
How to Prevent and Fix Medical Debt



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A handbook for
community advocates
assisting New Yorkers
with medical debt

This handbook will tell you:

- What common billing problems uninsured and underinsured patients face.
- How to get financial assistance for hospital bills.
- How to deal with collection agencies.
- What to do when patients are sued for medical debt.

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Why we wrote this handbook

Over two million adults and 350,000 children in New York State are uninsured. More than half of these individuals live in New York City.¹ Many more cannot afford their medical care because they are underinsured. Patients are underinsured if their insurance plan is inadequate to cover their medical expenses. A recent study by the Commonwealth Fund found that 29% of adults with medical bill problems are unable to pay for food, heat, or rent because of their bills; 30% took on credit card debt.²

Even with the enactment of New York State's Hospital Financial Assistance Law in January 2007, The Legal Aid Society continues to see New Yorkers who cannot pay their medical bills. Hospitals and medical providers have sued our clients, frozen their bank accounts, and garnished their wages.

This guide was written to provide information about how to understand medical bills, how New York State's Hospital Financial Assistance Law works to limit hospital bills, how to deal with other types of medical bills, and what to do if a medical bill is sent to a collection agency or to court.

Large Print Format: We are happy to provide this handbook in large print. Please contact the Health Law Unit directly at 212-577-3575 or 888-500-2455 and we will send a large print version to you.

Acknowledgements & Disclaimer: This handbook was written by The Legal Aid Society's Health Law Unit to provide practical advice for advocates assisting patients with hospital and medical bills that they cannot pay. Special thanks to Trilby de Jung at Empire Justice Center, Kinda Serafi at Children's Defense Fund, and Jenny Rejeske at the New York Immigration Coalition for their review of various drafts of this handbook. This handbook is not a substitute for advice from a qualified lawyer or other expert. For more information on how to obtain assistance with medical debt, see the list of resources beginning on page 38 of this handbook.

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Chapter 1: Common Billing Problems Faced by Uninsured and Underinsured Patients

Higher hospital charges for the uninsured

Hospitals often charge uninsured patients more than they charge patients who have insurance. This “self-pay” rate can result in charges that are significantly higher than what public or private insurance companies are asked to pay.³

Hospitals have claimed that federal regulations force them to charge the uninsured their highest prices, but the federal government has denied this.⁴

Since the enactment of New York’s Hospital Financial Assistance Law (HFAL) on January 1, 2007, patients whose income is at or below 300% of the Federal Poverty Level (FPL) may not be charged more than the hospital would charge a managed care plan.⁵

Hospitals could charge the uninsured over 300% more than insured patients

Before New York’s Hospital Financial Assistance Law was passed, one hospital charged uninsured Legal Aid client Rebecca Nix the highest “self-pay” rate – \$14,000 – for her emergency appendectomy and two-day inpatient stay. This amount was between three and six times more than the Medicaid or private insurance rates. For example, the hospital charges a commercial HMO only about \$2,500 for the same treatment, and bills Medicaid about \$5,000 for these services.

Source: “A Young Woman, an Appendectomy, and a \$19,000 Debt,” *Wall Street Journal*, March 17, 2003.

● ***Understanding medical bills after hospitalization***

Hospital bills can be confusing. Patients often receive separate bills from the hospital and from the medical providers who treated them during their hospital stay.

By understanding which provider sent the bill(s) and for what service(s), patients will be better able to know what bills they have *a right* to have discounted and what bills they *might be able to negotiate*.

“A few months ago, I was in the hospital for a week. I’m still getting bills. There are so many bills, and they are from different departments in the same hospital! How can I tell them apart?”

TIPS

How to better understand medical bills

- Keep every medical bill.
- Separate doctors’ bills from the hospital’s bills. Not every service that was provided during the patient’s hospital stay will be included in the hospital’s bill.
- The origin of the bill is a significant factor in determining whether the patient is entitled to a discount.
- The different account numbers on the bills may help tell the difference between providers.
- Ask the hospital’s billing office for an itemized bill. This bill will separately list all hospital charges. Patients have a right to know what they are being charged for.⁶
- If you have trouble understanding what services the patient is being charged for and by whom, call the telephone number listed on the bill to help clarify.
- Review the patient’s insurance policy to better understand which expenses the patient is responsible for and which are covered by the plan.

● **What to do if the patient's charges are wrong**

"I disagree with the way the hospital calculated my inpatient hospital bill. It charged me twice for my surgery and for an extra night. What can I do?"

Patients can challenge their hospital bills for many reasons:

1. If they believe the bill was not calculated correctly.
2. If they believe they are being charged twice for a single service.
3. If they believe their insurance – either public or private – should have covered some or all of the charges they are being billed for.

TIPS

Good steps to take

- Call or write to the hospital's billing office. Keep notes that include the name of the person spoken with, what was said, and the date of the conversation.
- Send all written complaints to the hospital by certified mail/return receipt requested. Keep copies of those letters with the return receipt.
- Make sure that the hospital and the patient's doctors have an accurate account of all of the patient's current insurance information. Notify the hospital *and* all doctors of any changes in coverage.

Chapter 2: Dealing with Hospital Bills

Have you said this about your hospital bill?

- *“I can’t afford to pay my whole bill.”*
- *“I don’t qualify for government health insurance.”*
- *“My health insurance won’t cover all my bills.”*
- *“I can’t afford other health insurance.”*

If you have, you may qualify for discounted or free care.

Patients who cannot afford to pay their hospital bills should call the hospital’s financial aid office right away. All hospital bills must include the telephone number of the office to call for patients who need financial assistance.

Hospitals have a duty to find out if the patient is eligible for Medicaid and to help them enroll.⁷

Hospitals are required to provide financial assistance to eligible uninsured patients under New York State’s Hospital Financial Assistance Law (HFAL).

● ***The Hospital Financial Assistance Law***

For many years New York State provided funding to compensate hospitals for providing care to low-income uninsured patients. However, until recently, hospitals did not have to prove that they actually provided the care.

Since the implementation of New York State’s Hospital Financial Assistance Law (HFAL) in January 2007, all public and private hospitals are required to offer financial assistance to low-income patients.

HFAL requires hospitals to provide a sliding fee scale rate for uninsured patients living at or below 300% of the Federal Poverty Level (FPL). In some situations, patients' savings⁸ must be below a certain level.

How much income can I have and be under 300% of the Federal Poverty Level?

	300% FPL Eligibility Requirements*					
Family Size	1	2	3	4	5	6
Monthly Income	\$2708	\$3643	\$4578	\$5513	\$6448	\$7383

** Figures are based on FPL for 2010*

- HFAL requires hospitals to inform patients about the availability of financial assistance during registration and on all medical bills.⁹
- HFAL requires the hospital to post signs about financial assistance in public care areas such as waiting rooms, outpatient clinics, billing and Medicaid offices. These signs must be posted in English and other languages commonly spoken in the community.¹⁰
- HFAL limits collection practices for hospitals. For example, HFAL prohibits hospitals from issuing bills or collections notices while an application for financial assistance is pending.¹¹
- HFAL does not apply to health care providers who are not hospitals or directly employed by hospitals. Patients who are billed by doctors practicing at hospitals but not employed by the hospital do not have the same protections.

TIPS

Encourage patients to ask questions and explain their situation.

- Each hospital's financial assistance program is different. For example, some hospitals provide assistance to patients with income up to 400% of the Federal Poverty Level (FPL), some have been approved by the State to consider patients' savings in their determination, some provide assistance with co-pays and deductibles. Most, however, will consider exceptional circumstances on a case by case basis. To find out each hospital's HFAL policy go to the hospital's financial assistance office.

● ***Eligibility for financial assistance***

Patients must apply for any financial assistance by completing the necessary paperwork. Patients who reside in the hospital's primary service area whose income is equal to or less than 300% of the FPL are eligible for financial assistance right away while their application is being processed. As a result, bills and collections notices must not be sent until the financial aid paperwork has been fully processed.

Hospitals must provide eligible patients with discounts according to the following fee schedule:

Patients **at or below 100% of the FPL** may not be charged more than the following:

Inpatient services: \$150/discharge

Ambulatory surgery and MRI testing: \$150/procedure

Adult ER or Clinic services: \$15/visit

Pediatric ER/clinic or prenatal services: no charge

Patients **between 101% and 150% of the FPL** pay on a sliding scale from the nominal fee up to 20% of the *standardized charge*.

This means that the patient is charged only 20% of what the hospital would charge a public health insurance plan.

Patients **between 151% and 250% of the FPL** can be charged between 20% and 100% of the cost the hospital would charge a public health insurance plan.

Patients **between 250% and 300% of FPL** cannot be charged more than the hospital would charge a health plan.

For example:

A client comes to you with a bill for an MRI. His monthly income is \$1400. Based on the 2010 standards his income is 155% of the FPL. Accordingly, this client falls between the 151% and 250% bracket of the FPL. You find out that the standardized charge for an MRI at the hospital is \$1000. According to the HFAL's fee schedule, his reduced charge should be between \$200 (20% of standardized charge) and \$1000 (full standardized charge). However, since his income is on the lesser side of the sliding scale, his reduced charge will be closer to \$200 and not \$1000.

● ***Are savings counted for HFAL eligibility?***

Hospitals may take savings into consideration on a case by case basis but *only* for those patients whose income is below 150% of the Federal Poverty Level. Even in these cases, certain rules apply.¹²

To consider savings, hospitals must obtain prior approval from NYSDOH.

- Savings cannot be used to deny financial assistance, only to increase the amount the patient owes. Even though patients

may be required to pay more if they have savings, they can never be charged more than what the hospital charges a health plan.

- The following savings are not counted:
 - Primary home
 - Tax-deferred retirement savings accounts
 - College savings accounts
 - Cars regularly used by patient or immediate family

● ***Immigration status***

Hospitals must make financial assistance available to eligible patients, regardless of their immigration status, race or language. Hospitals have a duty to maintain patient confidentiality¹³ and they should not report a patient's immigration status.

● ***Residency requirements***

Hospitals must make financial assistance available for emergency services to eligible patients who reside anywhere in New York State.

Hospitals may limit financial assistance for non-emergency services to patients living within the hospital's "primary service area" (PSA). The PSA for patients living in New York City includes all 5 boroughs. Queens and Bronx residents may also use hospitals in neighboring counties. Every hospital's PSA can be determined by visiting the New York State Department of Health's website at <http://hospitals.nyhealth.gov/index.php>, then clicking on the relevant county and then the relevant hospital. The term "primary service area" may not appear, but the area for which the hospital is required to offer reduced charges will be stated.

● ***Medical services that are excluded***

A patient may not get financial assistance for the following services:

- Services not provided by a hospital
- Services by providers not employed by a hospital

- Services that the hospital deems are “not medically necessary” or “therapeutically contraindicated,” e.g. entirely optional services such as cosmetic surgery
- Services provided at hospitals that only provide mental health services

● ***Applying for financial assistance under HFAL***

- If financial assistance is not offered, patients should ask how they can apply. Applications must be readily available, and simple to understand and fill out.
- Hospitals are required to provide assistance to those who ask for help in completing the application.
- Hospitals must allow 90 days, starting from the date of discharge or service, for the patient to file an application.
- Once the application process is started, patients have 20 days in which to complete it.
- Once the application process is started, the hospital must take no action to collect on bills until the application is processed. This rule does not apply to non-hospital providers' bills incurred during the hospitalization.
- Decisions on these applications must be in writing and must be made within 30 days after the complete application is submitted. Patients must be told about the right to appeal an unfavorable decision.
- Hospitals may require patients whom they reasonably believe are eligible for Medicaid to apply as a condition for receiving financial aid, but they do not have to apply and be denied before they can apply for financial assistance.
- When patients apply for financial assistance they should be prepared to show proof of their current income, address, and in some cases, proof of resources.
- Hospitals may not ask an applicant to submit tax returns and may not ask about monthly bills.

- Patients cannot be denied consideration for financial aid because they cannot show proof of their income.
- Hospitals must provide written notice to the patient that they have denied financial assistance at least 30 days before referring a debt to collections.

Examples of Income and Types of Proof

<u>Income</u>	<u>Proof</u>
Employment	Pay stub Letter from employer
Alimony Child Support Social Security Pension Unemployment Rental Income	Copies of bank statements or checks

● ***When the bill cannot be paid all at once***

HFAL requires that each hospital allow patients to pay in installments. This means that patients can stretch out their payments to the hospital instead of paying the whole bill at once. The law says patients cannot be required to pay more than 10% of their gross income each month.

TIPS

If a patient's financial needs change while they are in the process of paying installments (e.g. they lose their job) they should contact the hospital office that helped set up the payment plan immediately.

● ***When patients do not qualify for help under HFAL but cannot pay their bills***

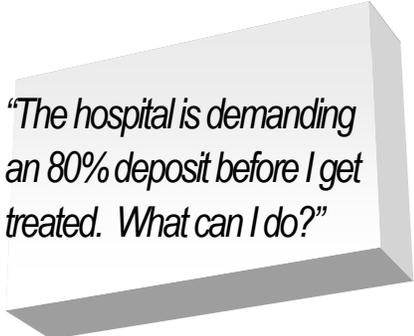
Even if the patient does not qualify for financial assistance, patients may still be able to reduce what they owe or get more time to pay. Patients will need to show the provider's billing office that they need help. Be prepared to offer proof of income, expenses and possibly savings.

TIPS

Doctors' and hospitals' office administrators are likely to be accustomed to negotiations. According to a March 2009 New York Times article, "the office may be able to offer you a discount of 10 to 30 percent depending on the practice, or propose a plan in which you pay your balance in a few installments or on a monthly basis – typically at no interest."¹⁴

● ***When the hospital wants a deposit before beginning treatment***

Sometimes hospitals will ask patients to pay up front before they are treated or admitted. This is called a pre-admission deposit.



“The hospital is demanding an 80% deposit before I get treated. What can I do?”

Under HFAL, payment deposits are permitted but must be based on the patient’s ability to pay, must not be an undue obstacle to obtaining financial aid or needed health care, and the amount must be included in the maximum charges allowed.

Under federal law, hospitals cannot turn patients away if they cannot pay for emergency care.¹⁵ Note that this federal law applies to emergency care only. Also, under New York State regulations, hospitals cannot discriminate against a person because of his or her inability to pay.¹⁶

There are a couple of things patients can do if the hospital requests a pre-admission deposit that they cannot afford:

- Negotiate with the hospital to pay no more than 10% of their monthly income as a deposit.¹⁷
- File a complaint with the New York State Attorney General’s Health Care Bureau if they think they have been turned away from a hospital or denied necessary care because of inability to pay. (See page 38 for a list of resources and phone numbers.)

● ***Keeping track of the situation***

Patients are likely to need to talk with people in different hospital departments when they are dealing with big bills. They will probably receive many kinds of papers, such as bills and late-payment notices. It is

important for patients to keep track of every piece of paper they receive and every person they talk to. Here are some tips to give patients to help them do this:

- Keep copies of everything that the hospital, doctor, or anyone else involved sends. Use a file folder or large envelope, and keep all papers together.
- Keep copies of everything that is sent to anyone about the bills.
- Always take notes of the exact words used by a hospital representative or any other person involved. Also make a note of what the patient tells them.
 - Write down the date and time of every call.
 - Write down the name, phone number and department or company of everyone the patient speaks with.

● ***Agreements to avoid***

In the past, hospitals have sometimes asked patients to agree to pay the entire amount due as a penalty for missing a payment under an installment payment plan. A statement that this kind of penalty will apply is called an *acceleration clause*. It is now illegal for hospitals to use acceleration clauses.

Two other kinds of agreements that patients should refuse to sign are:

- (1) those that place responsibility for payment on family members or legal representatives
- (2) those that make patients responsible for the hospital's collection costs.

When a hospital does not comply with the law, a complaint should be made to the Centralized Complaint Hotline of the New York State Department of Health (NYSDOH) at 800-804-5447.

Contact NYSDOH if:

- The patient was not informed by the hospital about the right to apply for financial assistance.

- The patient was not provided with an application or the hospital's policy upon request.
- The patient was unable to apply for financial assistance because of a language barrier.
- The patient was required to present excessive or unnecessary information in the application process.
- The patient was contacted by a collection agency before receiving a decision from the hospital on their financial assistance application.
- The patient is being forced to sell or give up their home because they could not pay a bill.
- The patient was required to sign an *acceleration clause* as part of the payment plan.

Chapter 3: Dealing with Doctors' Bills

HFAL protections and financial assistance do not apply to patients who are billed by doctors practicing at a hospital but not directly employed by the hospital. However, there are ways to deal with billing issues that arise.

"I have so many bills from the doctors I saw while I was at the hospital. Can I get help for my doctors' bills?"

● ***When the patient has health insurance***

Take steps ahead of time to *avoid* billing problems.

- Make sure the patient's doctors know about *all* insurance coverage that they have, including identification numbers. This includes employer or private insurance, Medicaid and Medicare.
- Call the health plan ahead of time to confirm the patient's insurance coverage is active.
- Before being admitted to the hospital, confirm that all the patient's doctors and the hospital are in-network providers.
- Understand the plan's policy on obtaining prior approval. If the patient requires emergency treatment, the patient or a family member should contact the plan within 24 hours after being admitted.

TIPS

Unlike Medicaid Managed Care, commercial insurance plans do not require their in-network doctors to refer patients to other in-network doctors. As a result, it is not uncommon for patients admitted to an in-network hospital by their in-network provider to incur huge bills as a result of out-of-network referrals during their hospital stay.

Patients in plans providing only limited out-of-network coverage, or none at all, should tell their doctors not to refer them to out-of-network doctors. They should ask each specialist who treats them in the hospital whether he/she accepts their health plan. Anesthesia bills can be very costly - make sure the surgeon knows that the patient requests an in-network anesthesiologist who accepts their plan and ask to have this request written in their chart.

Patients should call their doctor right away if they think their bill is wrong.

- Find out what the bill is for. Patients may be responsible for co-pays or deductibles, depending on their plan.
- Make sure that the doctor has *all* of the patient's insurance information. If they have coverage from more than one source - e.g. private insurance, Medicare, and Medicaid - make sure that the doctor knows about *all* insurance plans and has sent claims to *all*. Some insurance sources require payment to be made in a certain order, so if the doctor fails to submit a claim to all sources, a patient's claim may be denied. E.g., Medicaid pays last; as a result, Medicaid will deny payment if the claim was not first submitted to the patient's other insurers such as Medicare or commercial plans for payment.
- Patients who receive care from an out-of-network doctor may have to pay up-front and submit the claim themselves. They should clarify this with their doctor. For help submitting a claim, call the plan.
- Most insurance plans have time limits for submitting claims. Make sure not to miss these deadlines.

● ***Can Medicaid recipients be billed?***

- Medicaid doctors must bill Medicaid directly.

- It is against the law for Medicaid doctors to bill Medicaid patients over and above what Medicaid pays for the service, even if the patient agrees.
- Medicaid patients must go to a doctor who accepts Medicaid according to their particular enrollment, such as fee-for-service or a managed care plan. For example, patients who have Medicaid coverage through a Medicaid managed care plan must obtain services from a Medicaid provider that accepts their plan.
- Non-Medicaid providers cannot be reimbursed by Medicaid.
- Non-Medicaid providers are under no obligation to treat Medicaid patients but if they do so they may bill Medicaid patients *only* if they tell the patient before providing service that they do not accept Medicaid *and* if the patient agrees to self-pay. The agreement should be clear and in writing.
- Patients on Medicaid who receive a bill from their doctor should call Medicaid to confirm that their benefits were active on the date of service. Then they should ask their doctor to bill Medicaid. If their Medicaid was active on the date of service and their doctor continues to send them a bill, call the New York State Department of Health's Centralized Complaint Hotline at 800-804-5447, or call the Legal Aid Society's Health Law Helpline at 212-577-3575.

● ***Persuading doctors to reduce their bills***

- Patients should tell their doctors if they are having a hard time paying a bill. They can ask for a discount and offer to send recent financial information such as proof of income, recent bank statements, and proof of major expenses.
- If they received financial aid for their hospital bill, they can ask the private doctor if she or he would be willing to reduce their bill on that basis.
- Patients can ask their doctor not to send their bill to a collection agency and instead to let them pay a certain amount each month until

the bill is paid off. This is called an installment plan or a payment plan.

- If the doctor agrees to an installment plan, the patient should ask for it in writing.
- It is important to stick to an installment plan. Patients who cannot afford the installment plan any more should be sure to call their doctor. If they just stop paying, their account may be sent to a collection agency.

Chapter 4: Dealing with Collection Agencies

● ***When the hospital or doctor uses a collection agency***

“The hospital was billing me but now they sent my case to a collection agency. What happened? I am getting calls and mail from the collection agency. What do I say?”

Providers often send unpaid patient accounts to collection agencies. A collection agency is in the business of getting people to pay overdue bills.

Under the Hospital Financial Assistance Law (HFAL), the hospital must warn patients 30 days in advance that it plans to give an account to a collection agency.¹⁸

The collection agency will ask the patient to pay the hospital’s or doctors’ bills. The collection agency may call or write to the patient. At this point, the patient may have to work with the collection agency instead of the hospital or doctor to discuss the bill.

Even if a bill is sent to a collection agency, patients may still be able to apply for discounted or free care or work out a flexible payment plan with the hospital. Under HFAL, the collection agency must follow the hospital’s financial assistance policy and procedures.¹⁹

The tips for keeping track of the situation when dealing with a hospital apply when dealing with a collection agency, too. In addition, patients should ask for a written notice of their debt if a collection agency contacts them by phone. Under federal law, patients have a right to a written notice of their debt, sent within five days after they are first contacted by a collection agency.²⁰

The written notice should tell them:

- The amount they owe
- The name of the creditor – that is, the hospital or doctor seeking payment

- What action they can take if they think they do not owe some or all of the bill.

● ***When patients dispute the bill sent by the collection agency***

Patients who think that they do not owe the money they are being asked for or think that they owe a different amount should follow the steps below.

- Send a letter to the collection agency stating that they are challenging the bill. Patients can tell the collection agency not to contact them, but must understand that this will not resolve the underlying dispute. Send a copy of the letter to the hospital or doctor.²¹ Advise the collection agency of the steps being taken to resolve insurance issues and ask them to stop from proceeding to court while the matter is being investigated.
- Contact the hospital or doctor to explain the dispute. If it is a coverage issue, it is wise to have information from the carrier(s) regarding the status of the insurance on the date they received medical care. Request that claims be submitted to all insurance plans if provider has not already done so.
- Advise both providers and collections agency if the patient had active Medicaid.
- Send all correspondence to the hospital, doctors, or collection agencies via certified mail / return receipt requested. Keep the green postcard receipt.

● ***When the collection agency keeps harassing the patient***

There are certain things a debt collector cannot do. Debt collectors may not:²²

- Contact people at unreasonable times or places. They cannot call before 8:00 A.M. or after 9:00 P.M. unless the individual says it is okay.
- Contact people at work, if they are told the individual's employer disapproves.
- Contact people who write a letter telling them to stop, except to notify the individual when the debt collector or creditor intends to take some specific action, like filing a lawsuit.
- Contact friends, relatives, employer or others, except to find out where the individual lives and works.
- Tell friends, relatives, employer or others that the individual owes money.
- Threaten to harm the individual's reputation, use swear words, or make frequent telephone calls.
- Make any false statements, including saying that the individual will be arrested.
- Threaten to have money deducted from the individual's paycheck or sue them, unless the collection agency or creditor actually intends to do so and it is legal to do so.

Debt collectors who engage in any of these activities are harassing the individual. There are some things that can be done to stop them:

- Send the collection agency a letter stating that they should stop contacting the individual. Say that they will be reported to a government agency if they continue to harass the individual.
- File a complaint with one or more government agencies, such as the ones named below. If filing by phone, the individual may need to

answer a lot of questions from an answering machine before they can speak with someone.

- a. File a complaint with the New York City Department of Consumer Affairs. Call (212) 487-4110, or go to www.nyc.gov/consumers.
- b. File a complaint with the New York State Attorney General's Office of Consumer Frauds and Protection. Call (518) 474-5481 or go to www.oag.state.ny.us.

Chapter 5: When the Hospital or Doctor Sues for an Unpaid Bill

When a provider sues a patient for unpaid medical bills, the provider must file a summons to begin the court case.

“I just received court papers. I think I’m being sued. What do I do?”

The provider must give copies of these papers to the patient who is called the defendant in the court proceeding. This is called being served. Defendants can be served in person (someone hands the papers to them) or by mail.

TIPS

What to do when served with court papers

- **Do not ignore any papers from lawyers or the court!** Defendants have the right to go to court and tell the judge their side of the story. Pay attention to deadlines. Don’t let the provider win just because of a missed court date.
- Individuals served in person have 20 days from the time they are handed the court papers to go to court and file an answer. If they were served by mail, they have 30 days from the date they received the papers in the mail to answer.
- Individuals served with papers should go to the Clerk’s Office at the Civil Courthouse in the borough or county where they live. Defendants will need to give the clerk their name or the index number of the summons. The index number is found in the upper right-hand corner of the court documents.
- Individuals should ask to file an answer. They should fill out the forms and write down all of the defenses they have that explain their side of the story (see below).
- The clerk will then give the defendant a return date. They will also receive instructions on how to properly serve a copy of their answer to

the doctor or hospital who is suing them. NOTE: It is very important to follow the clerk's instructions exactly.

- Serve all the documents as directed by the clerk. Bring the mailing receipts to court on the return date.

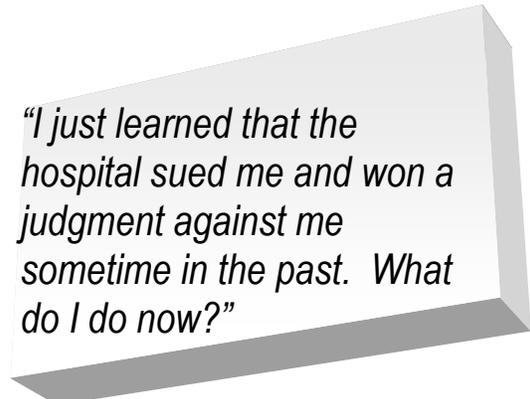
Here are some typical defenses to hospital and doctor collection cases.

- Defendant had Medicaid or other insurance when they were treated, and the hospital failed to properly bill their insurance provider.
- Defendant was eligible for Medicaid, but the hospital did not help them file an application, ask them to provide more documents, or tell them that their application was denied.
- Defendant never received a bill or other notice that they owe money to the hospital or health care provider.
- The hospital's charges are too high or are not right.
- Defendant is low-income and the hospital never offered financial aid.
- Defendant has some other reason why they should not be responsible for all or part of the bill.

● ***Contesting a default judgment***

If a defendant does not file an answer, the medical provider can win simply because the defendant did not show up. This is called a default judgment.

Sometimes patients may find out they were sued by a medical provider after the provider has already gone to court and won a default judgment against them.



“I just learned that the hospital sued me and won a judgment against me sometime in the past. What do I do now?”

If this happens, the patient should go to the court and file papers to *set aside* this default judgment. This will also give them an opportunity to go to the judge and explain their side of the story.

The Court Clerk can explain how to file these papers. The patient must not delay going to court. These papers should be filed within 1 year.

Here are some typical reasons for asking the court to set aside the default judgment:

- Patient never got court papers from the hospital’s lawyers.
- Patient was insured at the time the bills were incurred and thought the insurance paid the bill.
- Patient was sick or couldn’t make the court date for some other reason.

The patient may also want to contact a lawyer who can look over the court file and see if there is any other way to challenge the judgment, especially if the patient does not have a good excuse for missing the court date.

● **When a patient's bank account is frozen**

Often bank accounts are frozen because a medical provider sued the patient and won a judgment. When a bank account is frozen, the bank cannot let the account holder have the money in the account. Creditors with court judgments can place a *restraining notice* against a bank account and freeze it until they can take the money in the account.²³

*"My bank account is frozen:
What can I do?"*

A new law called the **Exempt Income Protection Act (EIPA)** went into effect on January 1, 2009.²⁴ EIPA protects bank accounts that contain funds such as government benefits, pensions, and some earned income. EIPA prevents creditors and debt collectors from freezing these accounts to pay private debts such as medical debts.

Normally, collection lawyers can freeze twice the amount of the judgment, plus costs, and interest. However, judgment creditors and banks must follow strict rules when it comes to freezing a bank account. Under EIPA, **if there is \$1,740 or less in the account, the creditor cannot freeze the account.**

For accounts with more than \$1,740, the bank must determine if any of the funds are exempt. Exempt funds should not be frozen. That means it should not be frozen or taken even if there is a judgment against the account holder.²⁵

Exempt funds include:

SSI	Disability benefits
Social Security	Worker's Compensation
Public Assistance	Pension
Alimony/child support	Veteran's Benefits
Unemployment benefits	Black Lung benefits
Railroad Retirement benefits	

If an account contains exempt funds that have been deposited within 45 days prior to the restraining order on the account, the first \$2,500 of exempt funds cannot be frozen. If the account holds less than \$2,500, no exempt funds are frozen and the restraining order is void. However, if it has been more than 45 days since the funds were deposited, the funds are not considered “exempt.” Usually, the bank will freeze the funds, and the account holder will have to prove that the funds are exempt in order to have them released.

TIPS

How to release exempt funds

WITHIN TWO BUSINESS DAYS OF RECEIPT OF THE RESTRAINING NOTICE, THE BANK MUST SEND THE ACCOUNT HOLDER A COPY OF THE RESTRAINING NOTICE, AN EXEMPTION NOTICE AND TWO EXEMPTION CLAIM FORMS.

- If the exemption claim forms are not returned to the bank, the funds will remain frozen and will eventually be removed to pay the judgment creditor.
- To contest the restraining notice, the account holder must fill out the exemption claim forms and return them by mail to both the bank and judgment creditor within 20 days. Exemption claim forms should show proof that the funds are exempt. Examples of proof are Social Security Administration award letters and check stubs.
- If the judgment creditor fails to respond or if the account holder provided proof that the funds are exempt, the bank must release the account within 7 days.
- If the judgment creditor disagrees, they may file papers for a court to decide if the funds are exempt.

TIPS

The process of freezing a bank account and transferring the funds is very expensive. Take action quickly to avoid the following types of charges:

- The bank may charge a fee of \$100 to \$200 for freezing the account.
- The judgment creditor can charge 9% annual interest on the amount of the unpaid judgment.
- Hundreds of dollars may be charged by the Sheriff to cover the cost of transferring money from the frozen account to the judgment creditor.

TIPS

How to get a frozen bank account released:

Follow these steps to release a bank account:

1. Do not pay the collection agency unless the court refuses to consider the case.
2. Go to the court that filed the judgment and get a copy of the court file.
3. Ask the court clerk for help filing papers so that a judge can hear the case quickly.
4. The application to the court must include reasons why the account should be released, why the judgment should be set aside, and why the defendant should be permitted to file an answer.

Possible reasons to support the release of a bank account:

- The hospital never billed the defendant or the bill is wrong.
- The hospital is charging too much. Remember, the law limits what low-income people can be charged.
- Defendant never received papers telling them that there was a court case against them.
- Defendant had Medicaid or other insurance at the time they received medical care. The hospital or doctor is responsible for billing Medicaid or other health insurance.

● ***Garnishment: When an employer takes part of an employee's wages to pay the judgment***

"My employer tells me that she has to garnish some of my wages? What can I do?"

If a worker makes more than the minimum wage, a creditor with a court judgment can place an income execution or garnishment against their wages. However, there are some limits and procedural requirements.

- First, the judgment creditor must properly serve the employee with notice that it is seeking garnishment of wages because of an outstanding judgment. Under New York law, judgment creditors can garnish only a certain amount of wages.²⁶
- Judgment creditors **cannot garnish more than 10% of gross income** (total earnings before paying taxes and Social Security).
- If weekly disposable earnings (earnings after taxes and Social Security) are less than \$217.50 no deduction can be made from earnings to pay the judgment creditor.
- The judgment creditor may take only one garnishment against earnings at a time.

There is also another important protection for debtors: Employers are not allowed to fire employees because their wages are being garnished.

- Employees who think that a wage garnishment is more than what is permitted by law must act promptly because any amounts taken will be applied to the outstanding judgment. They should contact their employer and consult with an attorney about seeking a modification of the wage garnishment. They can also go to court and try to have the garnishment lifted or reduced (based on hardship).²⁷
- Employees can also try to negotiate the removal of their garnishment directly with the party that brought the suit (either the medical provider or the collection agency) through voluntary payments.

Chapter 6: Advice for Immigrants

● ***Immigrants' eligibility for public health insurance***

Rules governing the eligibility of individuals who are not citizens of the United States for state and federal public benefits, including medical assistance, can be complicated.

In addition to meeting the financial and non-immigrant related requirements of particular programs, immigrants are subject to certain other eligibility rules.

"I am an immigrant. Can I apply for government health insurance or receive medical care without being reported to USCIS?"

Immigrants who are qualified aliens or Persons Residing Under Color of Law (PRUCOL) are eligible for all medical assistance programs in New York State, including Medicaid, Family Health Plus, and Child Health Plus (CHP).

The following immigrants are in qualified alien status:

- Lawful permanent residents (green card holders)
- Humanitarian-based immigrants
 - Refugees and asylees
 - Persons granted "withholding of deportation"
 - Cuban/Haitian entrants
 - Amerasians
 - Victims of trafficking
- Cross Border Native Americans (at least 50% Native American blood)
- Persons paroled into the U.S. for one year or more for humanitarian reasons or in the public interest
- Lawfully residing members of the armed forces or honorably discharged veterans and their dependents
- Battered spouses and children of U.S. citizens or of lawful permanent residents, who have an application or petition pending before the

USCIS (United States Citizenship and Immigration Services) and who are no longer living with their abuser

Persons considered PRUCOL because USCIS or ICE (Immigration and Customs Enforcement) has given them permission to remain in the U.S. or is not contemplating their removal includes those who have filed applications for:

- Adjustment of status to lawful permanent resident
- Asylum
- Cancellation of removal
- Requesting deferred action
- Temporary Protected Status (TPS)

Or who have been granted:

- Deferred action
- Temporary Protected Status (TPS)
- An order of supervision
- Parole of less than 1 year
- Either a K3 or K4 or V or U visa

Undocumented immigrants and most non-immigrant visa holders (those who are here temporarily and for a specific purpose such as students or tourists or temporary employees) are not eligible for Medicaid or Family Health Plus.

However, in New York State, undocumented immigrants and non-immigrants are eligible for:

- Prenatal Care Assistance Program (PCAP)
- Family Planning Extension Program (FPEP)
- AIDS Drug Assistance Program (ADAP)
- Child Health Plus (CHP) (for undocumented children)
- Medicaid Coverage for the Treatment of an Emergency Condition

● *Immigrants' concerns*

Use of Medicaid or government health insurance generally does not affect adjustment of immigration status or someone's ability to get a green card, or someone's ability to sponsor a family member.

"If I use any of these programs, can I still get my green card?"

Individuals permanently living in a nursing home or who have a chronic medical condition which affects their ability to work should consult with an immigration attorney before applying to adjust status to lawful permanent resident.

● *Financial assistance for immigrants at hospitals*

"I am an immigrant. Can I ask for financial aid at the hospital?"

Status as an immigrant does not prevent patients from being eligible for financial assistance from public or private hospitals pursuant to HFAL.

Public hospitals and community health centers often provide discounted or free medical care for uninsured individuals who have little or no income or resources. This includes immigrants without legal status who are generally ineligible for most public insurance programs.

The structured financial assistance program that operates in the New York City public hospitals (the Health and Hospitals Corporation) is called **HHC Options**.

HHC Options

HHC Options provides for a sliding scale fee structure similar to that in the Hospital Financial Assistance Law for inpatient care, outpatient clinics, and prescriptions. To find the closest public hospital to you, call the New York City non-emergency information line, which is 311.

While NO hospital should report undocumented individuals to USCIS or ICE, the Health and Hospitals Corporation has a particularly strong confidentiality policy and has given public, written assurance that it will not share information about a patient's immigration status with ANYONE else.²⁸

● ***Language help***

Federal and state laws require equal access to government benefits by individuals whose language is other than English. This means that hospitals and clinics must provide care to patients in the language that they speak.

Family and friends should not be asked to translate except where free interpreter services have been offered and declined, and only with the patient's informed consent. The patient's minor child should never be used as an interpreter.

Patients whose right to interpreter services is violated can contact the federal Office of Civil Rights of Health and Human Services. An explanation of how to do this can be found at <http://www.hhs.gov/ocr/civilrights/complaints/index.html>.

Complaints can also be filed with the Department of Health by phone or by letter. An explanation of how to do this can be found at <http://www.health.state.ny.us/nysdoh/healthinfo/complaintform.htm>.

Chapter 7: Resources

Signing up for government insurance programs

Medicaid: (888) 692-6116

Medicare: (800) 772-1213

Child Health Plus: (800) 698-4KID (4543)

Family Health Plus: (877) 934-7587

Prenatal Care Assistance Program (PCAP): (800) 522-5006

Public Hospitals

NYC Health and Hospitals Corporation: (212) 788-3321

Legal advice and representation

The Legal Aid Society Health Law Unit: (212) 577-3575 (NYC callers)
(888) 500-2455 (Outside NYC)

Medicare Rights Center: (212) 869-3850

U.S. Office of Civil Rights: (212) 264-3313

Help filing for bankruptcy

The NYC Bar Association – Bankruptcy: (212) 626-7383 (English)
(212) 626-7374 (Spanish)

Complaints about hospital billing

New York State Department of Insurance: (212) 480-6400

Complaints must be sent by letter to:

Consumer Services Bureau
New York State Insurance Dept.
25 Beaver Street
New York, NY 10004.

The letter must include:

- Hospital name
- The problem
- Insurance provider, policy number and claim number, if applicable
- Copies of any other documents that help to explain the problem

New York State Attorney General's Health Care Bureau Helpline:
(800) 771-7755, option 3

Reporting fraudulent billing in Medicare or Medicaid

To report Medicare fraud: (800) 447-8477

To report Medicaid provider fraud - Medicaid Fraud Control Unit:
(212) 417-5397

Complaints about harassment by collection agencies or lawyers

New York City Department of Consumer Affairs: (212) 487-4110

New York State Attorney General's Consumer Hotline:

(800) 771-7755, option 2

New York State Attorney General's Health Care Bureau Helpline:

(800) 771-7755, option 3

Federal Trade Commission: 877-FTC-HELP or www.ftc.gov

Complaints about interpreter services

Office of Civil Rights of Health and Human Services:

<http://www.hhs.gov/ocr/civilrights/complaints/index.html>

New York State Department of Health

<http://www.health.state.ny.us/nysdoh/healthinfo/complaintform.htm>

Immigrant issues

New York Immigration Coalition: (212) 627-2227 or www.thenyic.org

Appealing insurance denials

New York State Department of Insurance: (800) 400-8882

Appendix

Sample letter to a hospital or collection agency

Letter Writer's Name
Letter Writer's Street Address
City, State, Zip Code

Date

Name of Person at Hospital or Collection Agency
Name of Hospital
Street Address of Hospital or Collection Agency
City, State Zip Code

Patient Name: _____
Patient Account Number: _____
Date of Medical Service (Month/Day/Year): _____

Dear Mr./Ms. _____:

I write to request your full and thorough review of my account. Your balance due notice indicates that I owe \$_____ on the account. I do not believe the balance due to be a reasonable price for the services rendered.

I am submitting this letter under the federal Fair Debt Collection Practices Act ("Act") to serve as written notification of the following:

- (1) I demand full and complete compliance with requirements of the Act and the New York Public Health Law 2807-k (9-a), and any similar or related state laws, and will, if necessary, pursue all available remedies and relief provided by law;
- (2) I deny and dispute any amounts that you allege that I owe to (Name of Hospital) and specifically deny that I owe any amounts for the fees, costs, and expenses of medical supplies, services, diagnosis, or treatment in excess of the amount charged to Medicaid, Medicare, or the highest volume payer;
- (3) I demand that you do not contact me any further, except as expressly permitted by law, at my home or place of employment regarding this disputed debt.

Sincerely,

Your Name

Sample Telephone Log

Dates of Service:

Hospital:

Doctor:

Treatment:

1. I spoke to:

Name: _____

Date: _____

Office: _____

Telephone Number: _____

Notes: _____

2. I spoke to:

Name: _____

Date: _____

Office: _____

Telephone Number: _____

Notes: _____

3. I spoke to:

Name: _____

Date: _____

Office: _____

Telephone Number: _____

Notes: _____

Citations

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- ¹ United Hospital Fund, “Health Insurance Coverage in New York, 2006 - 2007,” June 2009 at 6.
- ² Source: Collins, Sara R, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families* (2008), The Commonwealth Fund (August 20, 2008), <http://www.commonwealthfund.org>.
- ³ Families USA, *A Pound of Flesh: Hospital Billing, Debt Collection, And Patients’ Rights* (March 2007) (available at <http://www.familiesusa.org/assets/pdfs/medical-debt-PDF>).
- ⁴ Letter from Tommy G. Thompson, Secretary of Health and Human Services, to Richard J. Davidson, President, American Hospital Association (February 19, 2004)(on file with author).
- ⁵ This is defined in the law as amount that would have been paid by the “highest volume payer,” the commercial health insurance company with the highest number of claims, Medicare or Medicaid, whichever amount is higher. NY Pub Health L § 2807-k (9-a).
- ⁶ NY Pub Health L § 2803(1)(g); 10 NYCRR § 405.7(c)(16).
- ⁷ Mt. Sinai Hospital v. Kornegay, 75 Misc. 2d 302 (New York County Civil Ct., 1973).
- ⁸ Savings can be bank accounts, property other than a primary residence, stocks, bonds, vehicles not used regularly by patient or family members, and most other items with cash value other than exceptions listed on page 12.
- ⁹ NY Pub Health L § 2807-k (9-a)(c).
- ¹⁰ NY Pub Health L § 2807-k (9-a)(c).
- ¹¹ NY Pub Health L § 2807-k (9-a)(h).
- ¹² NY Pub Health L § 2807-k(9-a)(b)(vi).
- ¹³ 10 NYCRR § 405.7(b)(13).
- ¹⁴ Alderman, Lesley, *Bargaining Down the Medical Bills*, 2009(2). The New York Times (March 14, 2009), <http://www.nytimes.com/2009/03/14/health/14patient.html?ref=health>.
- ¹⁵ 42 USC § 1395dd.
- ¹⁶ 10 NYCRR § 405.7(b)(2).
- ¹⁷ NY Pub Health L § 2807-k (9-a)(d).
- ¹⁸ NY Pub Health L § 2807-k (9-a)(h).
- ¹⁹ *Id.*
- ²⁰ 15 USC § 1692g.
- ²¹ 15 USC § 1692c.
- ²² 15 USC § 1692d-f.
- ²³ NY CPLR § 5222.
- ²⁴ *Id.*
- ²⁵ *Id.*
- ²⁶ NY CPLR. § 5231.
- ²⁷ NY CPLR § 5231(i).
- ²⁸ <http://www.nyc.gov/html/hhc/html/community/letter-to-immigrants.shtml>.