Uncharitable?

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Margaret Loncar was about to leave her trailer home in Bridgeview, Ill., one April morning in 2003 when she noticed her 49-year-old husband, Michael, hunched over the side of the bed and coughing up fluid. Although he had battled a variety of lung and liver ailments for years, he seemed worse than usual, Margaret recalled not long ago -- bad enough, she thought, that he should get to the emergency room.

The nearest E.R. was at Advocate Christ Medical Center, four miles away in Oak Lawn, a mostly working-class Chicago suburb. Both Loncars had been admitted and treated there before; a few months earlier, doctors performed emergency surgery on Michael's lungs. The Loncars were satisfied with the treatment at Christ Medical, as it is known. Their problem was that they already owed the hospital more than $40,000. Michael, who for years had been too sick to work, had no health insurance, and Margaret had acquired hers only a few months before. Margaret's salary as a Wal-Mart cashier was barely enough to support the couple and their two children -- a 17-year-old daughter at home and a 22-year-old daughter away at college. It left no money for adding Michael and the kids to her health plan, let alone for paying a five-figure hospital bill.

During Michael's past admissions to the hospital, Margaret says, she asked staff members if there was some way to discount or waive the charges -- figuring that Christ Medical, a nonprofit institution sponsored by religious organizations, might be inclined to help. But the answer, she says, was always no. So, as the hospital bills piled up on the dining table, Margaret lay awake at night, wondering how the family would crawl out from under the debt. On that April morning, as Michael kept insisting that it was "just the flu," she suspected that it was something more serious. But Michael wouldn't let her take him to the E.R., and eventually Margaret headed to work. When she returned that night, she found him on the floor, dead.

Margaret had Michael's body cremated a few days later. But the family's dealings with Christ Medical were not over. That July, Margaret learned that the hospital had sued her over part of their debt, winning a judgment allowing it to garnishee her wages. (Margaret says she never received summons papers before the wage-garnishment hearing.) Soon the hospital was taking the maximum amount from Margaret's salary that state law allowed, or about $100 of the $680 in gross pay she earned every other week. Margaret says that this left her with no money for repairs when the furnace in her trailer broke down the following winter. She and her younger daughter moved to an apartment, which Margaret says she could afford only by skipping the medications she took for her asthma and high blood pressure.

That fall, researchers from the labor union trying to organize Advocate Health Care, the parent company that owns Christ Medical, came across the Loncars' file while investigating the company's treatment of uninsured patients. With the help of the union's attorneys, Margaret eventually persuaded a judge to overturn the garnishment order based on her testimony that she had never received the summons to that hearing. In April 2004, the judge ordered Christ Medical to repay the money it had taken, some $1,800 in all, although Advocate complied only after several months. Margaret still had other unpaid medical bills at Christ Medical -- from separate hospitalizations not included in the initial lawsuit. At one point, according to her attorneys, Advocate's collection agent threatened to pursue those debts if Margaret continued to demand that her garnished wages be returned. (Advocate denies ever making such a threat, but a spokesman acknowledged that it cannot vouch for the behavior of the bill collector, an outside contractor.)

When a faith-based hospital sues a grieving widow over medical debt, plunging her family deeper

into poverty, some part of the health care system has clearly failed. But which part, exactly? One answer is to blame the hospital, which is precisely what many advocates, elected officials and academics have been doing as stories like the Loncars' have made headlines in the last year. ''To put so much silent agony on hapless, hard-working low-income Americans, that's just absolutely unacceptable as conduct,'' says Uwe Reinhardt, the well-respected Princeton health economist. Along with this indignation has come the threat of costly retribution. Illinois officials have already revoked property-tax exemptions for the Provena Covenant Medical Center in Urbana, after a Wall Street Journal article documented the hospital's use of ''body attachments'' -- court orders authorizing the police to haul unresponsive medical debtors into court, by force if necessary. In other states, patients who have been sued by hospitals have started suing back, charging that the hospitals' conduct violates consumer-fraud statutes and the legal obligations that come with tax exemptions. In perhaps the most ominous sign for the hospitals, a group of litigators led by Richard Scruggs, the Mississippi attorney whose pursuit of the tobacco industry famously yielded a $206 billion settlement, have filed class-action lawsuits naming more than 400 nonprofit hospitals around the country.

But executives of nonprofit hospitals say that they are victims, too -- of unions that have spread misinformation to embarrass the hospital industry, and of a society that has made impossible demands of financially beleaguered health care providers. According to the calculations of trade groups, hospitals in the United States already deliver unreimbursed care worth billions of dollars every year. ''We have roughly 44 million uninsured in the U.S., 1.7 million in Illinois,'' says Ken Robbins, longtime president of the Illinois Hospital Association. ''It's unrealistic to think that we can solve that problem by hospital behaviors alone.'' As for their seemingly harsh collection efforts, the hospitals say that the stories are more complicated than most people realize -- that they typically sue only after patients refuse to complete paperwork, fail to seek government help or are otherwise unresponsive to outreach efforts. ''In our experience,'' Ed Domansky, the Advocate Health Care spokesman at the time, told me in June, ''lack of patient cooperation often poses a significant roadblock to us being able to make charity care available to patients in financial need.'' Although Advocate would not comment on the Loncars' case specifically, citing patient-confidentiality laws, Margaret herself confirmed that Advocate staff members suggested that Michael apply for coverage under the Illinois state Medicaid program. (He did, but he died before his application could be approved.)

The transformation of the nonprofit hospital from savior to scourge is particularly evident in and around Chicago, where two large religious-based health care organizations now face withering public criticism over their practices. One is Advocate, a group of hospitals, physicians' practices and related subsidiaries sponsored jointly by the Evangelical Lutheran Church in America and the United Church of Christ. The other is Resurrection Health Care, a similarly diverse collection of Catholic facilities sponsored by the Sisters of the Holy Family of Nazareth and the Sisters of the Resurrection. Both systems trace their roots to the great hospital-building boom of the late 19th century, when religious orders established hospitals for the growing enclaves of impoverished immigrants in America's cities.

On into the 1970's, these hospitals were still serving the urban poor, largely thanks to a convoluted system of indirect financing. Every time a health insurer, whether private or a government provider like Medicare, wrote a check to a hospital for a medical service, it was in effect paying more than the actual cost of that service; hospitals could then use the extra money to finance care for those people who had no way to pay. But the arrangement began to unravel as the cost of care rose. In the 80's, the federal government, nervous that Medicare spending was out of control, reduced the program's payments to hospitals. Not long afterward, private insurance companies, pressured by employers concerned about their own premium costs, moved most of their business into managed care, which limited inpatient admissions and pressured hospitals to cut prices. By the late 90's, after another round of Medicare cuts, one-third of American hospitals said they were losing money. Among the worst off were those nonprofits that served large numbers of the uninsured, since they depended on the old system's subsidies.

Hospitals survived by adapting, which in some cases meant consolidating into large systems that had leverage with insurance companies and spending money to lure professional executives with the business savvy that the ministers or nuns who formerly ran these institutions often lacked. (In fiscal year 2002, Joseph Toomey, president and C.E.O. of Resurrection Health Care, received $2.3 million, including benefits and one-time bonuses.) It was also around this time that nonprofit hospitals began trying to lure customers -- that is, patients -- who had good insurance coverage. Making the hospital more attractive to the affluent was essential to this effort, which is why a patient strolling through the courtyard inside Resurrection Medical Center today can pray at the statue of Saint Joseph or order a latte from Seattle's Best Coffee.

Fancy coffee wasn't the only sign that nonprofit hospitals were evolving into consciously commercial enterprises. A more significant shift was evident in the way hospitals billed patients. Before the 80's and the advent of managed care, hospitals limited themselves to a single set of charges -- say, $1,000 for use of a surgical room. But when private insurers began demanding lower prices, hospitals would typically meet those demands by offering the insurers special discounts -- so an insurer with a 50 percent discount would pay only $500 for the surgical room. Inevitably, as the hospitals sought to generate more revenue, they would raise the "sticker price" for services, which just as inevitably prompted the insurers to demand even steeper discounts the next time both sides negotiated. The gap between charges and insurance payments grew, and today, according to Gerard Anderson, who directs the John Hopkins University Center for Hospital Finance and Management, charges for something like an operating room can be four times as much as what insurance companies actually pay when their beneficiaries are treated.

But no one is negotiating discounts on behalf of the uninsured. Nor do they benefit from the prices that government dictates for its Medicare and Medicaid enrollees. When the Service Employees International Union, which is trying to organize Advocate workers, analyzed Advocate's billing in 2001, it found that uninsured patients were being asked to pay 140 percent more than those with private insurance. Advocate disputes the figure but did acknowledge that a payment gap exists, just as it does at most hospitals.

Nobody seriously believes that hospitals deliberately created a tiered pricing structure with the intention of singling out the uninsured. But many critics believe that hospitals could have done more to offer "charity care" -- discounted or free care. In a nationwide survey of the uninsured conducted in 2000 by the Access Project at Brandeis University, 70 percent of needy respondents who had been through emergency rooms said they were never told that the hospitals would discount or forgive their bills if they couldn't pay. And among the patients I interviewed, even those who had been informed about charity care said the information was incomplete or delivered in a haphazard way.

When Robin Lee Kemp received emergency room care at Resurrection's Westlake Hospital in 2000, she had two young children and had just lost her job. But the only conversation about financial assistance that she recalls came while she was heavily medicated, when a nun suggested that she write a letter asking the hospital to discount the charges. According to Kemp, the next time she heard from the hospital was when she was served with a summons for an unpaid bill for nearly $9,000. (Kemp insists that she left a valid address and never received a bill.) At that time, she says, she offered to pay the collection agent $500 immediately and then monthly installments of $100, only to be told that it was too late. She ended up filing for bankruptcy. Advocate and Resurrection say they have done their best to tell patients about charity care -- that it's usually the patient, not the hospital, who fails to communicate. In a written response to questions submitted by The New York Times Magazine, Phyllis Pavese, a Resurrection spokeswoman, disputed Kemp's story, saying that its representatives "attempted to work with [her] to file applications both for R.H.C. financial assistance and Medicaid, but Ms. Kemp declined to provide information." (Pavese also says that Kemp never left a valid address.)

At least at Resurrection, the unions say, hospital administrators have been waging a stealth campaign to limit the admission of uninsured patients ever since 2002. According to memos first obtained by the organizers from the American Federation of State, County and Municipal Employees (A.F.S.C.M.E.) -- which has been investigating Resurrection as part of its organizing efforts there -- two years ago the hospital instructed its employees to offer financial assistance only to those living within certain local ZIP codes and to require 50 percent prepayment from uninsured patients seeking nonemergency care. (In accordance with federal law that prohibits withholding lifesaving care from any patient who needs it, such requirements do not apply to emergency cases.) Along with these rules came strict documentation requirements, demanding that applicants for assistance submit their tax returns, bank statements, recent pay stubs or other proof of income, rent or mortgage receipts and proof of citizenship. "If any of the above are missing/incomplete," a leaked document read, "the application should be 'DENIED!'"

In a written statement, Pavese said that the documents were "written by one individual for use in a training program." Pavese added that Resurrection provided new training to employees because the documents were "inconsistent with our values." Still, Pavese acknowledged that some of the guidelines described in the memo exist. "We believe that requiring substantiation is responsible stewardship of our resources," Pavese wrote, noting that assistance programs like Medicaid require detailed documentation, too. She denied that Resurrection substantially revised its charity-case policies in 2002. But A.F.S.C.M.E. union officials and other critics of the hospitals contend that the practical effect of the supposed changes has been to reduce charity care either by intimidating would-be applicants, many of whom have poor English skills, or simply trapping them in bureaucratic confusion. Filings with the state government show that charity care declined by one-third in the first year after A.F.S.C.M.E. claimed that these policies went into effect. All told, in 2003, the union calculated that Resurrection hospitals gave back just six-tenths of 1 percent of its gross charges in the form of charity care. The average for other private hospitals in Cook County was more than twice as much.

Resurrection challenges the import of these statistics, partly blaming a change in accounting methods, while its physicians say they still see a steady flow of indigent patients. "We've never been told to cut back," Dr. Timothy McCurry, director of the family practice center at Resurrection Medical Center, told me. "In fact, we're always being told to be more mission-oriented and out finding patients that need care." Even the hospital's fiercest critics would concede that Resurrection provides indigent patients with care all the time -- just as it did two years ago, when the Chicago Fire Department transported a homeless man to one of its E.R.'s. Over the next few months, the hospital performed several operations on him, sometimes admitting him to the intensive-care unit. Eventually, Resurrection social workers tracked down the man's family -- in Poland -- and arranged for him to return to them. Resurrection estimates that it absorbed nearly $140,000 in hospitalization and surgical costs alone.

Stories like that are why Dr. Neil Rosenberg, medical director of the intensive-care unit at Resurrection's Westlake Hospital, gets angry about the current criticism. "We give away care routinely," he said. "I don't think there's another business alive that does close to what we do." Indeed, hospitals say focusing narrowly on "charity care" figures produces a skewed picture of their true value to the community. They prefer to consider estimates of "uncompensated care," a broader category that includes all charges that ultimately go unpaid. In all, the Illinois Hospital Association said that state hospitals -- most of which are nonprofit -- provide some $2 billion in uncompensated care to the uninsured each year. "I'd like to see somebody buy a car and not get a bill -- it just doesn't happen," Rosenberg said. "Why don't the hotels in this country give free rooms to the homeless?"

But car dealers and hotels don't get millions of dollars in property- and corporate-tax breaks; nonprofit hospitals do. And while hospitals lose some money on uncompensated care, critics say that uncompensated care hardly qualifies as charity if the hospital has relentlessly pursued collections, as Resurrection Medical Center did after Marijon Binder visited the hospital in August 2001. Paramedics insisted on taking the 62-year-old to the E.R. after she complained of chest

pains when attending a disabilities-product show. But they also gave her a choice. "I'll take the Catholic hospital," Binder, who happens to be a former nun, recalled telling them.

Binder is a live-in aide for a severely disabled elderly woman, a job that provides no health insurance. When she told the hospital that she had no way to pay the bill, she was given a charity-care application, which she says she submitted. But soon a bill arrived in her mailbox, detailing $11,395 in charges for her two-night stay. Resurrection said it never received the charity application or responses to half a dozen notices over the next few months; Binder says she called when the first bill arrived, explained that she was supposed to be a charity case and was told not to worry, that the mailing was probably caused by a clerical error. Either way, Resurrection eventually decided to pursue collection a different way: it sued.

Binder learned about the lawsuit when a police officer showed up on her doorstep, summons in hand. She quickly faxed a handwritten letter to Resurrection's collection attorney, explaining that she had "devoted the last 10 years to caring for the elderly" and worked full time for an infirm woman. The letter gave a detailed picture of Binder's financial situation, explaining that the housemates lived off the elderly woman's Social Security and pension, which in a typical month left no more than $40 after expenses. Sometimes, Binder wrote, the two even shared a Meals on Wheels dinner to save money. Binder made sure to attach two documents to her fax: a balance sheet from the bank (showing an end-of-month balance of $41.27), plus an affidavit to the Chicago Housing Authority vouching for her financial status. Then she asked for instructions on again applying to become a charity case. A few days later, Binder made a similar appeal -- this time in person, to a nun who worked in hospital administration. But the hospital wouldn't give up the case. Not until the following April -- after repeated appearances in court -- did Binder find somebody sympathetic to her story: a judge. After listening to her testimony in person, he immediately ruled in her favor, absolving her of any responsibility for the bill.

To this day, Resurrection argues that its records show Binder to have been the irresponsible party. "While we strive to ensure fairness and reasonableness in the collection process," Pavese wrote in Resurrection's statement, "it can be particularly difficult when individuals do not respond to our attempts to discuss financial arrangements." But while Binder says she now wishes she had called the hospital more than once after the bills started coming, she remains bewildered that the hospital refused to stop the lawsuit after she made a personal appeal. Nor does Binder understand why Resurrection's attorney continued to pursue the case after her first appearance in court, since on that day she filed for "indigent" status, which exempted her from a court-appearance fee. To do this, Binder had to sign a sworn affidavit that her income was less than $11,225 a year.

Binder's economic circumstances are hardly unusual among the defendants in Chicago's medical-debt cases. From 2000 to 2003, Resurrection pursued cases against at least 77 other people who qualified for indigent status. And because the legal system does very little to advertise the availability of indigent status -- Binder found out only because she overheard somebody in line at the courthouse talking about it -- many more defendants would probably qualify if they knew to apply. To Michael Zucker, director of corporate affairs and strategic research at A.F.S.C.M.E., this alone suggests that the hospitals have gone too far, no matter how supposedly unresponsive some patients may be. "The court's approval of an indigent petition has to be taken at least as an indication that the debtor is a good candidate for charity care," Zucker said. "Why pursue litigation instead of charity care at that point?"

Binder was fortunate in one sense. Aside from a little dignity, her losses were limited to the $1,500 she spent paying professional aides to look after her housemate while she went to court. But the legal system isn't always so forgiving. In Chicago, the proceedings over medical debt take place at the Richard J. Daley Center, an intimidating 31-floor building that occupies almost an entire city block. For a defendant facing a hospital lawsuit, the first stop is the clerk's office, where defendants pay a court-appearance fee -- $90 for debts under $5,000, $140 for debts over $5,000 -- unless they file for indigent status. The trials take place upstairs, in the

courtrooms, where there are typically no juries and, except in rare cases, no defense lawyers, either -- just a judge, some court personnel and collection attorneys scurrying about, exchanging files with the clerks as they dispatch cases involving defendants who haven't shown up. When a defendant is present, the judge will customarily ask him or her to meet with the collection attorney privately and work out a mutually acceptable arrangement. On any given day, if you troll the hallways during the morning or afternoon ''calls,'' you will see people huddled in conversations, as the attorneys pepper defendants with questions about their assets, employment and access to cash.

Although a judge must approve any agreement before it takes effect, the outcome of any particular case depends a great deal on the attorney involved, and Judge Wayne Rhine, a two-decade veteran of the bench, says he has seen all kinds in his courtroom. There are compassionate lawyers who try to work out fair payment plans -- the kind who pursue wage garnishments only against patients who have been blatantly irresponsible or clearly have the means to pay. And then, he says, there is the other kind, the ''guys who would take the fillings out of your teeth.'' Alan Alop, deputy director of the Legal Assistance Foundation of Metropolitan Chicago, says he has ''seen hospital attorneys at citation proceedings say to the debtor, 'How much money do you have in your pocket?' And the debtor says something like, '$42,' and they say, 'Well, let's turn it over to the hospital right now.'" In fact, in Illinois, though few debtors realize it, $2,000 worth of their personal property is exempt from being collected.

Both Advocate and Resurrection maintain that their attorneys act in ways consistent with their religious values. But Bruce Vladeck, a former director of Medicare during the Clinton administration who recently joined Ernst & Young, says that until the latest controversies, ''90 percent of the hospital C.E.O.'s in the U.S. had no idea what the collection offices were doing.'' That would explain why Advocate might not know that its collector was holding on to Margaret Loncar's garnisheed wages or why Resurrection might not know that Robin Kemp had offered to make payments on her bill. Today, Resurrection still uses the standard method for paying its collection attorneys -- offering them a percentage of the money they collect. Under this scheme, if an attorney discovers that a defendant was wrongly denied charity care and refers the patient back to Resurrection's financial-assistance office, that attorney would get no compensation. (The Grabowski Law Center, the firm that seems to handle many of Resurrection's cases, declined multiple interview requests.) In 2003, Advocate began paying its attorneys even if they refer cases back for charity assistance.

If everybody is supposed to have a right to basic medical care, how much responsibility does an individual hospital have to provide it? ''Providing health care for the uninsured should be addressed by a great many governmental and societal sectors,'' Pavese wrote in her lengthy statement. ''Relying solely on hospitals to absorb all the costs of care for uninsured individuals is neither feasible nor realistic.'' And it's not just hospital officials who think that other parties, particularly the government, could do more. If Illinois had processed Michael Loncar's Medicaid application more quickly, his wife says today, he might have felt comfortable going to the E.R. and have received the treatment he needed to live.

But while critics agree that the problem of the uninsured is bigger than the hospitals, they also think the hospitals could do much more to help, particularly when they are spending large sums of money on executive compensation and expensive marketing schemes. ''As a policy matter, if you're going to waive a large tax burden to a billion-dollar corporation, what do you get in return as a society?'' Zucker asked. ''I think what society has asked for in its laws is a real effort to deliver free care to all who need it.'' And whether or not Zucker is correct, the spectacle of nonprofit hospitals suing the indigent may provoke the courts and lawmakers to intervene -- a possibility some of the hospital industry's most powerful friends have already considered. ''I cannot overstate the level of concern this chain of events has given some of the more sophisticated people in the credit-granting area,'' said James Unland, president of the Chicago-based Health Capital Group, which assesses hospital finances on behalf of would-be creditors. ''I

can't have a whole bunch of hospitals being sued in class-action lawsuits and being threatened with huge property-tax bills and reasonably predict the cash flow of the hospitals.''

Today, when hospitals approach Unland to rate their credit-worthiness, he urges management to take a proactive approach to its charity policies: set strict guidelines about collections, clearly define charity-care policies and advertise them sufficiently. ''I don't mean posting a sign,'' Unland insisted. ''I mean a person saying, 'It's clear you don't have insurance -- you may qualify for charity care.'' Some nonprofit hospitals already seem to be moving in that direction. Provena Covenant Medical Center in Urbana has given up asking the police to take debtors to court and established a committee of community representatives to monitor its treatment of the uninsured. (The hospital has appealed the state's decision to revoke its property-tax exemption.) Advocate has introduced new charity-care policies, offering financial assistance to patients with incomes up to four times as much as the poverty line, or well into the middle class. Resurrection has also expanded its offerings and ended the ZIP code restriction. And in perhaps the most sweeping remedial action to date, after being sued by the litigators led by Richard Scruggs, North Mississippi Health Services, a six-hospital system based in Tupelo, settled for a reported $150 million in August, promising, among other things, to repay money it collected from needy uninsured patients in the past few years. It also vowed never to ask uninsured patients to pay more than 10 percent of their income for medical bills.

For now, the hospitals can afford such changes. The last two or three years have actually been relatively profitable, largely because hospitals have extracted higher prices from insurance companies and because Congress eventually restored some of the late-90's Medicare cuts. But financial experts continue to fret over these institutions' long-term financial outlooks. The demand for hospital services by those who cannot pay is rising as employers shift medical costs to employees and relatively more employers simply drop coverage altogether. The competitive pressure on hospitals may be increasing, too, particularly given the recent explosion of physician ownership of specialty facilities that draw lucrative lines of business, like orthopedics and cardiovascular surgery, away from hospitals. As Jacob Hacker, a Yale political scientist and author of ''The Divided Welfare State,'' explained, the mandate to be competitive and the mandate to be compassionate are in some ways simply incompatible: ''We can't ask nonprofits to be more like for-profits in the ways that we like -- efficient, responsive, aggressive -- without expecting that they will also become more like for-profits in the ways that we don't: rapacious, hardheaded and, yes, sometimes selfish.''

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