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# Sick and in Debt:

Improper Practices that Cause Medical Debt for Low-Income Californians

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*A Report by the  
Health Consumer Alliance*



THE HEALTH CONSUMER  
ALLIANCE

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*Summer 2004*

The **Health Consumer Alliance** (HCA) is a partnership of independent consumer assistance programs operated by community-based legal services organizations. HCA has helped tens of thousands of low-income consumers obtain essential health care by employing three related strategies: (a) individual consumer assistance; (b) community education events for consumers and community-based organization staff; and (c) local, regional, and statewide systemic advocacy directed at both public and private decision-makers. The following organizations make up the collaborative:

- National Health Law Program (NHLP) is HCA's lead agency and provides substantive and administrative support.
- Western Center on Law and Poverty (WCLP) provides substantive support and legislative advocacy in Sacramento.
- Eight legal services organizations provide direct services to health care consumers:
  - Bay Area Legal Aid
  - Central California Legal Services
  - Greater Bakersfield Legal Assistance
  - Legal Services of Northern California: Health Rights Hotline
  - Legal Aid Society of Orange County
  - Legal Aid Society of San Diego
  - Legal Aid Society of San Mateo County
  - Neighborhood Legal Services of Los Angeles County

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For more information on the Health Consumer Alliance, visit our Web site at [www.healthconsumer.org](http://www.healthconsumer.org).

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## **We wish to thank the following people for their comments and suggestions:**

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The opinions expressed in this report are solely those of the Health Consumer Alliance.

## Executive Summary of Findings

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## Introduction

The **Health Consumer Alliance** (HCA) provides independent assistance to consumers with health care problems. HCA is a partnership of community-based legal service agencies that helps health consumers, particularly those with low incomes, in twelve counties: Alameda, El Dorado, Fresno, Kern, Los Angeles, Orange, Placer, Sacramento, San Diego, San Francisco, San Mateo and Yolo.<sup>1</sup> In 2002, the programs collectively served approximately 1,100 health care consumers each month through seven local Health Consumer Centers. In addition to assisting individual consumers, HCA diagnoses systemic health access issues and seeks improvements in the health care system for the 22 million people who reside in their combined service area, which comprises 63% of California's population.<sup>2</sup>

HCA also includes the National Health Law Program (NHeLP) and the Western Center on Law & Poverty (WCLP), support centers that provide assistance to HCA advocates. NHeLP and WCLP provide training, research, policy analysis, advocacy materials, and health law expertise to assist the local Health Consumer Center advocates to achieve the best possible results for consumers.

By addressing the systemic issues that are identified through serving consumers, HCA effectively improves the health care system for all low-income Californians. Comprehensive database systems allow HCA to collect detailed information about the problems that consumers experience and the results achieved by advocates. *Sick and in Debt* analyzes data collected from 13,123 consumers with cases opened during calendar year 2002. Individual case reviews revealed patterns which lead to the findings which follow. Analyses of that data show that billing or charges to or payments from

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<sup>1</sup> The Community Health Advocacy Project, HCA's San Francisco partner expanded into Alameda County in March 2003, and the Kern Health Consumer Center opened in Kern County in April 2004. Data from Alameda and Kern counties are not reflected in this report. The Health Rights Hotline, ("Hotline"), which serves El Dorado, Placer, Sacramento, and Yolo counties, joined HCA in March 2003. In 2002, when the data for this report was collected, the Hotline collaborated closely with HCA. Data for this report was combined from the Hotline's database and the database used by the rest of the HCA programs.

<sup>2</sup> California HealthCare Foundation, *County Data* (accessed April 29, 2004). Based on U.S. Census Bureau July 2002 estimates. Available at: <http://www.chcf.org/topics/medi-cal/index.cfm?subsection=countydata>.

consumers constitute 21% (1239 cases) or one in five service problems seen in HCA offices. Thirty-one percent (402 cases) of these medical debt issues arise when consumers are seeking emergency or urgent care. Prescription drug issues (101 cases), hospital care not involving surgery (95 cases), and office visits other than for preventive care (90 cases) account for the next three highest types of services sought which resulted in billing problems for consumers.

For low-income Americans, Medicaid is supposed to cover medical expenses and help them avoid medical debt. Medicaid is a state- and federally-funded program that provides health insurance for low-income people. In California, the program is referred to as Medi-Cal and is administered by the California Department of Health Services (DHS). Under Medi-Cal rules, services are free except for some recipients who pay a “share of cost,” an amount in medical costs that must be incurred during a month before Medi-Cal will begin to pay for medical care. The share of cost is roughly equal to the difference between the beneficiary’s adjusted income and the “Maintenance Need Level,” an amount which is currently set at approximately 68–80% of the Federal Poverty Level, depending on the size of the family unit.<sup>3</sup> Participation in the Medi-Cal program obligates medical providers to accept Medi-Cal payments as full payment of the debt for a covered service.<sup>4</sup> “Balance billing,” the practice of billing the difference between the insurance reimbursement rate and the provider’s “usual and customary” rate is illegal under the Medicaid program.<sup>5</sup> The federal Medicaid Act requires states to limit participation in the program to providers who accept the Medicaid payment as payment in full, other than cost sharing that the program may require a beneficiary to pay.<sup>6</sup>

Many low-income Californians are not eligible for Medi-Cal or any other public health insurance. Many working poor and others neither have the means to pay for medical services nor public health insurance programs to fall back on.

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<sup>3</sup> The Maintenance Need Level for a family of two is \$750 per month; for a family of four, \$1,100 per month.

<sup>4</sup> 42 C.F.R. § 447.15, Cal. Welf. & Inst. Code § 14019.3(d). Providers who disagree with the amount of reimbursement for a Medi-Cal service have an exclusive remedy in the provider grievance process. Cal. Welf. & Inst. Code §§ 14115, 14104.5.

<sup>5</sup> Cal. Welf. & Inst. Code § 14019.4(a), Cal. Code Regs. tit. 22, § 51002(a).

<sup>6</sup> 42 U.S.C. § 1396a(a)(25)(c), 42 C.F.R. § 447.15.

*Sick and in Debt* analyzes the issues of health debt that most frequently cause consumers to seek assistance from HCA. The report sets forth findings based on consumers' experiences and proposes recommendations based on HCA's experience with resolving health debt for consumers.

The public perception is that medical debt happens primarily to consumers who are financially irresponsible. HCA data brings to light many improper, and sometimes illegal, practices by state administrators and providers that cause medical debt to fall on low-income consumers. *Sick and in Debt* shows that medical debt for low-income Californians is about more than just not having enough money. The medical debt of HCA consumers is caused in large part by the improper actions of others.

Medical debt dashes the future hopes and dreams of low-income individuals. An expensive, unplanned trip to the hospital can mean higher education is postponed or never pursued. A credit record with outstanding debt effectively prevents many families from realizing the dream of home ownership. Outstanding debt means that precious family resources are directed to debt servicing, not to other family needs. Forcing consumers to continue carrying an increasing amount of medical debt creates barriers to health care, steering consumers away from lower cost preventive care and toward high cost acute care. A goal of this report is to bring to light the real reasons behind low-income consumers' medical debt in order to steer policy makers to solutions that will make a difference.

# Findings and Recommendations

## I. Bureaucratic barriers cause Medi-Cal beneficiaries to become saddled with unnecessary medical debt.

Medi-Cal eligibility errors accounted for almost 10% (129 cases) of the problems HCA found in medical debt case files. Determining an applicant's eligibility for Medi-Cal is a difficult task. A county eligibility worker must work within a complex array of federal and state laws, regulations, and policies that are condensed down to a county eligibility manual. Frequent changes in existing programs and the addition of new programs make it difficult to keep up-to-date. As the state and counties face increasingly tight budgets, fewer eligibility workers are available to handle a greater numbers of cases.

### **Finding 1: Eligibility processing delays force Medi-Cal beneficiaries to pay for care out-of-pocket.**

Of the 129 cases involving Medi-Cal eligibility errors, HCA found that twenty-two percent resulted when Medi-Cal beneficiaries were wrongly billed due to delays in processing their Medi-Cal applications. Application processing delays happen in several ways. Some applicants are asked to provide documentation that is repetitive or otherwise not required. When applicants or current beneficiaries do not submit this documentation, their applications may be inappropriately and illegally denied. These problems also occur when beneficiaries lose eligibility for one Medi-Cal program and must have their eligibility for another Medi-Cal program determined. Under the provisions of SB 87,<sup>7</sup> eligibility workers are prohibited from requesting documentation from beneficiaries where that information does not change (e.g. a birth date) or can be found in the information submitted for other public programs such as CalWORKs or Food Stamps. Nevertheless, too many eligibility workers are still unaware of or lack an understanding of the SB 87 prohibitions.

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<sup>7</sup> Ch. 1088, Stats. 2000.

**Consumer Story:** A 46 year old consumer suffered a heart attack and was admitted to a private hospital. For a time, he was put on life support, then once stabilized, he was discharged to a skilled nursing facility where he remained for three months. He applied for Medi-Cal at the time of his hospital admission, but five months later, still had not received an eligibility determination. He received bills for medical and rehabilitation services totaling over \$500,000. The Health Consumer Center intervened with the county welfare agency to locate and take immediate action on his Medi-Cal application. When he was finally approved, he again needed assistance to correct the county's approval of a limited scope of benefits which would not have paid the consumer's medical bills. As a result of the Health Consumer Center's advocacy, the consumer stopped receiving bills, and the medical care providers were able to bill Medi-Cal for the services the consumer received.

Ten of the cases reported to HCA in which Medi-Cal beneficiaries were wrongly billed for services showed that the beneficiaries did not receive their Benefits Identification Card (BIC) in a timely manner. A beneficiary who does not have a BIC may not know that she may request that the provider later submit a claim to the state for the cost of the services she received or that the provider retrieve her Medi-Cal record using her Social Security number. Providers sometimes also do not know this.

Applicants who seek Medi-Cal on the basis of a disability often face processing delays that extend beyond what the law allows. A Medi-Cal eligibility determination based upon disability must be made within 90 days.<sup>8</sup> However, in many cases this determination takes longer. If the applicant qualifies for Medi-Cal, Medi-Cal can pay for health care received during the time that the application was pending. Those beneficiaries who are able to pay for their care during the pendency of an application encounter problems getting reimbursement for these expenses from either the state or the health care provider.

During the last couple of years, California has successfully implemented programs accelerating eligibility or presumptively enrolling applicants into the Medi-Cal program based on minimal initial information. These efforts help consumers avoid medical debt by providing coverage when beneficiaries receive services and obviating the need for a quick eligibility determination. Women with breast or cervical cancer who need immediate treatment can obtain instant Medi-Cal coverage through a health provider. Children applying for Medi-Cal or the Healthy Families Program through the single point of entry, a central processing location for these applications, can receive immediate Medi-Cal coverage if they appear to be eligible for no cost Medi-Cal based on a review of the application. Children applying for these programs through the new Children's Health and Disability Prevention (CHDP) Gateway can get instant Medi-Cal coverage. The applicant still may need to

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<sup>8</sup> 42 C.F.R. § 435.911(a)(1), Cal. Code Regs. tit. 22, 50177(a)(2).

submit a complete application, but access to vital health care is not postponed until a complete eligibility decision is made at the county level. In this way, eligible beneficiaries are protected from delays in making eligibility determinations and hopefully are less likely to receive bills while waiting for their Medi-Cal eligibility determinations.

***Recommendations:***

1. The state should provide additional opportunities for beneficiaries to get accelerated or presumptive eligibility for Medi-Cal programs to the maximum extent allowable under federal law.
2. Counties should provide additional training and tools to eligibility workers to clarify eligibility documentation requirements, particularly the requirements under SB 87 regarding ex parte data collection.
3. The State should enforce the laws requiring that disability determinations for Medi-Cal applications be completed within statutorily required timelines.
4. Along with the BIC, the state should send the beneficiary information about getting reimbursed by providers for Medi-Cal covered services that the beneficiary paid for while waiting for her BIC.

**Finding 2: Eligibility errors cause Medi-Cal beneficiaries to pay for health care services that Medi-Cal should cover.**

Of the billing problems reported to the HCA programs, fifty-six (56) of those arose from clients who had their Medi-Cal eligibility determined incorrectly. Errors may involve counting income or assets incorrectly. For some beneficiaries, the share of cost amount may be calculated incorrectly, causing those beneficiaries to pay more for their health care than they should. For example, HCA found some consumers to be eligible for the state's Aged and Disabled Federal Poverty Level Medi-Cal program which would provide them Medi-Cal with no share of cost. In a number of those instances, the eligibility worker knew little or nothing about this program.

Sometimes when a Medi-Cal beneficiary tries to get services, she encounters difficulty establishing her current eligibility. This problem may

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**Consumer Story:** A new mother was wrongly terminated from Medi-Cal. When she sought medications at the pharmacy, she was required to pay for the drugs out of her own pocket. When the consumer was reinstated in Medi-Cal, the pharmacy told her that she would have to file a health insurance claim in order to get reimbursed. The Health Consumer Center contacted the pharmacy. The pharmacy then billed Medi-Cal and reimbursed the consumer.

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take one of a couple of forms. A beneficiary's eligibility may not be recorded in the state's database. The state's computer may incorrectly show that the beneficiary is ineligible for that month. In other instances, the beneficiary may have been incorrectly removed from the program altogether.

In some instances, beneficiaries have been assigned to the wrong aid code, the two digit code that indicates which services a beneficiary may obtain and whether the beneficiary has a share of cost. For example, sometimes immigrants who are eligible for the full scope of Medi-Cal benefits are assigned to an aid code which limits them to benefits for emergencies and pregnancy-related care only.

Computerization of Medi-Cal eligibility determinations has caused numerous processing errors. For example, Los Angeles County depends on its LEADER computer system for tracking Medi-Cal beneficiaries and determining eligibility. It is well established that LEADER cannot determine eligibility for a number of Medi-Cal programs due to programming limitations and costs to update the system. In those cases, workers must override the system and input information manually. The system also sometimes issues multiple and conflicting notices of action which leave beneficiaries confused and unsure of their Medi-Cal status. Since this system is responsible for determining eligibility for 39% of the Medi-Cal population,<sup>9</sup> these "glitches" and programming issues have a huge impact in the state.

Transfers of Medi-Cal cases between counties when a beneficiary moves have long caused coverage problems for consumers. When a beneficiary moves from one county to another, her case file should be transferred to the new county, and she does not need to re-apply for benefits.

However, eligibility workers sometimes tell consumers who are moving to another county that their case files will be closed and that they will need to re-apply in the new county. When a county transfers a consumer's file to the new county of residence, the originating county may terminate the consumer's Medi-Cal status and the transfer may not

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<sup>9</sup> Cal. Dept. of Health Services, Medical Care Statistics Section, Pivot Table of Beneficiaries by age and demographics, Jan. 2003, available at <http://www.dhs.ca.gov/mcss>.

be completed for weeks. In the meantime, beneficiaries experience breaks in coverage and disruption in health care and may be forced to pay out-of-pocket for health services.

***Recommendations:***

1. The State must hold counties accountable for input errors that result in medical debt for Medi-Cal beneficiaries.
2. The State should coordinate a review of systemic problems of eligibility errors and commit resources to eliminating those errors.
3. The State should establish a corrective action plan and offer training to address eligibility error problems.
4. The State should establish specific protocols or guidelines for county eligibility workers to follow to resolve errors or miscommunication at all levels.

**Finding 3: Medi-Cal beneficiaries who also have other health insurance coverage encounter problems using Medi-Cal coverage and sometimes end up paying health care costs that Medi-Cal should cover.**

Some Medi-Cal beneficiaries have insurance in addition to Medi-Cal coverage. Many seniors and people with disabilities have Medicare coverage. Issues of people who have both Medicare and Medi-Cal are covered in Finding 7 below. Some children also have private coverage that a non-custodial parent must provide under a child support order. Employed beneficiaries may have insurance coverage through an employer.

When a beneficiary has other health coverage (OHC), Medi-Cal will only pay for the Medi-Cal covered services that the OHC does not pay because Medi-Cal is always the payer of last resort. The existence of OHC is revealed when the provider swipes the beneficiary's BIC through the Point of Service device or otherwise requests eligibility information from the Medi-Cal program.

HCA identified twenty-eight cases in which Medi-Cal beneficiaries were billed due to problems with OHC. Problems with OHC take several forms. Sometimes the state computer will show a beneficiary as having OHC when in fact she does not. When a Medi-Cal provider bills Medi-

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**Consumer Story:** A young adult who had health coverage only under a Medi-Cal managed care plan required ambulance transportation when she had an accident. When she received a bill, the ambulance company told her that payment was denied because the Medi-Cal record showed that she had other health coverage besides Medi-Cal. After getting the consumer's Medi-Cal record corrected and after almost two months of calls to the provider, the Health Consumer Center was able to resolve the problem for the consumer.

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Cal for services, the state denies coverage because the nonexistent OHC has not been billed first. When Medi-Cal refuses to pay for the services rendered, some providers bill the patient for the entire cost of the services. A busy provider may not take the time to investigate the problem with the patient's Medi-Cal record. Even if the provider understands the problem and informs the patient, it can be difficult to get the incorrect OHC notation off of the beneficiary's record. The beneficiary may not know where to call or how to have her record corrected.

If the beneficiary, in fact, has both OHC and Medi-Cal, she needs to ensure that any provider she sees accepts both of her forms of coverage or she will be billed. It is difficult for consumers to get information about providers who accept both their insurance plans and Medi-Cal. The state does not provide such a list or even a list of Medi-Cal providers.

Conflicts between Medi-Cal managed care and a different managed care plan under the beneficiary's OHC can lead to coverage disputes that result in medical expenses to the consumer. If a consumer has OHC and that insurer does not contract with the beneficiary's Medi-Cal managed care provider, she only has the option to get her care from the OHC, and Medi-Cal will not cover the costs that the OHC does not cover.

***Recommendations:***

1. The State and managed care plans should develop notices and mechanisms for improving assistance to beneficiaries with problems involving coordination between Medi-Cal and beneficiaries' other health insurance.
2. The Department of Health Services should maintain, distribute, and regularly update a list of Medi-Cal providers by specialty and county to help consumers coordinate coverage between Medi-Cal and other health insurance.
3. The Department of Health Services and health plans should provide notices to beneficiaries and providers when a service is denied due to other health coverage. Beneficiaries' notices should include information on how to appeal a denial of coverage.

## II. Health provider errors and improper billing practices result in medical debt for Medi-Cal beneficiaries.

Even when consumers have coverage to pay for services, numerous problems result in inappropriate billing. Forty-four percent (576) of the consumers who came to HCA for assistance with medical debt issues in 2002 already had Medi-Cal coverage. Of these medical debt cases presented by Medi-Cal beneficiaries, 24% involved emergency or urgent care (140 cases), 11% involved maternity care (62 cases), and 10% involved prescription drugs (57 cases). Eighteen percent of HCA medical debt cases (237) of Medi-Cal beneficiaries were caused by provider errors and improper billing practices.

### **Finding 4: In hospitals and emergency rooms, ancillary providers such as specialists are not always made aware of the patient's Medi-Cal coverage, and patients end up with the bill.**

Seventeen of the billing problems presented to HCA by Medi-Cal beneficiaries involved an ancillary provider who either did not know the patient had Medi-Cal or was not a Medi-Cal provider and therefore billed the patient directly.

Although a patient may present a Medi-Cal BIC when she seeks medical services, the information about her insurance coverage is not always forwarded to providers of ancillary services that are part of the patient's continuum of care.

The HCA has seen this problem arise under three particular scenarios. HCA programs hear from Medi-Cal beneficiaries who are billed for out-patient emergency room services even if the beneficiary presented proof of Medi-Cal eligibility. Emergency room physicians frequently work under contract with hospitals, and these physicians often have their own billing systems. While the hospital admissions desk may take note of the person's eligibility, this information may not be passed on to these contracted physicians.

In a second scenario, specialists working in a hospital may separately bill Medi-Cal beneficiaries for in-patient services. When a patient is hospitalized, the primary physician may recommend that the patient receive an assessment by a specialist. Alternatively, if the patient has

surgery, then she likely will require the services of an anesthesiologist and a variety of other specialists. These specialists may be working under contract with the hospital, and some are not Medi-Cal providers. As in the first scenario, even if they do participate in the Medi-Cal program, the hospital does not always share the admitted patient's Medi-Cal status with the specialist.

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**Consumer Story:** A Spanish-speaking Medi-Cal consumer suffered a miscarriage and was treated in an emergency room. Medi-Cal paid the hospital's bill, but a specialist refused to accept Medi-Cal for his \$1,000 bill, saying that he had been but was no longer a Medi-Cal provider. After the Health Consumer Center intervened, the specialist sought and received approval from Medi-Cal to bill the Medi-Cal program for the services.

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Hospitals that do not assure that Medi-Cal beneficiaries have access to Medi-Cal providers for all medically necessary services fail to meet their obligations under federal law. In order to participate in the Medicare and Medicaid programs, hospitals must meet certain conditions of participation.<sup>10</sup> Ultimately, the governing body of the hospital is responsible for services furnished in the hospital, whether those services are provided under contract or not.<sup>11</sup> The hospital must develop procedures to ensure that the Medi-Cal patient's entire continuum of care while hospitalized is covered by Medi-Cal.

A third scenario occurs when a consumer goes to see her primary care physician, and the physician requests services performed outside the physician's office, such as laboratory testing, X-rays, or other tests. The patient usually assumes that the charges will be billed to Medi-Cal. Medi-Cal coverage includes X-rays and laboratory work.<sup>12</sup> But the physician's office may not transmit information regarding Medi-Cal coverage to the testing center or clarify how the patient may convey that information to the independent provider.

In these scenarios, consumers receive bills from specialists or statements of charges due from laboratories demanding payment. Consumers who receive these bills often erroneously think that Medi-Cal will not cover the charges, leading consumers to think that they are obligated to pay them. If, in fact, the provider participates in the Medi-Cal program, consumers will have additional, unnecessary hassles trying to get the provider to bill Medi-Cal. HCA's Health Consumer Centers educate the

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<sup>10</sup> See generally 42 C.F.R. Part 482. 42 C.F.R. § 482.1(a)(5) applies the Medicare obligations to the Medicaid program, except in the case of medical supervision of nurse-midwife services.

<sup>11</sup> 42 C.F.R. § 482.12(e).

<sup>12</sup> Cal. Code Regs. tit. 22, § 51311.

consumer that the billing provider who knows that the consumer has Medi-Cal coverage should bill Medi-Cal for payment. If the consumer has already paid the bill, HCA works with the consumer to ensure that the provider bills Medi-Cal and reimburses the beneficiary.

HCA programs have seen Medi-Cal beneficiaries in these situations with bills from providers who do not participate in the Medi-Cal program. A beneficiary usually will not know that the specialist to whom she was referred is not a Medi-Cal provider, nor is she often in a position to “shop” for a specialist who participates in the program. When laboratory work is performed, she will not have a choice of laboratories, nor does she usually know to which laboratory the specimens will be sent. The referring provider often has not inquired whether the laboratory or specialist accepts Medi-Cal for payment.

These scenarios illustrate a breakdown in what should be a Medi-Cal-covered continuum of care. In most instances, presentation of a BIC should be enough for a beneficiary to access Medi-Cal benefits, and the beneficiary should not be obligated for more than the cost sharing which is allowed under state and federal law. Upon proof of a beneficiary’s eligibility for Medi-Cal, a participating provider must submit the bill to the Medi-Cal program for reimbursement.<sup>13</sup> Participation in the Medi-Cal program obligates the provider to accept Medi-Cal payments as full payment of the debt for a covered service.<sup>14</sup>

***Recommendations:***

1. The State should enact laws that require hospitals to establish procedures to inform ancillary providers who bill separately such as specialists, emergency room physicians, and laboratory and X-ray facilities of a patient’s Medi-Cal status and sufficient information for the provider to bill Medi-Cal.
2. The State should enact laws requiring Medi-Cal participating hospitals to include provisions in their contracts with physicians who have admitting privileges or are on contract to the hospital to agree to participate in Medi-Cal.

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<sup>13</sup> Cal. Welf. & Inst. Code § 14019.3(c).

<sup>14</sup> Cal. Welf. & Inst. Code § 14019.4(a), Cal. Code Regs. tit. 22, § 51002(a).

3. The State should require participating Medi-Cal providers to ensure that Medi-Cal beneficiaries are only referred to laboratories and other ancillary service providers that accept Medi-Cal.

**Finding 5: Providers who fail to get necessary prior authorization through Medi-Cal sometimes improperly bill the patient directly for the services.**

Debt problems due to providers' failure to obtain prior authorization for services accounted for twenty-two billing problems reported to HCA in 2002. Providers are required to file a Treatment Authorization Request (TAR) with the Department of Health Services and receive prior authorization before providing certain services to Medi-Cal consumers.<sup>15</sup> If the TAR does not include the documentation that the Medi-Cal reviewer is seeking, it will be denied or deferred, i.e. returned to the provider with a request for additional information.<sup>16</sup> The provider may think that Medi-Cal will deny the service no matter what additional proof of medical necessity is sent. Some providers then abandon the process and do not take the time to appeal. A provider is particularly unlikely to pursue an appeal if arguing for Medi-Cal coverage is difficult or time-consuming or if it would not be cost-effective. HCA also hears from consumers who were simply told that Medi-Cal does not cover a particular service or prescription drug without being advised that the service might be covered if the provider submitted a TAR.

The Medi-Cal program is required to send notice of a denial of services to the beneficiary.<sup>17</sup> When the denial notice is sent to the provider, but not to the beneficiary, the party with the most at stake does not know that more needs to be done. The beneficiary does not have timely notice of the denial, and she may lose her appeal rights. A busy health care provider may not provide her with much assistance for pursuing an appeal, requiring her to forego the service, pay out-of-pocket, or find another doctor to begin the TAR process anew.

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<sup>15</sup> Cal. Welf. & Inst. Code § 14133.3.

<sup>16</sup> Cal. Welf. & Inst. Code § 14103.6.

<sup>17</sup> Cal. Code Regs. tit. 22, § 51014.1(a).

If the beneficiary gets the medically necessary care without the prior authorization, the provider will bill the patient for the services, usually at the provider's higher "usual and customary" rate. Thus, the beneficiary becomes indebted for a service that should have been covered by Medi-Cal.

***Recommendations:***

1. The State must provide notices of denial to beneficiaries for all service denials to protect consumers' appeal rights.
2. The State should provide better training and written instructions to health care providers on how to complete a TAR thoroughly and correctly.
3. The State should remind health care providers that they bear the burden of properly documenting services in order to receive reimbursement.
4. The State should more widely publicize and explain the provider grievance procedure.
5. The State should sanction providers who bill beneficiaries for services that could be obtained through the TAR process when the provider has not submitted a TAR.
6. The State should provide beneficiaries with a card informing the beneficiary that pharmacies should not charge, other than co-payments, for medications. The card would also contain a brief explanation of the TAR process.

**Finding 6: Some health care providers inappropriately bill Medi-Cal patients for services, even though they are aware of the patients' Medi-Cal coverage.**

Despite showing eligibility for Medi-Cal, some consumers nevertheless receive bills from providers who do not bill Medi-Cal. In 2002, HCA identified 56 cases in which a Medi-Cal provider billed a patient who he or she knew had Medi-Cal coverage. In the case of relatively inexpensive services, the provider may find that billing Medi-Cal will not be cost-effective. A small corner pharmacy that dispenses relatively few prescriptions to a Medi-Cal beneficiary sometimes will ask the beneficiary to pay for the medications, rather than deal with the paperwork of submitting the claim to the state for reimbursement.

HCA sees instances of billing from ambulance companies to consumers who are Medi-Cal beneficiaries. Although a beneficiary or a family member may have given proof of Medi-Cal coverage to the ambulance driver, the beneficiary may receive a bill for the services. The bill leaves the impression that the beneficiary is liable for the full payment. The bill sometimes does not ask for insurance information or indicate whether Medi-Cal has been billed or even whether the ambulance company is aware that the beneficiary has Medi-Cal coverage. Consumers may find it difficult to convince the ambulance company to submit a Medi-Cal claim.

If the eligible consumer's Medi-Cal information is properly submitted to a provider who accepts Medi-Cal, the provider is required to bill Medi-Cal.<sup>18</sup> If a provider accepts the patient as a Medi-Cal beneficiary, then the provider may not bill the patient, other than to collect legally allowable co-payments or share of cost amounts.<sup>19</sup>

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**Consumer Story:** A child who is a Medi-Cal beneficiary received services at a children's hospital. Although his parents presented the Medi-Cal card to the admissions personnel, the family was billed, and the bill was sent to collections. The family discovered the error when a negative credit report prevented them from purchasing a home. With the help of the Health Consumer Center, the accounting error and the credit report were corrected, and the family was able to purchase a home.

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Some providers illegally “balance bill” by charging the Medi-Cal patient the difference between the insurance reimbursement rate and the provider’s “usual and customary” rate, contrary to federal and state law. When HCA advocates become aware of Medi-Cal eligible consumers who receive these bills from providers and remind the provider of the law, collections usually stop. However, many other beneficiaries are victims of balance billing and pay the amounts demanded. Once the beneficiary pays the provider, it is an uphill battle to have the provider refund the beneficiary the amount the provider illegally collected.

***Recommendations:***

1. The State should educate providers on their duty to submit claims to the Medi-Cal program and on the prohibition against billing Medi-Cal beneficiaries.
2. The State should enact legislation to sanction providers who consistently bill beneficiaries for Medi-Cal covered services. Sanctions would include a range of measures in addition to the option of terminating a provider’s participation in the program.

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<sup>18</sup> Cal. Welf. & Inst. Code § 14019.3(c).

<sup>19</sup> Cal. Welf. & Inst. Code § 14019.4(a), Cal. Code Regs. Tit. 22, § 51002(a).

3. The Medical Board of California should make balance billing of a Medi-Cal beneficiary an ethical violation subject to a range of sanctions.
4. The State should publicize the toll-free provider fraud reporting number for beneficiaries to report provider balance billing.
5. The State should provide notice to beneficiaries informing them that they should not be billed for Medi-Cal covered services and indicating where they may go for help if they are billed.

**Finding 7: Some health care providers improperly bill beneficiaries who have both Medicare and Medi-Cal coverage.**

Many seniors and people with disabilities have both Medicare and Medi-Cal coverage, so-called “dual eligibles.” With this combined coverage, these beneficiaries should not have to pay most cost sharing. For example, beneficiaries with original Medicare alone must pay 20% of an office visit that is 80% covered by Medicare. If the beneficiary also has Medi-Cal, Medi-Cal will pay the balance up to the maximum that Medi-Cal alone would pay for that service. Some beneficiaries who are not in a managed care plan do not understand that they may need to present both health cards when requesting services. Those beneficiaries in a managed care plan under the Medicare+Choice program are sometimes charged co-payments or deductibles that would be permissible under Medicare alone, but are not permissible when the beneficiary has Medi-Cal as well.

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**Consumer Story:** A 77-year-old woman with both Medicare and Medi-Cal coverage was prescribed new eyeglasses after cataract surgery. She was unable to obtain the glasses because her managed care plan demanded a \$189 payment. Through the assistance of the Health Consumer Center, Medi-Cal covered the portion of the cost not paid by Medicare, and the consumer was able to receive her eyeglasses without payment.

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***Recommendations:***

1. The State should send an annual notice, including a telephone number to call for assistance, to dual eligibles to remind them that if they use providers who accept both Medicare and Medi-Cal, the providers should not charge them for services.
2. The State should develop better systems for enforcing prohibitions against providers’ inappropriate billing of dual eligible patients, including the processes recommended under Finding 6.

**Consumer Story:** A 19 year old consumer had an automobile accident and required emergency services in a private hospital. Soon thereafter, he applied for and received Medi-Cal and his BIC. His mother began receiving bills from the hospital. Although she sent copies of her son's BIC to the hospital multiple times at the hospital's request, she began to receive notices from a collection agency. The Health Consumer Center contacted the hospital on the consumer's behalf and was told that the hospital could no longer bill Medi-Cal because it had received the son's information more than a year after rendering the services. The Health Consumer Center helped the family obtain retroactive Medi-Cal coverage and a Medi-Cal form letter allowing claims older than one year. The family finally stopped receiving bills.

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**Finding 8: Health care providers and beneficiaries sometimes do not understand retroactive Medi-Cal coverage and how it works, leaving beneficiaries to pay for their care unnecessarily.**

In 2002, HCA assisted forty-five consumers with medical debt problems that stemmed from providers' lack of understanding of retroactive Medi-Cal and the procedures for billing Medi-Cal retroactively. Under the Medi-Cal program, a beneficiary may receive up to three months of coverage prior to the month of application.<sup>20</sup> During this retroactive period, a beneficiary may have sought and received services at her own expense. If the provider participates in the Medi-Cal program, the beneficiary may return to the provider and present proof of Medi-Cal eligibility for the month that the beneficiary received the services. When the beneficiary presents this proof, the provider must make a claim to Medi-Cal for the covered services.<sup>21</sup> The Medi-Cal payment to the provider constitutes full payment for the services.<sup>22</sup> When the provider receives reimbursement from Medi-Cal for those services, the provider must reimburse the beneficiary for the payment she made for the same services.<sup>23</sup> Alternatively, the Department of Health Services should be able to reimburse the beneficiary for the covered expenses that she paid while her Medi-Cal application was pending.<sup>24</sup> The recent case of *Conlan v. Bonta* requires DHS to create a mechanism for reimbursement.<sup>25</sup>

Some consumers report that providers refuse to reimburse the money paid before establishing eligibility for Medi-Cal. In other cases, beneficiaries are unaware of their right to reimbursement or how to go about getting reimbursed. These cases are particularly complicated if the services were provided more than a year before because Medi-Cal generally requires providers to bill within six

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<sup>20</sup> 42 C.F.R. § 435.914(a), Cal. Welf. & Inst. Code § 14019, Cal. Code Regs. tit. 22, § 50197.

<sup>21</sup> Cal. Welf. & Inst. Code § 14019.3(c).

<sup>22</sup> Cal. Welf. & Inst. Code § 14019.3(d).

<sup>23</sup> Cal. Welf. & Inst. Code § 14019.3(a), (e).

<sup>24</sup> *Conlan v. Bonta*, 102 Cal. App. 4th 745, 125 Cal. Rptr. 2d 788 (2002). DHS must develop regulations to allow for direct reimbursement of these expenses to the beneficiary.

<sup>25</sup> *Id.* Court decisions against Louisiana, New York, District of Columbia, Michigan, and Illinois have required these states to reimburse beneficiaries for Medicaid covered expenses paid out-of-pocket.

months of the date of service.<sup>26</sup> Providers can bill beyond a year's time under some circumstances, but they may not know how to do so. Some large providers have told consumers that they do not have mechanisms in place for issuing refunds when Medi-Cal later pays for the service.

***Recommendations:***

1. The State should require and educate participating providers to submit a claim to Medi-Cal once retroactive eligibility is presented and to reimburse the beneficiary for out-of-pocket costs for Medi-Cal covered services.
2. The State should quickly develop regulations and procedures to implement direct reimbursement to beneficiaries.
3. The State should require providers to create mechanisms for refunding beneficiaries' payments that are made incorrectly or later Medi-Cal reimbursable.
4. The State should notify beneficiaries of how to get payment reimbursement for services which Medi-Cal covers.

**Finding 9: Beneficiaries with restricted scope coverage sometimes receive bills for services that they thought that Medi-Cal would cover.**

Californians who have an immigration status that does not entitle them to the full scope of Medi-Cal benefits may still obtain restricted Medi-Cal benefits.<sup>27</sup> Restricted benefits pay for limited services, including pregnancy-related care, emergency care, and some long-term care.<sup>28</sup> In 2002, HCA assisted twenty-six consumers with restricted scope Medi-Cal coverage who received bills for services that they thought Medi-Cal would cover.

Medi-Cal may disagree about whether a service is pregnancy-related or obtained in an emergency. When the patient receives a bill in the mail, she does not know why

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**Consumer Story:** On the advice of an emergency room physician, a mother took her 8 year old son to an orthopedic surgeon to treat a fractured arm. When she received bills from the orthopedic surgeon, she contacted the doctor's office, and she was told that Medi-Cal had refused to pay the bill because her son only had restricted Medi-Cal coverage. The Health Consumer Center helped the mother request an administrative hearing and argued that the child's services constituted an emergency. The hearing judge agreed and ordered the doctor to bill Medi-Cal for the services.

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<sup>26</sup> Cal. Code Regs. tit. 22, § 51008. With good cause, providers may submit bills up to one year after rendering services. Cal. Code Regs. tit. 22, § 51008.5.

<sup>27</sup> Cal. Welf. & Inst. Code §§ 14007.4(d) (emergency services), 14007.65 (long-term care), 14007.7 (pregnancy-related services).

<sup>28</sup> Cal. Code Regs. tit. 22, §§ 50302, 50302.1(e), Ch. 1441 Stats. 1988.

she is expected to pay for the services. Medical care providers often do not inform a patient when they know that a particular service will not be covered by Medi-Cal. Alternatively, the patient does not understand why these services are not covered. She may have family members with full-scope benefits, see them getting a variety of services, and assume that she may obtain the same range of services with her BIC.

***Recommendations:***

1. The State should notify beneficiaries of which services are covered under restricted-scope Medi-Cal when the State sends out the BIC.
2. The State must provide notice to a beneficiary when Medi-Cal denies a service based on the beneficiary's restricted scope of benefits.
3. The State should educate providers about what services are covered under restrictive scope of benefits.

**III. Health providers' billing practices create needless medical debt for consumers.**

**Finding 10: Some health care providers wrongly bill insured consumers to pressure their health plans to pay a medical bill or to collect more than the insurance would pay.**

HCA assisted thirty-three consumers in 2002 with medical bills caused by health providers using inappropriate tactics to force consumers to pay. Even having the best insurance coverage is no guarantee that a consumer will not be burdened with hospital bills. For the hospital, direct patient billing offers the opportunity to get reimbursement at rates far higher than those negotiated with insurance companies. A hospital's "usual and customary" rates are often many times higher than any insurance company will pay, and yet some hospitals demand payment at these rates from consumers, regardless of whether the consumer has insurance. Billing the insured patient forces her, in essence, to act as a collection agency for the hospital when she urges her insurance company to pay the hospital bill.

If the insurance company does not make timely payment, the consumer may endure harassment from the hospital billing department or collection agencies. In order to stop the harassment and to preserve her creditworthiness, a consumer may resort to paying part or all of the hospital bill.

Connecticut recently passed a law to protect patients from aggressive hospital collections.<sup>29</sup> This law lowers the interest rate that hospitals may charge on unpaid bills from 10% to 5%.<sup>30</sup> The law prohibits hospitals from suing for unpaid bills if the patient is eligible for Medicaid or other funds that could pay for or offset the cost of the care.<sup>31</sup> The latter provision may encourage greater screening for funding for low-income programs or indigent care resources as set forth in Finding 13 below.

***Recommendations:***

1. The legislature should pass laws to require providers to first bill insurers and only bill privately-insured patients for legitimate cost sharing or after the insurer has denied payment
2. The legislature should pass laws to limit the amounts and interest rates hospitals may charge for medical services.
3. The legislature should pass laws to allow consumers a reasonable period of time to make payment arrangements with hospitals before bills are referred to collection agencies.
4. The legislature should pass laws to require hospitals to make reasonable attempts at payment arrangements with a consumer before suing the consumer in court.
5. Hospitals should be prohibited from using certain post-judgment debt collection tactics such as wage garnishment until a patient has had a reasonable opportunity to make payment arrangements.

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**Consumer Story:** A woman had purchased a private managed care plan before she gave birth to a very premature baby. Three and a half months after the baby was born, the health plan still had not paid over \$1 million in claims and was telling the hospital that it would not cover the pregnancy as it was a “pre-existing condition.” The hospital financial office was pressuring the new mother to borrow thousands of dollars from friends and family in order to make a “down payment” on the bills. The Health Consumer Center reviewed the consumer’s insurance coverage and the law and found that the pregnancy could not be considered a pre-existing illness and that the insurance should cover the baby’s expenses. Thereafter, the health plan started processing and paying the claims.

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<sup>29</sup> 2003 Conn. Pub. Acts 03-266.

<sup>30</sup> 2003 Conn. Pub. Acts 03-266, § 7(b).

<sup>31</sup> 2003 Conn. Pub. Acts 03-266, § 3 (a).

**Consumer Story:** An uninsured, elderly consumer lost consciousness and was taken to a private hospital for emergency treatment. Hospital staff asked the patient's adult son, whose primary language is Spanish, to sign a standard form in English entitled "Authorization to Pay Benefits" without explaining the nature of the form. The distraught son signed the form believing that it was an authorization to treat his father, who, unfortunately, later passed away at the hospital. A year later, the son received a collection notice for over \$13,000. The Health Consumer Center successfully defended the son in a collection action, and in a settlement agreement, the hospital agreed to implement new policies for consent forms signed by non-responsible family members.

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**Finding 11: Some health care providers pressure non-responsible relatives to accept liability for medical bills.**

Under California law, each of us is liable for our own medical expenses and those of a spouse or of our minor children.<sup>32</sup> However, parents are not liable in most instances for the medical expenses of an adult child, and an adult child usually is not responsible for the medical expenses of a parent.<sup>33</sup> However, in 2002, HCA assisted 11 consumers who became indebted when health care providers pressured them into unnecessarily accepting liability for relatives' medical expenses.

Some consumers are wrongly held responsible for a relative's medical bills, such as may occur when an adult child takes a parent to the hospital with a medical emergency. While processing the parent's admission, hospital personnel sometimes require the adult child to sign a contract making her liable for the cost of her parent's care. Sometimes the import of the document is explained; sometimes the adult child is led to believe that the parent will not be given medical care without the agreement. In one case, a neighbor took an extremely ill person to a hospital and was forced to sign a document making him liable for the cost of the ill person's medical care.

**Recommendations:**

1. The legislature should enact laws specifically prohibiting coercion of a non-responsible party to agree to be liable for another's medical expenses illegal.
2. The State should require hospital payment agreements to contain specific notices warning against these illegal collection practices.
3. The State should prohibit hospitals from combining consent to treatment with acknowledgment of financial responsibility in the same form.

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<sup>32</sup> Cal. Fam. Code §§ 720, 914,

<sup>33</sup> Cal. Fam. Code §§ 3910, 4400, 4401; Cal. Welf. & Inst. Code § 12350. *See also*, Cal. Welf. & Inst. Code § 14008.

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**Finding 12: Health provider billing errors lead to denial of coverage, and some providers directly bill the consumer for services that insurance should have covered.**

Properly billing for services can be a challenge for any provider. If paperwork does not contain the required information or service codes, the request for payment will be returned unpaid. Medical office workers who are not adequately trained in billing procedures sometimes neglect to include necessary documentation or submit a bill too late for payment. The insured has no control over these circumstances.

Unlike with Medi-Cal, the provider faces no prohibition against billing a patient who only has private insurance. When the health care provider receives a denied claim for services for a patient not on Medi-Cal, the provider is faced with the decision to resubmit a revised claim or bill the patient. If the provider cannot determine how to make the claim acceptable to the insurer, billing the consumer will encourage her to advocate with her insurer to pay the provider's bill. This effectively makes the consumer serve as the provider's debt collector. If the consumer is unsuccessful in advocating with her insurance or health plan, a technical claims error can leave her burdened with medical debt.

***Recommendations:***

1. The State and health insurers should create incentives for providers to properly bill insurers and avoid billing patients for covered services.
2. Health plans and insurers should develop better training in the billing process for providers.
3. The State should develop laws and policies to prohibit health care providers from billing patients for services that health plans or health insurance should cover.

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**Consumer Story:** A consumer with employer-based insurance was transported by ambulance for emergency care. Later, the consumer received a bill from the ambulance company. The insurance company had not paid the bill because it was submitted too late. A Health Consumer Center advocate was able to assist with appealing the insurance's denial of the bill, and eventually the insurance company paid for the ambulance services.

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#### IV. When health care providers fail to screen uninsured consumers for resources that may pay for their health care, consumers are burdened with medical debt.

Twenty-three percent (296) of the consumers who sought HCA's assistance with medical debt issues in 2002 had no insurance coverage. Uninsured consumers experience medical debt differently than consumers with Medi-Cal coverage. While 24% (140) of Medi-Cal consumers' medical debt problems concerned emergency or urgent care services, over 56% (167) of HCA's uninsured consumers with medical debt problems encountered the problems when seeking emergency or urgent care. Uninsured consumers were more likely to encounter payment problems with hospital care not involving surgery (9%, 25 cases) and with emergency transportation (8%, 23 cases). Almost 19% (252) of medical debt issues arose when a provider failed to screen or inadequately screened the patient for programs or funding sources that could assist with the cost of the health care.

**Finding 13: Some health care providers fail to screen uninsured consumers for Medi-Cal eligibility or for funds such as Proposition 99, Hill-Burton, or charity care to assist consumers with the cost of health care.**

In March 2001, the UCLA Center for Health Policy Research estimated that more than two-thirds of the 1.85 million uninsured children in California are eligible for either Medi-Cal or Healthy Families.<sup>34</sup> Another 685,000 uninsured, non-elderly adults are eligible for Medi-Cal.<sup>35</sup> In 2002, HCA assisted 160 consumers who became indebted for medical services when providers failed to screen the consumers for Medi-Cal, Proposition 99, Maddy EMS Funds, Hill-Burton, or charity care eligibility.<sup>36</sup>

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<sup>34</sup> E. Richard Brown, et. al, UCLA Center for Health Policy Research, *The State of Health Insurance in California: Recent Trends, Future Prospects*, March 2001, at 32.

<sup>35</sup> *Id.* at 47.

<sup>36</sup> Proposition 99, approved by California voters in November 1988, increased taxes on tobacco products to fund indigent care, as well as anti-smoking programs. The Maddy Emergency Medical Services Fund (Cal. Health & Safety Code § 1797.98a *et. seq.*) provides funding for otherwise unreimbursed emergency services. Hill-Burton is the popular name for the Hospital and Construction Act of 1946 (42 U.S.C. § 291 *et. seq.*) which funded construction and modernization of health care facilities. Health care facilities that received Hill-Burton funds must provide certain amounts of uncompensated care to low-income individuals. Even after the facilities have satisfied the uncompensated care obligation, they have a continuing community service obligation. Charity care programs and policies vary from one health care facility to another.

Perhaps surprisingly, many hospitals do a poor job of screening uninsured patients for eligibility for available public programs. A recent study by The Access Project found that only 3 of 10 respondents said that staff at safety net hospitals and primary care clinics “always” offered to look into possible financial assistance, while 48% said that staff “never” offered such help.<sup>37</sup> When an uninsured person was offered financial assistance, the offer most often was to allow payment of the full bill in installments, rather than a discounting or waiving of the bill.<sup>38</sup> In recognition of the fact that hospitals do not screen these patients adequately, the American Hospital Association has issued guidelines for screening and assisting patients with the cost of their health care.<sup>39</sup>

In many hospitals, financial screeners lack knowledge of the specifics of the various public health insurance programs. Financial screeners may be able to do little more than give the patient an application for the program for which the patient appears to be eligible. However, until the patient is able to prove eligibility for one of these programs, the financial office sometimes continues to seek payment directly from the patient.

Qualifying a person for a public health insurance program saves money for the patient as well as for local governments. If a patient is found eligible for Medi-Cal, the state and federal governments will each pay 50% of the cost of the services provided to that patient, thus bringing in state and federal resources to support safety net providers. The Medicaid program covers “outstationing” which requires states to accept and perform initial processing of short-form Medicaid applications for pregnant women and children at locations such as hospitals.<sup>40</sup>

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**Consumer Story:** A working immigrant who supports his working wife and three children could not afford health insurance for himself. After experiencing intense stomach pains and becoming unconscious at work, he was transported by ambulance to a hospital. He told the hospital staff that he could not stay because he did not have insurance. The staff told him that it would be “taken care of” and that he must stay. The hospital receives federal money to allocate care to needy patients, but it made no offer of charity care and billed him for \$20,000. Despite his pleading, he was told that he must pay the entire sum and had to pay at least \$200 per month, a sum that would leave his family unable to pay for their basic necessities. When the hospital sued him, the Health Consumer Center negotiated on his behalf. Finally, the hospital agreed to allow him to apply for charity care and erased his debt.

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<sup>37</sup> The Access Project, *Paying for Health Care When You’re Uninsured: How Much Support Does the Safety Net Offer?* January 2003, available at <http://www.accessproject.org>.

<sup>38</sup> *Id.*

<sup>39</sup> Hospital Billing and Collection Practices, Statement of Principles and Guidelines by the Board of Trustees of the American Hospital Association, available at: [http://www.hospitalconnect.com/aha/key\\_issues/bcp/content/guidelinesfinalweb.pdf](http://www.hospitalconnect.com/aha/key_issues/bcp/content/guidelinesfinalweb.pdf).

<sup>40</sup> 42 U.S.C. § 1396a(a)(55), 42 C.F.R. §§ 435.904, 435.907(c).

Many hospitals also fail to adequately screen patients for hospital charity care or similar resources. There is no uniform policy or requirement that hospitals provide charity care. The standards for obtaining charity care are frequently vague or haphazard. Hospitals may be reluctant to publicize their charity care eligibility criteria. A recent study indicates that many hospitals are giving less charity care than in previous years.<sup>41</sup> Non-profit hospitals actually may be providing less charity care than for-profit hospitals.<sup>42</sup> The state of Florida is considering requiring hospitals to provide certain levels of charity care.<sup>43</sup> Some municipalities are passing legislation to require hospitals to report on the number of applications for charity care and the amount of charity care provided annually.<sup>44</sup>

***Recommendations:***

1. The legislature should pass laws to require hospitals to show that they have effectively screened uninsured and underinsured patients for eligibility for public health insurance programs and charity care before billing patients.
2. Providers should ensure that their billing departments are aware of a pending application for financial assistance or charity care and should suspend billing and collection activity until the application is processed.
3. The State should provide for more outstationing of Medi-Cal eligibility workers in facilities with the greatest number of uninsured patients to ensure that low-income people get coverage.
4. The State should expand presumptive eligibility to encourage screening and immediate application at hospitals.
5. Hospitals should increase and improve the training of financial screeners in eligibility criteria for programs and funding to offset the cost of care.
6. The legislature should pass laws requiring a hospital to write off patient charges if the hospital did not screen the patient for charity care.

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<sup>41</sup> Patrick Reilly, *Charitable dropoff, uncompensated care drops to lowest level in years*, Modern Healthcare, February 17, 2003, at 4. According to an American Hospital Association Health Forum Survey, uncompensated care in 2001 dropped to 5.6% of total expenses, the lowest level since 1983.

<sup>42</sup> Patrick Reilly, *Hospital health, monitoring, charity care needed at Fla. not-for-profits*, Modern Healthcare, February 24, 2003, at 12.

<sup>43</sup> *Id.*

<sup>44</sup> See, e.g. Nassau County Administrative Code § 9-23.0 *et. seq.* (New York).

7. The State's Office of Statewide Health Planning and Development should report annually on the amount of charity care that non-profit hospitals provide to indigent patients.
8. The State should require non-profit hospitals to provide a set percentage of charity care annually in order to retain their non-profit status.
9. The State should require hospitals to provide consumers with notices of the availability of charity care and other funds that are available.
10. The State should develop better systems for linking eligible consumers with available government programs and health care funding.

**Finding 14: When county hospitals and county-contracted hospitals fail to screen for county medically indigent programs, patients who are least able to afford their care end up with medical debt.**

California Welfare and Institutions Code Section 17000 provides that counties are responsible for the care of indigent persons who reside in the county. The implementation of this obligation varies from county to county with some counties providing a large range of health care services, including preventive care, and other counties providing little more than assistance with life and death emergencies. The cost of care may be free or deeply discounted upon proof of indigency, or the patient may be billed for the full cost of the care. A few counties still have county hospitals while most counties now contract with private hospitals to provide services to fulfill the county's Section 17000 obligations. In 2002, HCA assisted 92 consumers who became burdened with medical debt when a health care provider neglected to screen or inadequately screened the consumer for county medical assistance for indigent persons.

Despite the existence of this obligation, the poorest members of society receive bills for services that the county should be subsidizing. Eligible consumers may be taken to the nearest emergency room which is not one of the facilities providing

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**Consumer Story:** A non-English speaking couple went to a county hospital for medical services for each of them. After waiting for hours at the financial services office, they were informed, despite the fact that they had no income, that they were ineligible for the county's medically indigent program. They were charged a pre-set amount for their visits, and they had to borrow money to pay their bills. The Health Consumer Center intervened to have the couple properly screened for the medically indigent program. The county demanded that the consumers be interviewed in person, but refused to give them an appointment time. The county also refused to provide an interpreter or to refund the amounts that the

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consumers had already incorrectly paid. The Health Consumer Center provided the consumers with an interpreter during the screening and ensured that the consumers were screened and received full refunds.

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county indigent care. Even in counties with sizeable county facilities, many of these facilities are operating at or beyond capacity. On days when the emergency room is unable to take more patients, ambulances are diverted to other facilities, usually a nearby, private hospital, where the patient may not be able to access county funding for her care.

Consumers sometimes receive inadequate information about sources of county-funded assistance to offset the costs of treatment. Additionally, proving eligibility for county funds can involve completing burdensome forms and providing documented proof of indigency. This can pose an enormous burden for an individual who is homeless, sick, or has no access to transportation.

***Recommendations:***

1. The State and the counties should provide sufficient funding for indigent emergency care, coupled with a requirement that county and county-contracted hospitals effectively screen patients for eligibility in order to access the funds.
2. The State should require counties to have systems for reimbursing non-county facilities when indigent county residents are diverted to hospitals outside of the county's health system.

**V. Health care is unaffordable for many uninsured consumers.**

Fourteen percent (188) of consumers' medical debt problems brought to HCA stemmed from the unaffordability of health care.

**Finding 15: Some hospitals charge uninsured consumers much higher rates for medical services than they charge any other consumers.**

Uninsured consumers have little bargaining power to negotiate reasonable rates, unlike private health plans and public health programs. Health plans can use their market bargaining power to negotiate lower rates for health care goods and services. Doctors and hospitals have limited power to change low Medi-Cal and Medicare reimbursement rates. Hospitals make up for those low rates by charging higher rates to those consumers without insurance. When uninsured consumers come to HCA with hospital bills,

the rates for services on these bills can be exorbitant. The large discrepancy between what insurance companies pay and what uninsured patients must pay has prompted the U.S. House Energy and Commerce Committee's Subcommittee on Oversight and Investigations to study the problem.<sup>45</sup>

Hospital patients are at the mercy of the hospital and staff. Patients are rarely in the position to pick and choose hospitals or particular services. A seriously ill person can hardly check herself out and go across town to a less expensive hospital. With the recent consolidation and closures of hospitals in many communities, a hospital essentially may have a monopoly on local acute care services. Even if a patient asks, it is unlikely that the hospital will furnish her with a price list that might permit her to choose which services she wishes to have and which she declines. Nor can the patient take advantage of lower cost options. As just a small example, most hospitals will not allow her to bring in her own bottle of aspirin which she bought at the corner drugstore, but instead require her to take the hospital-provided painkiller for which she may be charged several dollars per pill.

Because the vast majority of uninsured people have low incomes, these bills are hitting the people who are least able to pay. Consumers who are unable to pay these debts can face wage garnishments, bank account levies, and foreclosures on their homes. Inability to pay destroys a consumer's creditworthiness making it nearly impossible to get home loans at reasonable rates or to seek financial assistance for higher education. Medical debt keeps a family mired in poverty.

***Recommendations:***

1. The State should pass legislation to require hospitals to bill uninsured patients at a rate no more than the highest discounted rate negotiated with health plans or paid by public programs.
2. The legislature should enact legislation to expand access to affordable health care coverage through both public programs and private insurance.
3. Hospital ratings should include price comparisons.

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**Consumer Story:** An uninsured senior citizen was billed over \$35,000 by a hospital for an angioplasty and related diagnostic tests. Despite the consumer's limited means, the hospital did not offer her charity care and refused her request for an itemized bill so she could see whether the charges were reasonable. With the Health Consumer Center's assistance the consumer secured the hospital's agreement to charge the significantly lower Medicare rates. Finally, after extensive negotiations, the consumer was granted charity care to pay the bill.

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<sup>45</sup> Mary Chris Jaklevic, *House panel seeks data detailing billing practices*, Modern Healthcare, July 21, 2003, at 8.

## Conclusion

By combining objective data and compelling anecdotes, *Sick and in Debt* sheds light on how the medical system works for low-income Californians and the problems they face paying for care.

The findings in *Sick and in Debt* clearly show that inappropriate practices, which the Department of Health Services and health care providers could act to rectify, are major causes of low-income Californians' medical debt. Medi-Cal eligibility errors and delays keep consumers from needed coverage. Provider errors and improper billing practices burden consumers with debt that should be covered by insurance. Consumers are not always screened for the chance to apply for programs that would help them. Uninsured patients receive exorbitant charges.

Policymakers need to look at ways of amending the laws, enforcing existing law, or regulating the health care industry in order to curtail these practices. Allowing the rising costs of medical care to increasingly fall on consumers as debt is not a viable option.

## Appendix A

### **Data Collection and Problem Category Descriptions**

Each year, the Health Consumer Alliance assists thousands of individual consumers, collects a significant amount of information about each consumer, and documents the services provided. Comprehensive data collection allows HCA to analyze and provide feedback on consumers' concerns in order to improve the health care system. HCA collects data concerning the nature of the problem, the particular health condition around which the consumer is experiencing the problem, the type of health coverage the consumer has, as well as personal demographic information. Though consumers are not required to provide all of this information, most do.

The demographics of consumers who faced medical debt problems and the breakdowns of the services consumers sought when they encountered medical debt problems came from the HCA database. Further in-depth review of the medical debt case files revealed the source of the medical debt problems.

## Appendix B

### Data

Between January 1, 2002 and December 31, 2002, 1239 consumers reported problems with medical debt. Each consumer may report more than one problem. In-depth case reviews revealed the following 1344 problems those consumers reported regarding medical debt and the services consumers were seeking when they encountered medical debt problems.

**Table 1.** Medical Debt Issues by Consumer Health Coverage and Select Cross-Cutting Medical Debt Issue Areas

MEDICAL DEBT ISSUE AREA	TOTAL OCCURANCES OF ISSUE	PERCENT
<b>MEDI-CAL BENEFICIARIES</b>	<b>485</b>	<b>36.1%</b>
<b>Medi-Cal Errors</b>	<b>129</b>	<b>10.0%</b>
Delayed eligibility processing errors	29	
Eligibility status errors	56	
Other health insurance conflicts	13	
<b>Provider Errors</b>	<b>237</b>	<b>17.6%</b>
Ancillary providers (specialist or lab in continuum of care or emergency room physician)	17	
Fail to get prior authorization	22	
Billing known Medi-Cal patient	56	
Retroactive Medi-Cal issues	42	
Restricted scope Medi-Cal	26	
<b>Other</b>	<b>119</b>	<b>8.9%</b>
<b>MEDICARE BENEFICIARIES</b>	<b>40</b>	<b>3.0%</b>
<b>PRIVATELY INSURED CONSUMERS</b>	<b>50</b>	<b>3.7%</b>
<b>UNINSURED CONSUMERS</b>	<b>286</b>	<b>21.3%</b>
Provider fails to screen for Medi-Cal	53	
Provider fails to screen for charity care or state/federal funding	107	
Provider fails to screen for county medically indigent program	92	
<b>SELECT CROSS-CUTTING DEBT ISSUES</b>		
Consumer liable for the service, but unable to pay	188	
Consumer does not understand coverage	34	
Patient cannot get reimbursement from provider	20	
Coordination of benefits problems	18	
Provider pressures relatives to accept liability	11	
<b>Other consumer medical debt issues</b>	<b>212</b>	<b>15.8%</b>
<b>All consumer medical debt issues</b>	<b>1344</b>	

The services that consumers sought when they encountered medical debt problems (Tables 2–4) derive from a separate analysis of the HCA database, and therefore, the total number of issues is different from the total in Table 1.

**Table 2.** Services the consumer sought when he or she encountered a debt issue: All Consumers

SERVICES NEEDED	NUMBER OF CONSUMERS	PERCENTAGE <sup>46</sup>
Emergency/Urgent care	402	30.9%
Prescription drugs	101	7.8%
Hospital care (not surgery)	95	7.3%
Office Visits (excluding preventive care)	90	6.9%
Diagnostic tests and X-rays	82	6.3%
Maternity care/perinatal	78	6.0%
Emergency transportation	68	5.2%
Other	385	29.6%
All	1301	

**Table 3.** Services the consumer sought when he or she encountered a debt issue: Consumers with Medi-Cal coverage.

SERVICES NEEDED	NUMBER OF CONSUMERS	PERCENTAGE <sup>47</sup>
Emergency/Urgent care	140	24.4%
Maternity care/perinatal	62	10.8%
Prescription drugs	57	9.9%
Office visits (excluding preventive care)	45	7.8%
Diagnostic tests and X-rays	38	6.6%
Dental/Orthodontic	35	6.1%
Other	197	34.3%
Total	574	

**Table 4.** Services the consumer sought when he or she encountered a debt issue: Uninsured Consumers.

SERVICES NEEDED	NUMBER OF CONSUMERS	PERCENTAGE <sup>48</sup>
Emergency/Urgent care	167	56.4%
Hospital care (not surgery)	25	8.5%
Emergency transportation	23	7.8%
Surgery	13	4.4%
Office visit (excluding preventive care)	12	4.1%
Maternity care/perinatal	9	3.0%
Diagnostic tests and X-rays	7	2.4%
Other	40	13.5%
All	296	



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