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U.S. Senate Health Committee
Field Hearing at Minnesota State Capitol

Chaired by U.S. Senator Al Franken

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Room 15, Minnesota State Capitol, St. Paul

When Federal Law Is Undermined: The Case of Patient Harassment at US Hospitals

Chairman Harkin, Ranking Member Enzi, Senator Franken and members of the United States Senate Health Committee, my name is Michele Goodwin. I am the Everett Fraser Professor of Law at the University of Minnesota, where I also hold joint faculty appointments at the Medical School and the School of Public Health. My prior credentials include the directorship of one of the nation's top ten-ranked health law programs, as well as serving as the Chair of the American Association of Law School's Section on Health Care Law. My work has been reviewed in or featured by the New England Journal of Medicine, the Journal of the American Medical Association, and Nature, among numerous other periodicals. I speak with you today not only in my capacity as a law professor, but also as a trained bioethicist.

I come before you this morning to provide testimony about patients' access to care and privacy. Specifically, this testimony responds to the urgency of your hearing. That is, are federal laws protecting patients? I commend your leadership for holding this very important hearing and accepting my testimony.

My talk today covers two major components. The first is to explain why as a matter of law and policy members of Congress should be concerned about contemporary debt collection practices at some US hospitals. The second is to share with you a set of recommendations that can help to move your inquiry beyond the investigation stage to the exploration of meaningful options to improve patient access to health care, reduce if not eliminate nefarious collection practices, and shore up a commitment to patient privacy. I commend Senator Franken's efforts to provide more consumer protections against overreaching collection practices, including the increased use of warrants and the seizure of bank accounts to collect debt.

During the past several months, the Minnesota Attorney General, Lori Swanson, has investigated Accretive Health, Inc.'s debt collection practices and their contractual relationship with Fairview Hospitals, located in Minnesota. From that investigation, disturbing allegations have emerged that bring into question the effectiveness of current federal laws to secure patient privacy and access to care. To be clear, the use of debt collection organizations to recoup hospital expenses is not a new phenomenon, nor does that on its face violate federal law. Hospitals by law may

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utilize debt collection organizations to recover overdue, unpaid fees. For hospitals, if they are to collect on patient debt (just over $39 billion in uncompensated care in 2010), determining what information can reasonably be shared with debt collection agencies is a very important issue.

However, the allegations outlined by Ms. Swanson's office are worthy of your sustained attention, because they outline a disconcerting pattern of coercion, exploitation, fraud, near-extortion, quid pro quo emergency medicine, indifference to patient privacy, and abuse of patients. These activities were carried out under a contractual relationship that incentivized such conduct. These practices are not protected by law. Indeed, these practices are an egregious disregard of laws championed by Congress.

The tactics that you have heard about today and some that are described in this testimony, may be unscrupulous, but are they illegal? If there is some illegal practice occurring, what is it? Are these tactics (stalking at hospitals or embedding as medical personnel) permissible if a patient refuses to pay medical bills or simply lacks the financial resources to do so? In the Minnesota case, several federal laws appear to have been violated.

Specifically, the Emergency Medical Treatment and Active Labor Act (EMTALA), the Fair Debt Collection Practices Act (FDCPA), and the Health Insurance and Portability Accountability Act (HIPAA), are intended to protect patients when they are most vulnerable. These laws are intended to ensure patient privacy, access to medicine during emergencies, as well as to provide not a mild, but a very strong check against fraudulent, overreaching, and duress-inducing debt collection practices.

The FDCPA,[1] enacted in 1978, specifically guards against the latter activities. When Congress enacted this law, the following was noted in § 802. Congressional findings point out:

(a) There is abundant evidence of the use of abusive, deceptive, and unfair debt collection practices by many debt collectors. Abusive debt collection practices contribute to the number of personal bankruptcies, to marital instability, to the loss of jobs, and to invasions of individual privacy.

(b) Existing laws and procedures for redressing these injuries are inadequate to protect consumers.

(c) Means other than misrepresentation or other abusive debt collection practices are available for the effective collection of debts.

(d) Abusive debt collection practices are carried on to a substantial extent in interstate commerce and through means and instrumentalities of such commerce. Even where abusive debt collection practices are purely intrastate in character, they nevertheless directly affect interstate commerce.

(e) It is the purpose of this title to eliminate abusive debt collection practices by debt collectors, to insure that those debt collectors who refrain from using abusive debt collection practices are not competitively disadvantaged, and to promote consistent State action to protect consumers against debt collection abuses.

[1] See, http://www.ftc.gov/bcp/edu/pubs/consumer/credit/cre27.pdf

Nearly thirty five years later, this law is treated as a relic rather than a living robust feature of our nation's promise to its consumers. The FDCPA specifically prohibits the type of practices that Ms. Swanson's investigation reveals to be common amongst Accretive employees. For example, the law prohibits misrepresentation and deceit. According to the Attorney General's investigation, Accretive employees were embedded amongst Fairview Hospital's staff. Accretive employees hid in hospital waiting rooms and even stalked patients in the convalescing rooms to collect payments before and after treatments. These bed-side practices highlight desperate hospital tactics to collect money and recoup losses. But, the tactics are particularly troubling because they occur when patients are most vulnerable: seeking emergency care for a range of conditions, which may be life-threatening. The cases highlighted by the Attorney General's office detail clandestine debt collection schemes that not only misrepresent hospital staff, but likely produce a deterrent effect on individuals seeking treatment.

If these finding are correct, they reveal clear violations of federal law. Federal law obligates collection agents to reveal their identity and the purpose(s) of their communication with consumers.

Accretive and Fairview Hospital's failure to properly disclose collection agents' identities and the purposes of their communication with patients violates federal law. I refer you to §805 of the FDCPA, which specifically addresses Communication in connection with debt collection.

Subsection (a) prohibits collection agents from communicating with any consumer "at any unusual time or place or a time or place known or which should be known to be inconvenient to the consumer." Interfering with patients' emergency care through a barrage of questions and attempts to exact monies before treatment at hospitals indicates a pernicious pattern of violation that rises to the level of brazen disregard of federal law. The purpose of the FDCPA was to shield consumers from the unfettered reaches of debt collection agents by limiting location, method, and hours by which consumers could be contacted. However, this type of debt collection practice--in person harassment at the point of service--exemplifies the worst type of patient-chasing.

Section 807, subsection (5), speaks to these concerns as it prohibits collection agencies from "threat[ening] to take any action that cannot legally be taken or that is not intended to be taken," which is important in this particular context as much of these activities are reported to have occurred during emergency visits to hospitals.

The Minnesota Attorney General's report[2] outlined a range of nefarious practices,[3] including hospitals "embedding" debt collectors among their staff, including in emergency rooms. If this is true, hospitals deploying such tactics may have violated EMTALA if the practices resulted in turning away patients in need of emergency care. To explain, in 1986, Congress enacted

[2] See, Compliance Review of Fairview Health Services' Management Contracts with Accretive Health, Inc. at http://www.ag.state.mn.us/PDF/PressReleases/ComplianceReview/Vol.%201.pdf (Volumes 1-6 can be found here: http://www.ag.state.mn.us/)

[3] See, Compliance Review of Fairview Health Services' Management Contracts with Accretive Health, Inc Volume Two-Culture Wars at http://www.ag.state.mn.us/PDF/PressReleases/ComplianceReview/Vol.%202.pdf

EMTALA "to ensure public access to emergency services regardless of ability to pay." Specifically,

> Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.[4]

Indeed, the very purpose of this law is to ensure that patients in emergency situations are not turned away, sent off, or refused treatment. The legacy preceding EMTALA's enactment involved "patient dumping" a term used to describe the denial of emergency care to individuals because of their insurance status (or lack thereof), poverty, or even racial and gender status. Some patients died as a result of "dumping" or their conditions worsened. Quite relevantly, such decisions were neither medically nor ethically justifiable. Pregnant women were dumped if their pregnancies were perceived as complicated, often requiring them to deliver in compromised and unsanitary conditions, including in their cars while en route to other hospitals located miles away. This was particularly problematic in rural communities. Sick children without health insurance were dumped if their parents—working class Americans—lacked health coverage. And, years ago, black patients died on the steps of hospitals that refused to treat "colored" people. This is a shameful legacy, but EMTALA provided hope, backed by law for a new era. EMTALA was a bold Congressional effort to ensure care for sick Americans and others when at their most vulnerable.

EMTALA was inspired by a noble, American vision. That is, our commitment to patient access and the flourishing of human development cannot be subordinated or conditioned on money. The law specifies that hospitals may not start any payment processes or billing until after the patient has been stabilized to such a degree that working out billing will not detract from, interfere with, or compromise the patient's health care.

When collection agencies systemically and brazenly interfere with patients' efforts to seek and receive emergency care at hospitals, the law becomes more illusory than real. By this, I mean to impress upon you that the law must be more than what is scribed in order to effectuate real meaning and achieve Congressional goals. Harassment at hospitals at the time of service, before service and after service symbolically and substantially interferes with and undermines the spirit of this legislation. EMTALA was not intended to provide a new opportunity for bill collection at the point of emergency care. Specifically, legislators sought to prohibit money chasing in exchange for medical care. The law does not tolerate a medical quid pro quo in this regard.

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[4] See, Emergency Medical Treatment & Labor Act (EMTALA), at http://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/EMTALA/

Just briefly, before outlining a few recommendations, I want to turn your attention to HIPAA,[5] a federal law that protects patient privacy and restricts certain uses of patient information without their consent. Under HIPAA, hospitals are subject to the "Privacy Rule," which forbids data sharing or disclosures about "individuals' health information." Again, the Attorney General's office found significant and systemic breaches of patient privacy. Among their findings were examples of collection agencies having direct access to full patient files, which include dates of birth, social security information, health information, and other sensitive data. When concerns were raised about these direct violations of federal law, the concerns were dismissed. The immediate focus of this hearing relates to patient access and health, but an extended concern must include identity theft and data mining.

I urge you to evaluate these issues as matters of concern that extend beyond Minnesota.

Part II: Recommendations

How might we move forward? The problems outlined today concern not only formal law, but also public policy and ethics. The laws highlighted in my testimony are likely regularly trespassed due to poor enforcement and accountability mechanisms at the local and federal levels.

The important question here today, is what do we prioritize: patient health or corporate profit at all costs? That you sponsor this hearing is evidence of your aspiration that there must be dignity in the delivery of medicine.

As described above, debt collection harassment at hospitals is an illegal practice. However, the protections for patients are rather thin and there are no real disincentives to reduce such behavior. Hospitals have every incentive to engage in aggressive and sometimes illegal debt collection practices, because they desire to recoup losses, but also there are so very few disincentives. The damages awarded to aggrieved patients are minimal. Indeed, the potential recovery of $1000 for a successful claim under the FDCPA is so minimal that patients may be less-inclined to pursue these matters because recovery is so limited.

There is a significant problem with proportionality given the significant trauma that a family or individual may endure from egregious debt collection practices and the revenue these industries generate. To better discourage unfair debt collection practices there are a few matters that should be considered.

First, aggrieved consumers deserve a recovery that is more than symbolic; $1,000 does not provide the type of award that meets inflation standards. Medical costs have skyrocketed since the enactment of the FDCPA. The maximum statutory damages reflect the original 1977 version of the law. Further, even though that penalty by current standards might be about $4,000, even that is not a sufficient remedy for the consumer, nor is it an adequate penalty for the debt

[5] See, http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html

collectors. A more reasonable cap is $15,000. This is not to suggest that all awards would be this amount, but it does provide room for the more egregious cases, an incentive for consumers to "inform" on companies, and a sufficient deterrent to firms that violate the law.

Second, the FDCPA seemingly gives an out to the agency/company that hires debt collectors who engage in "unfair" or egregious debt collection practices. Fining the medical groups and hospitals that knowingly contract with companies that break the law would be a means of joining the liability. Joint and vicarious liability is a well established concept in tort law and it provides particular traction in these cases.

Third, introducing criminal sanctions in this domain is well worth considering. As described above, the incentives and disincentives are ill aligned in matters such as those under your review. In the worst case scenario, a company may be subject to a $1,000 penalty, which will be paid to an aggrieved consumer, but the punishment is symbolic and more illusory than real. Criminal sanctions are appropriate in instances where the proportion of harm is consistent with the level of breach. In other words, where the conduct could reasonably be understood to result in substantial humiliation, emotional distress, and reckless violation of federal laws, a criminal sanction could be reasonable. There are two approaches you might consider: a) every violation of the FDCPA might result in a fixed penalty payable to the state or federal government; b) each penalty might incur a different level fine depending on the scope and nature of the violation. Here intent, the degree of harm, and prior infractions might be relevant.

Fourth, registration and de-licensure are worth considering. In other words, the threat of losing the privilege to do business in a state should be considered to address repeat offenders. In thinking about creating new consumer protection norms, new norms must be fostered.

Fifth, when considering how these matters should be addressed on the front end, I urge you to evaluate hospital information-sharing on the front end. There are problematic information asymmetries between patients and hospitals. For example, patients are expected (required) to disclose billing information, ranging from their places of employment, insurance, and contact information for themselves as well as close relatives. Historically, this has been perceived as important for the delivery of medicine. The testimony today and Ms. Swanson's investigation indicate that hospital information collection also has another purpose, including debt collection. Yet, hospitals do not provide clear, detailed information regarding their collection practices, who they use to collect the debts, how those practices may affect the patient, or how the patient's sensitive personal information may be shared with third party collection agents. This is an information gap that can be filled. It will empower patients and may help hospitals in building trust with their patients.

In closing, these issues are relatable to all Americans. Each of us has experienced the fear, anxiety, and concern for a loved one's health if not our own while at an emergency room. That should be the last place in which social goods are distributed based on status.

Thank you for providing me the opportunity to present this testimony. It is an honor to participate in this process and I look forward to your questions.