs](#) for low-income people and [consumer law attorneys](#).
- State departments in charge of hospital licensure, public health, or health planning, as well as the local hospital association, for information on hospital billing laws and voluntary charity care policies.
- State departments of insurance for information on balance billing laws.
- State departments of banking and/or of financial institutions for general information about interest on debt and rules regarding garnishment and collection.

## Endnotes

<sup>1</sup> The Senate Finance Committee proposal does include several provisions that would help people with hospital debt: Nonprofit hospitals would have to develop and publicize their financial assistance programs; they could not bill uninsured low-income patients at higher rates than insured patients; and they could not put liens on patients' homes or take other drastic actions to collect debt without first informing them of available financial assistance. Further, if people who have coverage through the health insurance Exchange needed to use out-of-network providers in an emergency, they could not be charged higher cost-sharing for the emergency room services than they would pay in network.

<sup>2</sup> In debt collection statutes, state laws often limit interest to a certain amount but provide exceptions if a person has agreed to a higher amount in writing. This does not adequately protect patients who may have to agree to higher interest rates in writing in order to get treatment.

<sup>3</sup> The law defines patients with "high medical costs" (called underinsured in this brief) as people whose annual out-of-pocket costs at the hospital exceed 10 percent of the patient's family income; or, if the patient provides documentation, annual out-of-pocket medical expenses (whether at the hospital or for other care) exceed 10 percent of the family income.

<sup>4</sup> In most hospitals, uninsured people qualify for discounts with incomes up to 600 percent of poverty (\$64,980 for an individual in 2009). In rural and critical access hospitals, the income guideline is 300 percent of poverty (32,490 for an individual in 2009). The discounted price may still be more than the actual cost of services. Hospitals calculate the ratio between their charges and their actual costs and then must provide a discount of 35 percent of this amount to qualified uninsured patients.

<sup>5</sup> N.J.A.C. 10:52-11:14 says, "Persons determined to be eligible for charity care shall not receive a bill for services or be subject to collection procedures. Persons determined to be eligible for reduced charge charity care shall not be billed or subject to collection procedures for the portion of the bill that is reduced charge charity care." However, there are some disputes about whether providers within the hospital may still send bills. Personal communication between Lois Krieger, Community Health Law Project, and Cheryl Fish-Parcham, Families USA, October 30, 2009.

<sup>6</sup> For more detailed information on the law and its components, see *The Nuts and Bolts of Hospital Charity Care Rules*, available online at [www.empirejustice.org/issue-areas/health/medical-debt/the-nuts-bolts-of-hospital.html](http://www.empirejustice.org/issue-areas/health/medical-debt/the-nuts-bolts-of-hospital.html).

<sup>7</sup> The interest rate "shall not exceed the rate for a 90-day security issued by the U.S. Department of Treasury plus 0.5 percent."

<sup>8</sup> Office of the Minnesota Attorney General, *Attorney General Lori Swanson and Minnesota Hospitals Announce Continuation of Fair Medical Billing Agreement*, Press Release (St. Paul: Office of the Minnesota Attorney General, April 2007), available online at [www.ag.state.mn.us/Consumer/PressRelease/FairMedicalBilling.asp](http://www.ag.state.mn.us/Consumer/PressRelease/FairMedicalBilling.asp); Commonwealth Fund, *Minnesota: Discounted Care to Uninsured* (New York: Commonwealth Fund, 2005), available online [www.cmwf.org/tools/tools\\_show.htm?doc\\_id=305357](http://www.cmwf.org/tools/tools_show.htm?doc_id=305357).

<sup>9</sup> Chen May Lee, "Minnesota Sues over Allina's 18 Percent Interest Rate," *Star Tribune*, January 22, 2009, available online at [www.startribune.com/lifestyle/health/38138604.html?elr=KArksUUUU](http://www.startribune.com/lifestyle/health/38138604.html?elr=KArksUUUU); Office of the Minnesota Attorney General, *Minnesota Attorney General and Allina Hospitals and Clinics Settle Suit on MedCredit Interest*, Press Release (St. Paul: Office of the Minnesota Attorney General, April 2009), available online at [www.ag.state.mn.us/Consumer/PressRelease/090414MedCreditInterest.asp](http://www.ag.state.mn.us/Consumer/PressRelease/090414MedCreditInterest.asp).

<sup>10</sup> Wheaton Franciscan Services, Inc. agreement with the state of Wisconsin: "In the Matter of Wheaton Franciscan Services, d/b/a Covenant Healthcare Systems, Inc. and All Saints Healthcare System, Inc," May 2006. The full text of the agreement is available on the Wisconsin Department of Justice Web site at [www.doj.state.wi.us/docs/14648.pdf](http://www.doj.state.wi.us/docs/14648.pdf).

<sup>11</sup> Mercy Health Corporation agreement with the state of Wisconsin: "In the Matter of Mercy Health System Corporation," December 2006. The full text of the agreement is available on the Wisconsin Department of Justice Web site at [www.doj.state.wi.us/news/files/MercyHealthSystemCorpAgreement.pdf](http://www.doj.state.wi.us/news/files/MercyHealthSystemCorpAgreement.pdf).

<sup>12</sup> Managed care plans' contracts with providers that are in the network must also be "fair and reasonable" (California Health and Safety Code § 1367(h)(1)).

<sup>13</sup> Personal communication between Peg Brown, Colorado Division of Insurance, and Cheryl Fish-Parcham, Families USA, October 26, 2009.

<sup>14</sup> This calculation is based on 2008 Medicare rates, and then updated by medical inflation.



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