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Cash Before Chemo: Hospitals Get Tough

Bad Debts Prompt Change in Billing; $45,000 to Come In

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LAKE JACKSON, Texas -- When Lisa Kelly learned she had leukemia in late 2006, her doctor advised her to seek urgent care at M.D. Anderson Cancer Center in Houston. But the nonprofit hospital refused to accept Mrs. Kelly's limited insurance. It asked for $105,000 in cash before it would admit her.

Sitting in the hospital's business office, Mrs. Kelly says she told M.D. Anderson's representatives that she had some money to pay for treatment, but couldn't get all the cash they asked for that day. "Are they going to send me home?" she recalls thinking. "Am I going to die?"

Hospitals are adopting a policy to improve their finances: making medical care contingent on upfront payments. Typically, hospitals have billed people after they receive care. But now, pointing to their burgeoning bad-debt and charity-care costs, hospitals are asking patients for money before they get treated.

Hospitals say they have turned to the practice because of a spike in patients who don't pay their bills. Uncompensated care cost the hospital industry $31.2 billion in 2006, up 44% from $21.6 billion in 2000, according to the American Hospital Association.

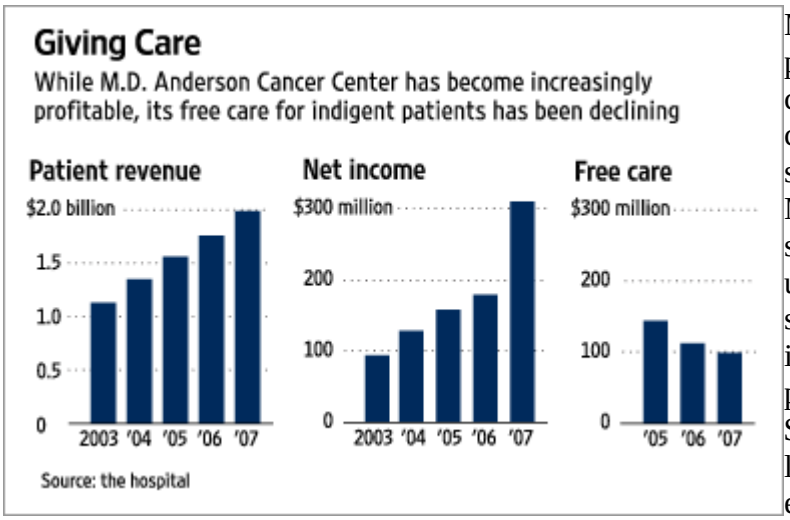
The bad debt is driven by a larger number of Americans who are uninsured or who don't have enough insurance to cover medical costs if catastrophe strikes. Even among those with adequate insurance, deductibles and co-payments are growing so big that insured patients also have trouble paying hospitals.

Letting bad debt balloon unchecked would threaten hospitals' finances and their ability to provide care, says Richard Umbdenstock, president of the American Hospital Association. Hospitals would rather discuss costs with patients upfront, he says. "After, when it's an ugly surprise or becomes contentious, it doesn't work for anybody."

M.D. Anderson says it went to a new upfront-collection system for initial visits in 2005 after its unpaid patient bills jumped by $18 million to $52 million that year. The hospital said its increasing bad-debt load threatened its mission to cure cancer, a goal on which it spends hundreds of millions of dollars a year.

The change had the desired effect: The hospital's bad debt fell to $33 million the following year.

Asking patients to pay after they've received treatment is "like asking someone to pay for the car after they've driven off the lot," says John Tietjen, vice president for patient financial services at M.D. Anderson. "The time that the patient is most receptive is before the care is delivered."



M.D. Anderson says it provides assistance or free care to poor patients who can't afford treatment. It says it acted appropriately in Mrs. Kelly's case because she wasn't indigent, but underinsured. The hospital says it wouldn't accept her insurance because the payout, a maximum of $37,000 a year, would be less than 30% of the estimated costs of her care.

Tenet Healthcare and HCA, two big, for-profit hospital chains, say they have also been asking patients for upfront payments before admitting them. While the practice has received little notice, some patient advocates and health-care experts find it harder to justify at nonprofit hospitals, given their benevolent mission and improving financial fortunes.

In the Black

An Ohio State University study found net income per bed nearly tripled at nonprofit hospitals to $146,273 in 2005 from $50,669 in 2000. According to the American Hospital Directory, 77% of nonprofit hospitals are in the black, compared with 61% of for-profit hospitals. Nonprofit hospitals are exempt from taxes and are supposed to channel the income they generate back into their operations. Many have used their growing surpluses to reward their executives with rich pay packages, build new wings and accumulate large cash reserves.

M.D. Anderson, which is part of the University of Texas, is a nonprofit institution exempt from taxes. In 2007, it recorded net income of $310 million, bringing its cash, investments and endowment to nearly $1.9 billion.

"When you have that much money in the till and that much profit, it's kind of hard to say no" to sick patients by asking for money upfront, says Uwe Reinhardt, a health-care economist at Princeton University, who thinks all hospitals should pay taxes. Nonprofit organizations "shouldn't behave this way," he says.

It isn't clear how many of the nation's 2,033 nonprofit hospitals require upfront payments. A voluntary 2006 survey by the Internal Revenue Service found 14% of 481 nonprofit hospitals required patients to pay or make an arrangement to pay before being admitted. It was the first time the agency asked that question.

Nataline Sarkisyan, a 17-year-old cancer patient who died in December waiting for a liver transplant, drew national attention when former presidential candidate John Edwards lambasted her health insurer for refusing to pay for the operation. But what went largely unnoticed is that Ms. Sarkisyan's hospital, UCLA Medical Center, a nonprofit hospital that is part of the University of California system, refused to do the procedure after the insurance denial unless the family paid it $75,000 upfront, according to the family's lawyer, Tamar Arminak.

The family got that money together, but then the hospital demanded $300,000 to cover costs of caring for Nataline after surgery, Ms. Arminak says.

UCLA says it can't comment on the case because the family hasn't given its consent. A spokeswoman says UCLA doesn't have a specific policy regarding upfront payments, but works with patients on a case-by-case basis.

Federal law requires hospitals to treat emergencies, such as heart attacks or injuries from accidents. But the law doesn't cover conditions that aren't immediately life-threatening.

At the American Cancer Society, which runs call centers to help patients navigate financial problems, more people are saying they're being asked for large upfront payments by hospitals that they can't afford. "My greatest concern is that there are substantial numbers of people who need cancer care" who don't get it, "usually for financial reasons," says Otis Brawley, chief medical officer.

Mrs. Kelly's ordeal began in 2006, when she started bruising easily and was often tired. Her husband, Sam, nagged her to see a doctor.

A specialist in Lake Jackson, a town 50 miles from Houston, diagnosed Mrs. Kelly with acute leukemia, a cancer of the blood that can quickly turn fatal. The small cancer center in Lake Jackson refers acute leukemia patients to M.D. Anderson.

When Mrs. Kelly called M.D. Anderson to make an appointment, the hospital told her it wouldn't accept her insurance, a type called limited-benefit.

"When an insurer is going to pay the small amounts, we don't feel financially able to assume the risk," says M.D. Anderson's Mr. Tietjen.

An estimated one million Americans have limited-benefit plans. Usually less expensive than traditional plans, such insurance is popular among people like Mrs. Kelly who don't have health insurance through an employer.

Mrs. Kelly, 52, signed up for AARP's Medical Advantage plan, underwritten by UnitedHealth Group Inc., three years ago after she quit her job as a school-bus driver to help care for her mother. Her husband was retired after a career as a heavy-equipment operator. She says that at the time, she hardly ever went to the doctor. "I just thought I needed some kind of insurance policy because you never know what's going to happen," says Mrs. Kelly. She paid premiums of $185 a month.

A spokeswoman for UnitedHealth, one of the country's largest marketers of limited-benefit plans, says the plan is "meant to be a bridge or a gap filler." She says UnitedHealth has reimbursed Mrs. Kelly $38,478.36 for her medical costs. Because the hospital wouldn't accept her insurance, Mrs. Kelly paid bills herself, and submitted them to her insurer to get reimbursed.

M.D. Anderson viewed Mrs. Kelly as uninsured and told her she could get an appointment only if she brought a certified check for $45,000. The Kellys live comfortably, but didn't have that kind of cash on hand. They own an apartment building and a rental house that generate about $11,000 a month before taxes and maintenance costs. They also earn interest income of about $35,000 a year from two retirement accounts funded by inheritances left by Mrs. Kelly's mother and Mr. Kelly's father.

Mr. Kelly arranged to borrow the money from his father's trust, which was in probate proceedings. Mrs. Kelly says she told the hospital she had money for treatment, but didn't realize how high her medical costs would get.

The Kellys arrived at M.D. Anderson with a check for $45,000 on Dec. 6, 2006. After having blood drawn and a bone-marrow biopsy, the hospital oncologist wanted to admit Mrs. Kelly right away.

But the hospital demanded an additional $60,000 on the spot. It told her the $45,000 had paid for the lab tests, and it needed the additional cash as a down payment for her actual treatment.

In the hospital business office, Mrs. Kelly says she was crying, exhausted and confused.

The hospital eventually lowered its demand to $30,000. Mr. Kelly lost his cool. "What part don't you understand?" he recalls saying. "We don't have any more money today. Are you going to admit her or not?" The hospital says it was trying to work with Mrs. Kelly, to find an amount she could pay.

Mrs. Kelly was granted an "override" and admitted at 7 p.m.

Appointment 'Blocked'

After eight days, she emerged from the hospital. Chemotherapy would continue for more than a year, as would requests for upfront payments. At times, she arrived at the hospital

and learned her appointment was "blocked." That meant she needed to go to the business office first and make a payment.

One day, Mrs. Kelly says, nurses wouldn't change the chemotherapy bag in her pump until her husband made a new payment. She says she sat for an hour hooked up to a pump that beeped that it was out of medicine, until he returned with proof of payment.

A hospital spokesperson says "it is very difficult to imagine that a nursing staff would allow a patient to sit with a beeping pump until a receipt is presented." The hospital regrets if patients are inconvenienced by blocked appointments, she says, but it "is a necessary process to keep patients informed of their mounting bills and to continue dialog about financial obligations." She says appointments aren't blocked for patients who require urgent care.

Once, Mrs. Kelly says she was on an exam table awaiting her doctor, when he walked in with a representative from the business office. After arguing about money, she says the representative suggested moving her to another facility.

But the cancer center in Lake Jackson wouldn't take her back because it didn't have a blood bank or an infectious-disease specialist. "It risks a person's life by doing that [type of chemotherapy] at a small institution," says Emerardo Falcon Jr., of the Brazosport Cancer Center in Lake Jackson.

Ron Walters, an M.D. Anderson physician who gets involved in financial decisions about patients, says Mrs. Kelly's subsequent chemotherapy could have been handled locally. He says he is sorry if she was offended that the payment representative accompanied the doctor into the exam room, but it was an example of "a coordinated teamwork approach."

On TV one night, Mrs. Kelly saw a news segment about people who try to get patients' bills reduced. She contacted Holly Wallack, who is part of a group that works on contingency to reduce patients' bills; she keeps one-third of what she saves clients.

Ms. Wallack began firing off complaints to M.D. Anderson. She said Mrs. Kelly had been billed more than $360 for blood tests that most insurers pay $20 or less for, and up to $120 for saline pouches that cost less than $2 at retail.

On one bill, Mrs. Kelly was charged $20 for a pair of latex gloves. On another itemized bill, Ms. Wallack found this: CTH SIL 2M 7FX 25CM CLAMP A4356, for $314. It turned out to be a penis clamp, used to control incontinence.

M.D. Anderson's prices are reasonable compared with other hospitals, Mr. Tietjen says. The $20 price for the latex gloves, for example, takes into account the costs of acquiring and storing gloves, ones that are ripped and not used and ones used for patients who don't pay at all, he says. The charge for the penis clamp was a "clerical error" he says; a different type of catheter was used, but the hospital waived the charge. The hospital didn't reduce or waive other charges on Mrs. Kelly's bills.

Continuing Treatment

Mrs. Kelly is continuing her treatment at M.D. Anderson. In February, a new, more comprehensive insurance plan from Blue Cross Blue Shield that she has switched to started paying most of her new M.D. Anderson bills. But she is still personally responsible for $145,155.65 in bills incurred before February. She is paying $2,000 a month toward those. Last week, she learned that after being in remission for more than a year, her leukemia has returned.

M.D. Anderson is giving Blue Cross Blue Shield a 25% discount on the new bills. This month, the hospital offered Mrs. Kelly a 10% discount on her balance, but only if she pays $130,640.08 by this Wednesday, April 30. She is still hoping to get a bigger discount, though numerous requests have been denied. The hospital says it gives commercial insurers a bigger discount because they bring volume and they are less risky than people who pay on their own.

The hospital has urged Mrs. Kelly to sell assets. But she worries about losing her family's income and retirement savings. Mrs. Kelly says she wants to pay, but, suspicious of the charges she's seen, she says, "I want to pay what's fair."

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