



Advanced Policy Analysis

# MEDICAL DEBT AND HOSPITAL CHARITY CARE POLICIES: A CASE STUDY

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# Executive Summary

Medical bills are unlike other types of bills. They are involuntary, unexpected, and often unnecessarily complex. The addition of a third party – the health insurance company, or insurer – further complicates matter on who is paying at what amount. Unpaid medical bills can have severe consequences, particularly for low-income individuals. Unpaid bills diminish credit scores, impacting an individual’s access to credit, loans, and housing. To help this issue, policies exist at the state and federal level to protect the poor from abusive collections and billing practices. One such policy is charity care.

Charity care refers to hospital financial assistance policies aimed to help the low- income and uninsured pay for medical bills through discounted or free care. In California, most hospitals are required to provide charity care as part of their community health needs assessment. Federal law requires nonprofit hospitals – which receive millions in federal, state, and local tax exemptions – provide charity care to communities as well, and also require publication of this resource. However, experience with the organization, Housing and Economic Rights Advocates (HERA), demonstrates that low-income, vulnerable populations are not receiving the assistance they are eligible for, nor are they informed of the option for free or discounted care. People either unable to pay the bills or unaware of their existence often find the shocking news when they apply for credit. The bills have downstream impacts resulting in decreased economic stability, as individuals find their housing, access to credit, loans, and health threatened.

In response to ongoing consumer complaints on high fees, collections notices, and the national discussion around charity care provision in the United States, we asked: ***what are issues clients at HERA face when it comes to medical bills, particularly seniors, and why are charity care policies ineffective despite the presence of federal and state laws?*** We hoped to gain a greater understanding of the problem in order to build a foundation for future policy advocacy work.

I examined charity care policies for hospitals in Alameda and Contra Costa county to see if they were complying with recent standards that requires hospitals to have written policies on financial assistance eligibility and adhere to notification standards and make information accessible. The findings and next steps are presented below.

## Key Findings

The presence of federal and state law in mandating charity care policies at the hospital level is not enough. Hospitals are not complying with notification requirements and enforcement seems nonexistent.

### *Client Takeaways*

- HERA clients may not be receiving the full suite of financial help they could. Review of client notes and interviews with clients illuminated that individuals often have multiple different types of debt, ranging from mortgage (the most common) to medical. They often forgo bringing up medical debt issues in lieu or more pressing housing issues.
  
- The biggest problem with medical debt that HERA clients face involves charity

care. Individuals came to HERA after discovering they had debt, and despite being eligible for charity care, they did not receive any notifications for it.

### *Charity Care Policies*

- Most hospitals are complying with federal and state law to have written policies on charity care, and to submit them to OSHPD. Most meet state standards of setting the eligibility level at at-least 350% of federal poverty for discounted and free care.
- However, three out of 13 comprehensive charity care policies are not complying with California law to define high medical cost patient as those who do receive third party payments
  - Deductibles are often excluded from eligible costs, which is counter to the goal of the Hospital Fair Policies Pricing Act that gives relief to poor individuals with high cost plans.
- Half of hospitals do not provide charity care information on their website, and less provide it in different languages as required by law.
- No hospitals adhere to the federal policy to provide information on charity care in at least three billing statements, as required under federal law.

### **Policy Recommendations**

- Expansion of reasonable payment plans under the Hospital Fair Pricing Act
- Explicitly allow Medicare enrollees to participate under the Hospital Fair Pricing Act
- Notification requirements: hospitals must include an easy to read, one page information sheet on charity care policies and the application process
- Assignment of a patient advocate to uninsured individuals and those who are underinsured

## **Project Overview**

Medical bills and medical debt have a lasting impact on the financial stability for families, particularly vulnerable populations. The uninsured and lower income groups are more likely to experience problems paying medical bills, although people of all socio- economic groups report experiencing problems with medical costs. The Affordable Care Act (ACA) aimed to increase protections for consumers by increasing access to private and public insurance coverage, as well as mandating charity care for low-income, uninsured or underinsured patients in nonprofit hospitals. While uninsured individuals do not have any insurance to help cover costs in the case of medical necessity, underinsured refers to a person who has health insurance but faces high medical costs. This is especially relevant today: recent surveys show that 35% Americans still experience issues with medical costs, and 47% of that group reported that they were unaware of charity care after receiving health care services. While health insurance mitigates the impact of

medical bills by providing some protection, medical bills nonetheless remain a problem for millions of insured and uninsured individuals.

This is particularly relevant for the client, Housing and Economic Rights Advocates (HERA), a legal advocacy clinic based in Oakland California. HERA provides legal services and information to Californians, particularly those most vulnerable, to promote financial security free of economic abuses. They also advocate for stronger consumer protections from debt at the state level. While HERA's focus in the past has centered around homeownership and protections from mortgage debt, over the past 6 years, HERA has opened its doors to address the vast array of debt and credit concerns experienced by tenants and homeowners alike that are unrelated to housing, while continuing to address housing related concerns for renters and homeowners.

The goal of this report is two-fold. The first is to analyze the current landscape of medical costs, bills, and debt for low-income individuals, with a case study on HERA clients, to understand why medical bills may persist among insurance coverage expansions and charity care policies in California. The second part of this paper examines charity care policies for hospitals in Alameda and Contra Costa counties in the Bay Area, California. California in particular has policy protections in place for low-income uninsured and certain insured individuals, yet data suggests that those policies are underutilized by eligible populations. The paper will conclude with policy recommendations on how to improve charity care and consumer protections in the U.S.

## Methodology

This research project's effort revealed that many of HERA's clients had experienced medical debt concerns but had not come to HERA for this problems, either because they did not realize HERA could assist, or because the problem had already been resolved (though not necessarily to their advantage).

### Introductory Framing

HERA's work over the course of our 13 years has involved becoming intimately familiar with clients' financial challenges and well-being. HERA opened just before the foreclosure crisis hit California. In the years that followed, HERA dedicated itself to preventing foreclosures across California and improving federal and state laws to protect residents' ability to keep their home. Their work also revealed the depth and breadth of financial crisis that residents were experiencing. HERA opened its doors in 2010 to address some of the other household financial problems low and moderate income residents, both tenants and homeowners, have beyond mortgage and other housing related concerns, and gradually expanded its range of challenges the office addresses for residents. Medical debt is one of those concerns. In 2016, HERA began coding to track when residents coming to HERA were raising medical debt concerns.

#### *Part I: HERA Client Case Study*

To find information on HERA clients that faced problems with medical bills, we generated reports from the data system that houses client information at HERA: Abacus Law. Because coding for medical debt was implemented relatively recently by HERA once staff started to see such concerns percolate up in their contacts with clients, database information was more limited.

Nonetheless, the client's files that did appear served as a selection for the case study. I read through relevant client notes to select those who had explicitly expressed problems with medical bills or debt.

To determine the extent of their medical bills and debt, I read through the client notes and emails, and looked at their data component on debts (medical and non-medical) and income, when available. This alongside informal conversations with a HERA staff attorney illuminated that one of the biggest issues client's face is in charity care.

The final list of individuals with medical bill issues was 50. Another report on charity care clients yielded a final number of 14 clients with charity care cases, who had come into the office from October 2016 to April 2017. I read through client notes to understand the issues they faced.

To speak with seniors regarding their medical bill issues, we scheduled three focus groups of one hour in length, and disseminated information about the focus groups by email and phone calls. Participants were given a \$15 token of appreciation for attending. However, only three individuals came (a couple on one day, and an individual on another), turning the focus groups into individual interviews. For the remaining three interviews, I conducted a random selection of seniors, and called 60 down the line. Three individuals both answered their phone and volunteered to speak with me. Interviews lasted from 30 minutes to one hour and were conducted in an informal, conversational-style format. Interviewees were asked what experience they had with medical bills and debt, the amount of the bills, and whether these were in collections. Finally, interviewees were asked what supports would have been useful or what they would like to see implemented at the state policy level.

## *Part II: Charity Care Analysis*

The Office of Statewide Healthcare Planning and Development, (OSHPD), is the reporting agency for hospitals in California. Under the Hospital Fair Policies Pricing Act, hospitals are required to submit charity care policies on the website. For this analysis, I read through each policy for hospitals in Alameda and Contra Costa County.

The goal was to determine whether these hospitals are following federal and state law, for defining eligibility and promoting information regarding charity care policies. Specifically, the following were relevant to understanding how charity care plays out for patients across these hospitals.

- Variation in eligibility standards and ineligible charges
- Notification policies
- Debt collection policies

I omitted the children's hospital in Oakland. While 25 hospitals were in the analysis, a share were part of major health systems such as Kaiser Permanente and Sutter Health, and hospitals in these systems tended to follow the same policy. For that reason, there were only 13 distinctly different policies and 13 different hospital websites, and so the qualitative data in terms of distinct policies. For example, while I studied seven Kaiser hospitals, they all use the same website and operate under the same charity care policy, so their information on charity care is listed as one policy, under Kaiser Permanente. I analyzed each distinct policy to understand their standards on eligibility, notification requirements, and more.

## *Website searches*

The methods of this part of the analysis are a further extension inspired by original analysis conducted by Community Catalyst in 2010 looking at whether nonprofit hospitals were complying with the law. Since the goal of this study was not to specifically distinguish between nonprofits and for profits (in California all hospitals must comply), the methods are modified to the following:

To determine whether hospitals were complying with notification requirements, I searched each of the 13 distinct hospital websites for their billing and insurance page, if any. I also searched in their search bar for the following words: “financial assistance”; “charity care”; “uninsured”; and “billing.” I then following search results to determine whether there was any information on charity care policies. The results are listed under findings.

## *Part I: Medical Debt and HERA clients*

### **Background on Medical Bills and Debt**

#### **Medical Bills and Debt**

*The unique nature of medical bills sets the foundation for consumers to incur medical debt.*

Bills arising from medical issues are different in nature than other bills, such as credit cards bills or loan payments. They are frequently involuntary, unexpected, and largely unpredictable. While health insurance coverage can act as a form of financial protection, that protection is incomplete due to increasing deductibles<sup>3</sup> and co-pays, out-of-network charges, uncovered expenses, billing errors, and confusion and complexity about patient-versus-insurer payment responsibility. While the Affordable Care Act (ACA) increased access to coverage, a recent survey found the one in five people who reported trouble paying their medical bills *had* health insurance.<sup>4</sup> Rising costs further complicates the problem. It is estimated that even among individuals with employer-sponsored insurance, the average worker in 2015 paid \$1,318 in out-of-pocket expenses *on top* of paying premiums, compared to \$584 in 2005.<sup>5</sup> Low-income and marginalized populations are more likely than others to report problems paying medical bills,<sup>6,7</sup> but studies show that inability to pay can impact people from all socio-economic groups, particularly as costs rise and most individuals’ unplanned funds reserve is not sufficient to cover today’s medical costs.<sup>8</sup> About a quarter (26%) of Americans reported in a survey that they or their family member had difficulty paying medical bills in the past year alone. Unfortunately, the increasing costs and payments to health insurance deplete families’ income and leave little for other needs. Millions of Americans do not have the financial means to pay for upfront costs or high monthly payment plans, and instead bills go unpaid become collections tradelines on their credit reports. Many file for bankruptcy due to loss of income from medical problems and costs<sup>9</sup>; currently, more than half of all bankruptcies filed are in part due to problems with medical bills.<sup>10</sup>

*Complexity with the health insurance system exacerbates medical bill issues and contributes to medical debt.*

Health insurance is intended to provide financial protection for consumers, yet often, medical bills are left unpaid due to complexities between insurers, providers and consumers. Bills go

unpaid and unresolved due to complexities for a variety of reasons, including if a provider does not properly bill the insurer.<sup>11</sup> Bill coding is a complex system, and often, providers make mistakes in charging patients for the correct services.

Processing errors in claims can also delay payments to providers resulting in unpaid bills or denial of coverage from insurers. It is estimated that one in five claims are processed inaccurately.<sup>12</sup> A study from the Government Accountability Office demonstrated the complicated communications between providers and insurers that leads to the burden of payment falling on the consumer, when the service should have been covered. For example, billing errors occur if a provider fails “to include a piece of required information the claim, such as documentation that the provider received prior authorization for a service, or submitting a duplicate claim.”<sup>13</sup> Claim denials can also occur if an insurer determines if the service rendered was “not appropriate...[or] not medically necessary.” While there has been an effort on third party consultants to negotiate with insurers and assist providers, these types of medical billing errors often leave the unsuspecting consumer with a confusing bill that goes against what their provider had mentioned and against their minimum benefits package. These errors also did not simplify under the ACA as initially predicted; while the law required full coverage of many preventive services and office visits without patient cost sharing, studies and anecdotal reports found that insurers would use “reasonable medical management” techniques to deny coverage of certain preventive services,<sup>14</sup> and instead unfairly burden consumers with what they believed was to be covered under their insurance plan. This, compounded with bill coding errors, often left unsuspecting consumers with unexpected expenses that they thought would be covered under their insurance plan.

Even when mistakes in billing are corrected, and the amount paid, reimbursements to providers can be delayed, during which bills are often sold off to debt collectors. In 2012, it was estimated that about seven million Americans had their medical bills sent to debt collectors due to billing mistakes.<sup>15</sup>

While bills are being adjudicated between insurers, providers, and themselves, consumers are often asked to pay for the bill. It is “routine practice for patients to sign treatment consent forms that include language stating that the patient will assume responsibility for payment in the event that his or her insurance company does not cover 100% of the amount of the medical claim”.<sup>16</sup> While there is a great need to reform how the medical billing system works as well as how insurance companies cover costs, that system is not likely to be changed without an overhaul to the health care insurance billing system.

Until changes are made to increase transparency and consistency in billing, the seemingly insurmountable burden of deciphering a medical bill will continue to be left to consumers. Consumers also are often left confused as to what service they are being charged for, and whether they should pay the provider or the insurer. This confusion also contributes to why medical bills go unpaid, as nearly one third of people with medical bills reported that they let their bill go to a collections agency because they did not understand the bill or explanation of benefits statement.

*Price discrimination harms the most vulnerable, leading them to disproportionately accrue debt.*

Medical debt often harms disadvantaged patients – those who are uninsured or underinsured – more than others with greater access to financial protection. Not only is knowledge about pricing of services difficult to decipher, but the great variability in pricing across hospitals<sup>17</sup> in the US makes it difficult to plan for such costs. Furthermore, “Not only do hospitals charge vastly

different prices for the same service, but the same hospital charges different prices to different payers, a phenomenon known as price discrimination.”<sup>18</sup>

Hospitals routinely charge uninsured patients the undiscounted price for services, known as the “chargemaster” list of fees for services, while government-sponsored insurers or private insurance companies are charged significantly less for the same services.<sup>19</sup> Chargemaster rates have evolved over time to be greatly inflated (3-4 times that of insured patient’s costs<sup>20</sup>) and no longer reflect the actual cost of the service. While hospitals argue that they do not actually harm consumers because most consumers do not have to pay the full price, “irrational hospital pricing harms many who do pay these inflated prices, including middle class uninsured patients and those insured with high deductible health plans or who receive out-of-network care. Irrational hospital prices also further distort the health care market and undermine efforts to keep costs under control, leading to higher prices overall.”<sup>21</sup> Often, consumers *are* left paying the differential, placing an unfair financial burden on those who are least likely to be able to afford the payment. These patients furthermore do not have the bargaining power to decrease payments, not the knowledge of how to do so.

Some states have taken action to limit how much more uninsured and underinsured patients would have to pay. For example, California passed the Hospital Fair Pricing Act in 2007 that prohibits balanced billing and chargemaster rates.<sup>22</sup>

*Protections for low-income and uninsured consumers available at certain hospitals, but protections fall short.*

Under the ACA, nonprofit hospitals are required to provide financial assistance for individuals who have trouble paying<sup>23</sup>, however, the ability of these hospitals to set income eligibility, and lack of transparency have diminished the impact of this requirement.

Currently, provisions in the ACA require nonprofits to implement policies with defined, publicized criteria for eligibility and information on how to apply for assistance.<sup>24</sup> The ACA also prohibits barring emergency services to individuals based on ability to pay, requires written billing and collection practices, and prohibits “extraordinary collection” practices without “reasonable”<sup>25</sup> attempts to determine patient eligibility for reduced or waived fees.<sup>26</sup> Rules released by the IRS in 2014 further enhance the ACA provisions to address unfair practices in medical billing and debt collection. The rules require that nonprofit hospitals maintain and publicize financial assistance policies, and also require limitations on amount billed to financial assistance recipients for medically necessary care. Finally, the rules also define “extraordinary collection actions” as “actions taken by a hospital facility against an individual related to obtaining payment of a bill for care covered under the hospital’s FAP [financial assistance policy] that require legal or judicial process or involve selling an individuals’ debt to another party or reporting adverse information . . . to consumer credit reporting agencies”.<sup>27</sup> Currently, the rules allow hospitals to use debt collection practices as long as they have made “reasonable efforts” for notice of financial assistance policies and time for application, but leave the type of assistance in the hands of hospitals.

Under the new rules hospitals can determine their own affordability thresholds, allowing for narrow financial eligibility cutoffs or exclusion of insured patients regardless of the burden of bills relative to income. Currently, studies show that hospital financial assistance policies vary significantly.

“Among the sample of financial assistance policies from 140 hospitals, eligibility cutoffs for financial assistance ranged from an income of 100 percent of the federal poverty level (FPL) to 600 percent of the FPL. Many hospitals with financial assistance policies offered free care to those with incomes up to 100-200 percent of the FPL and sliding scale discounts above that threshold. However, some hospitals did not offer any free care and only offered moderate discounts even to the poorest patients.”

Consumers do not necessarily choose their hospitals based on the level of coverage and assistance it may offer. Rather, it is frequently based on what is in-network, recommended by their physicians, or simply what was the closest to their site of emergency.<sup>28</sup> While the financial assistance policies are a start, they do not provide uniform coverage for consumers, leaving low-income consumers’ financial protection under the discretion of hospital administrative decisions.

## Medical Debt and Collections

*High prevalence of medical debt point to a need for greater regulation.*

Healthcare providers are generally the original creditors for consumers, but they are rarely the furnishers of medical debt. According to the Consumer Financial Protection Bureau (CFPB), 99.4% of medical debt collections tradelines<sup>1</sup> on consumer credit reports comes from third party debt collectors or collections agencies.<sup>29</sup> Healthcare providers sell off unpaid medical bills to debt collectors, collections agencies, or in house debt collectors to recover a portion of the unpaid accounts. Once in the hands of debt collectors, it becomes difficult for consumers to negotiate the cost of care or payment plans with hospitals, and they must instead work with the third-party debt furnishers. In some cases, consumers are not aware or informed that their debt is in the hand of debt collectors, but the presence of medical debt on a collections tradelines is far too frequent to ignore.

*Medical debt tradelines on credit reports are not indicative of a consumer’s creditworthiness, and is asymmetrical.*

Medical debt impacts millions of people, yet data and recent changes in credit scoring indicate that medical debt is often not indicative of a person’s credit worthiness. Furthermore, the system of reporting only unpaid medical debt only penalizes individuals, since there is no system in place that rewards individuals for paying medical bills on time. The unpredictable nature of medical billing and inconsistencies in reporting of debt point to how unpredictable medical debt is as an indicator of creditworthiness. As noted,

“Credit evaluators also have some concern about the appropriateness of using medical collection items in credit evaluations because these items (1) are relatively more likely to be in dispute, (2) are inconsistently reported, (3) may be of questionable value in predicting future payment performance, or (4) raise issues of rights to privacy and fair treatment of the disabled or ill.”<sup>30</sup>

Some credit evaluators report that they remove medical collections items because it may not

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<sup>1</sup> The CFPB defines a tradeline as an “entry by a credit grantor to a consumer’s credit history maintained by a credit reporting agency.” In this report, tradelines are referred to as both active accounts and collections accounts. CFPB. A study of medical and non-medical collections. 2014.

represent an individual's likelihood of fulfilling loan requirements, but this practice is not standardized.<sup>31</sup> There has, however, been some movement in the scoring model side. The Fair Isaac Corporation (FICO) develops and licenses credit scoring models used by lenders. After the CFPB found in its ground-breaking studies that medical debt skews credit scores in ways that do not predict overall credit risk, FICO undertook its own analysis. The newest model, FICO 9, ignores paid medical debt collections items, and also assigns different weight to unpaid medical debt compared to unpaid non-medical debt.<sup>32</sup> FICO reported that bad medical debt was not predictive of a consumer's ability to pay. However, they stopped short of ignoring unpaid medical debt, stating that "the vast majority (~90%) or those [medical collections] accounts are unpaid."

Most medical debt collections items are also for small amounts. Eighty-five percent has balances of \$500 or less,<sup>33</sup> however, any collections tradelines can have a negative impact on a credit score. The presence of any paid or unpaid collections tradeline with a minimum of \$100 would reduce the credit score of an individual, by 40 points for a score of 680 and 100 points by a score of 780.<sup>34</sup> Furthermore, once a medical tradeline is on the credit report, it will remain there and impact a credit score for seven years<sup>35</sup>. Some states have enacted policies to decrease the reporting of medical debt to credit bureaus. In California, for example, hospitals are not permitted to report negative information to credit reporting agencies or file a lawsuit against certain underinsured or uninsured individuals within 150 days of initial billing.<sup>36</sup>

It has been established that hospitals and providers vary greatly in their likelihood of selling debt, or what financial assistance programs they offer consumers. Debt is not reported consistently, and to add, once reported, only negative debt is reported on a credit report. On the other hand, mortgage and credit card companies do not distinguish between paid or unpaid payments, and report all, allowing positive and timely payments to increase an individual's credit score. However, in the case of medical debt, payments made on time do not result in boosts to one's credit score, but unpaid bills or missed payment negatively impact the credit score.<sup>37</sup> This asymmetry in reporting is due to the fact that the original creditors (healthcare providers) are not generally the furnishers of debt. While this distinction is important, the negative information on payments skews one's score towards unfavorable.

### *Practice of "parked debt" by debt furnishers negatively impacts consumer's credit reports.*

The CFPB estimates that about 15 million consumers may be unaware that they have medical debt that negatively impacts their credit score. Debt collectors sometimes report medical debt to credit reporting agencies without informing the debt account holder about their debt, or possible payment plans. This is known as "parking" medical debt.

"Parking" harms the consumer because he or she never has the opportunity to address or contest the debt, such as by seeking charity care or contacting the insurer to see why the debt was not paid by insurance coverage."<sup>38</sup>

As a result, consumers often find out about the debt when they apply for a mortgage or car loan, and discover that their credit score has been negatively impacted. Some then take actions to pay off the debt, much to the benefit of debt collectors. In these scenarios, collectors benefit from parking medical debt because they do not have to expend resources into collecting from the consumer, and instead the consumer comes to them. At that point, however, the damage has already been inflicted upon an individual's credit score, and penalizing the perceived creditworthiness of consumers. While the Fair Debt Collections Practices Act (FDCPA) requires

that debt collectors give notices to consumers,<sup>39</sup> it is required only when consumers have been notified of their debts to begin with.<sup>2</sup> There is little research regarding parked medical debt, and the existence of it itself is contrary to the way debt collectors deal with other types of debt. Debt collectors are known to excessively harass individuals regarding credit card debt or student loan debt, sending notices and calling multiple times a day.

## Special Seniors' Burden?

The share of seniors carrying debt into retirement is steadily increasing. The burden of this debt strains limited resources and impacts senior's ability to pay for everyday living expenses and bills. As the population ages and healthcare costs increase, the weight of this debt is likely to increase. In 2001, 50.2% of households headed by someone over 60 had some form of debt, with the share increasing to 61.3% by 2013. The amount of debt carried by older populations also increased; while the median total debt for older adult households was \$9,038 in 2001, it rose to \$40,900 by 2013.<sup>40</sup>

Debt impacts the economic security and financial stability of households, and especially seniors who have fixed incomes and are generally unable to gain more resources later in life. Medical debt among seniors is less prevalent than for the non-elderly population, in part due to protections available for seniors in the form of Medicare. Majority of seniors (44 million) are covered by Medicare, which generally provides financial protection against the cost of many health care services. However, Medicare beneficiaries still are subject to deductibles, cost-sharing requirements, and certain services that are important for the elderly but are not covered, including long-term services and supports, hearing aids, glasses, and dental services. Those with traditional Medicare – which is one third of the Medicare population – can still face 20% of cost-sharing on bills. Currently, beneficiaries of Medicare part D, which covers outpatient prescription drugs, may experience a coverage gap.<sup>41</sup> Furthermore, long-term care is not covered under Medicare, and while it is covered under Medicaid, only the poorest under 138% are eligible. This leaves the near-poor out of protection.

Despite the protection, seniors are susceptible to costs beyond their means. They face on average thousands of dollars in out of pocket costs per year; in 2010, the total average pocket medical expense was approximately \$4700. Since they have such limited resources, but are more prone to sickness, protecting the health and financial safety of seniors is necessary to caring for the elderly. They are likely to be on the receiving end of predatory financial scams and elder abuse as well. It is for these reasons – that they are a particularly vulnerable, and growing, group, that we chose to focus a portion of the report on them.

## Findings from HERA client case study

### *Observations from Client Files*

Examining client notes pointed to the importance of charity care policies and how individuals were falling through the cracks, even given the success of the ACA in enrolling people for health

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<sup>2</sup> This is known as debt validation. The CFPB in 2015 reached a settlement with a medical debt collections firm for \$5.9 million over the agency's failure to send debt validation notices after initial contact, as well as a failure to respond to consumer requests on complaints. These fell under violation of the Fair Debt Collection Practice Act and Fair Credit Report Act. Law 360. CFPB, Medical Debt Collector Reach \$5.9M Settlement. June 2015.

care. Even with the limitations in data from the HERA database, given the length of time in having coded for medical debt, information captured still provides a meaningful insight into the problems clients face.

- Identified 47 clients from 2015 – April 2017 who experienced issues with medical debt.
- Identified 14 clients from October 2016 – April 2017 that had issues with charity care. Most were eligible, either through income, or because they were homeless at the time they received care.
  - Out of these, two were two late to apply for retroactive charity care.
  - Clients often had no proof of receiving notification for charity care. This was in blatant violation of federal and state law.
  - Clients often stated that they had never heard of financial assistance policies.
- A handful of clients were possibly eligible for Medi-Cal. Follow up was not recorded.
- The majority of clients had multiple hospital debts, often from different hospitals.
- The amount of medical debt ranged from \$230 to \$72,000, with many debts between the ranges of 0-\$1000, or \$2500- \$5000.
- Individuals often had multiple accounts within the same hospital or dispersed between multiple hospitals. Often, one or more of these were already in collections.
- Most people with medical debt also had some form of other debt, not limited to mortgage debt, credit card debt, auto loan debt, and utilities debt.

One individual stated that her experience with medical bills is that it exacerbates other financial issues and places a massive strain on daily living. Due to breast cancer, she was no longer able to work, could afford insurance, and couldn't pay for her mortgage. She had her home for 30 years, but faced loss due to foreclosure and unmet payments. Her unpaid medical bills, some of which were mistakes, had adversely impacted her credit score, and she wasn't able to take out a loan.

"[It was] overwhelming to deal with the disease, having to pay for the medical insurance....and then have problems paying for my home [of 30 years]."

### *Observations from Client Interviews*

The interviews overwhelmingly matched national studies and reports on the issues individuals face when it comes to medical bills. The reason people faced medical bill issues were all too common and along the same vein – either they faced an unexpected illness (four interviewees) or they served as caregivers to their elderly parents (two interviewees). There was variation in why medical debt appeared – insurance issues or the lack of coverage, but the resulting conclusion was the same: a patient advocate to guide individuals through the murky process of billing and insurance would have been tremendously helpful during this period of time of illness.

Furthermore, we hoped to understand how medical bills impacted other aspects if

individual's financial lives and stability. While it is possible that this population is not generalizable to the whole population because they are a subset of clients who have specifically interacted with a legal advocacy organization, the issues they face are still relevant. The findings below represent the main takeaways from the interviews. More detailed summaries on the interviews and interviewees can be found in Appendix A.

### Impact of medical bills and health issues on other aspects of economic security

The biggest compelling reason why medical bills are an important issue is because they are frequently involuntary and have a lasting impact on health, financial stability and livelihood. Medical health problems can exacerbate problems in paying for housing, utilities and other needs.

- Two interviewees noted that medical bill problems were the reason they could no longer make housing payments, and that set off their housing problems. In the end, they choose to pay for housing and let certain bills go to collections, only to manage them later. Both of these individuals owned their homes, and were less impacted by poor credit scores as they would have been were they renters.
- All individuals mentioned that due to the bills, they faced financial strain and used up their savings.

The medical bills and having debt is stressful. But throughout our years, we have learned to do what we can, and don't do what we can't. We make payments when we are [financially] able" –  
Regina Goodman

### Rise of medical bills: Insurance and billing issues

Seniors are more likely than other groups to experience health problems. Furthermore, they have greater needs for prescriptions. However, often, Medicare rates and coverage do not apply consistently among all class of drugs and treatments that an individual may find medically necessary, and they apply limits on drug coverage without the approval from the governing federal agency, Centers for Medicare and Medicaid Services.

- All four individuals with medical bill issues noted that the issues persisted because of insurance and billing issues – insurers that were meant to cover the charge did not, and they did not receive help from hospitals. Hospitals then sent over the bills to collections.
- Three individuals encountered coverage issues with Medi-Cal, which they still have not been able to solve.
- One experienced problems with her private insurance, and had to go through a lengthy appeals process to get cancer treatment covered.
- One individual had debt she carried from before retirement into retirement.

### Impact of being a caregiver

- Interviewees mentioned the financial impacts of being a caregiver. They experienced great personal strain on their finances. One woman reported having to

take a second job to pay for her mother's care.

➤➤ Another interviewee hit on a key point on the importance of other companies that assist the elderly with managing insurance. The assistance of this company not only was able to save him stress and finances, but also able to get his mother the care she needed.

#### Putting off and delaying care due to cost of bills

➤➤ One interviewee reported that the cost of a treatment would be \$120 per treatment, with multiple treatments required over the remainder of her life.

➤➤ Interviewees reported skipping or delaying treatment or prescriptions in order to save on costs. This is extremely common.

➤➤ One interviewee cited lack of housing as a reason for delaying care – he mentioned that even if he did get recommended surgeries, he would not be able to recover properly.

➤➤ Interviewees were concerned with taking care of housing before tending to their health needs.

“The biggest medical bills are the ones that haven't happened yet – that can't happen.” – Tom Feldman

## Key Points

Analysis elucidated that many clients who were coming into the organization seeking help were coming as a last resort, not having received assistance they needed anywhere else. The confluence of multiple different debt accounts isn't common for all individuals with medical debt issues. However, it was particularly shocking to see the number of low-income individuals and homeless clients who under normal circumstances should have been identified by medical services providers and given charity care. Instead, they were coming to the clinic when the debt had already impacted their credit score, and would have a longer impact. Therefore, the best course of action was to examine hospital policies on charity care to see what distinguishing factors lead a hospital to either execute charity care effectively or ineffectively.

## Part II: Hospital Charity Care Policies

### Background

Charity care, or free care and discounted costs for hospital services, has long been an important benefit to families and communities who struggle to pay medical bills. Prior to national health care reform with the ACA, the cost of care posed financial barriers for those who were ineligible for health insurance, or those who had health insurance but faced low coverage and high costs. In recent years, requirements on the provision of charity care in hospitals has strengthened amid national conversation about the obligation of nonprofit hospitals to meet the charitable standard their 501(c)(3) status and tax exemptions mandate. Charity care refers to free and discounted care given to eligible low-income populations, and is different from another

category of hospital expenses known as “bad debt”, which is money that a patient owes but which has not been collected. The IRS defines a financial assistance policy (FAP) or charity care including “free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are unable to pay for all or a portion of the services.”<sup>42</sup> Often, this applies primarily to individuals who are uninsured or self-pay, meaning they have no connections to health insurance, or are underinsured. In this report, the term underinsured and “high medical cost patient” are used interchangeably to reflect individuals who have health insurance coverage, but also experience costs exceeding 10% of their income. This is particularly prominent today, since individuals report purchasing high cost plans on the state's health insurance marketplace. In light of increasing costs, 35% of Americans report that they had problems paying for medical bills or have medical debt.<sup>43</sup> In California, that share is lower, but is not insignificant; nearly one in four Californians report issues with medical bills and debt. With 8% of Californians uninsured, and 33% living under 200% of federal poverty,<sup>44</sup> then, charity care still remains an important safety net for the most vulnerable.

## Federal Policy

### *Pre-Affordable Care Act:*

A central ethos for nonprofit hospitals was the provision of care to those unable to pay, particularly as entities that championed moralistic missions as a reason for their tax-exempt status. However, as hospitals increasingly became part of larger health systems and saw the development of medical technology, even non-profit hospitals became increasingly concerned with the costs of providing free care. While the Internal Revenue Service required non-profit hospitals to provide financial assistance in the form of free or discounted care to indigent patients as a part of the greater community benefits standard, anecdotal reports of individuals saddling thousands of dollars of debt while accruing interest came to the national headlines. In the early 2000's, reports of hospital's lackluster charity care provisions demonstrated how millions of low-income and uninsured individuals were facing crushing bills and debt, despite the availability of assistance. Both Republican and Democrats in Congress conducted congressional hearings that illuminated aggressive billing and collections practices, including tactics to recuperate costs through wage garnishments, liens and home foreclosures. This, alongside the relative lack of financial assistance from nonprofit hospitals (even when compared to their private counterparts) compared to their \$24 billion in tax relief per year as a benefit of being 501(c)(3) charitable entities, signaled a need to reform provision of charity care.

### *Affordable Care Act*

Amidst this elevated scrutiny, the Affordable Care Act of 2010 established Section 501(r)<sup>45</sup> of the IRS code to set the standards nonprofit 501(c)(3) charitable hospitals and government hospitals must follow to qualify for their tax-exempt status. Section 501(r) maintains that hospitals must conduct a community health needs assessment every three years; governs financial assistance policies (FAP); limits certain hospital charges and billing; and sets rules on collections practices. Federal rules do not stipulate minimum standards hospitals must follow for financial assistance, but require that hospitals must 1) have written FAP policies and written emergency medical care policies and 2) make them publicly available. Under the IRS regulations, nonprofit hospitals are not allowed to charge financially eligible individuals more than the

amount generally billed<sup>3</sup> for emergency and medically necessary services. Furthermore, federal law requires that hospital organizations make “reasonable efforts” to determine whether patients are eligible for financial assistance before sending unpaid debts to collections.<sup>46</sup> Patients must be given 240 days after receiving the first bill to apply for financial assistance, and also must wait 120 days after the first post-discharge statement before sending unpaid bills to collections.<sup>47</sup>

### *Recent Credit Reporting Rules*

The waiting period before sending bills to collections was intended to allow patients time to finance their hospital charges, negotiate bills, enroll in payment plans, apply for financial assistance and/or apply for health insurance. While consumers oft report that they were unaware of their unpaid medical bills until they visualized on their credit reports, recent efforts to improve the accuracy of credit reports and fix erroneous debts can help ameliorate the impact of mistaken or unknown medical debt on credit scores. In 2015, the Attorney General of New York, Eric T. Schneiderman<sup>48</sup>, reached a settlement with the three main credit-reporting agencies (Experian, Transunion, and Equifax) requiring a 180-day waiting period before unpaid medical debt is reported onto a consumer’s credit report. Furthermore, the settlement requires CRAs to remove medical debt once it is paid by an insurer. These rules all aim to protect consumers, particularly low-income consumers, from being negatively impacted from unpaid medical bills. However, often consumers are unaware of their debt or hospital charity care policies until it is too late to apply for charity care. The new credit scoring model, FICO 9, may help reduce the impact of unpaid medical bills that do still remain on an individual’s credit report and impact their credit score.

### **State Policies in California: Hospital Fair Pricing Act**

California has paved the way for consumer protection for years, and in the same vein has been far ahead of other states’ and federal laws on strengthening the health care safety net. In 1994, SB 697 was signed and required nonprofit hospitals to develop community benefit plans. In 2006, Governor Arnold Schwarzenegger signed AB 774<sup>49</sup> – the Hospital Fair Pricing Act – which currently sets the requirements for provision of charity care by *all* hospitals regardless of ownership status. While the ACA was passed after AB 774, it seemingly does not pre-empt more stringent state laws, but instead sets a floor that California law has already surpassed.<sup>50</sup> For the past ten years, uninsured patients in California who go to an acute care general hospital, psychiatric hospital, or specialty hospital<sup>4</sup> may be eligible to receive financial assistance under the Hospital Fair Pricing Act, which requires hospitals to provide individuals below 350% FPL with free or discounted care for hospital services. In 2011, AB 1503 passed, requiring emergency room physicians who provide emergency care to provide free or discounted care to uninsured or underinsured individuals under 350% FPL.

### *SB 1276*

An amendment to AB 774 came in 2015, when California passed a SB 1276 redefining what it means to have “high medical costs” in response to rising health care costs under individual insurance policies purchased on Covered California’s health insurance marketplace. Previously, a

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<sup>3</sup> The method for determining the amount generally billed is defined in greater detail in the regulations.

<sup>4</sup> Hospitals or health facilities operated by the State of California or licensed as a Chemical Dependency Recovery Hospitals or Psychiatric Health Facilities are exempt.

person who had high medical costs (also known as underinsured) was defined as a person “whose family income does not exceed 350% of the federal poverty level and who does not receive a discounted rate from the hospital or physician as a result of his or her 3rd-party coverage.”<sup>51</sup> The bill revised AB 774 to define an individual with high medical costs as “a person whose family income does not exceed 350 percent of the federal poverty level” and where out-of-pocket expenses exceed 10% of the patient or patient’s family income in the prior 12 months.<sup>52</sup> The law also allows underinsured individuals to negotiate payment plans with living expenses in mind. To promote health insurance, a provision in the law requires that hospitals obtain information as to whether patients qualify for public health insurance programs or insurance on the healthcare insurance exchange.

To protect consumers from abusive and financially burdensome debt collections practices, and to give patients time to gather resources, the law must provide a 150-day time frame for uninsured and underinsured patients for them to negotiate payments.

Since 2007, each hospital is required to maintain comprehensible, written policies for charity care and clearly state eligibility requirements, procedure for application, and policies for debt collection practices and procedures to the public. The Office of Statewide Health Planning and Development (OSHPD) is the reporting agency to which hospitals must submit their charity care policies. Compliance is required for hospitals to maintain their licensure. While the OSHPD maintains each hospital’s charity care requirements, each hospital is also required to provide their policies to the public. Specific requirements on current governing California state laws and how they compare to federal law are outlined in Appendix B.

While California standards are more stringent than the ACA and set income eligibility, hospitals are allowed some discretion in setting eligibility criteria for free or discounted care. Hospitals serving different populations have different needs, and those that act as safety-net hospitals for the most vulnerable populations, or those that serve primarily Medicaid patients, are more likely to have less financial flexibility to have more generous charity care policies.<sup>53</sup>

Despite policies at the state and federal level, a number of studies demonstrate that individuals are unaware or uninformed of these policies.<sup>54</sup> According to a few stakeholder interviews, some individuals may have received one notice post-discharge on charity care, but then did not hear about the policy again and assumed that it either didn’t exist or that they were not eligible.

## **Continued Importance of Charity Care**

While national health reform made significant strides in insuring individuals,<sup>55</sup> 29 million individuals remain uninsured in the United States, with 2,980,000 individuals in California. Many low-income folks remain uninsured due to ineligibility for Medi-Cal, and high costs in the health care marketplace. Even among the insured, 43% of adults report that they have difficulty affording coverage, and roughly one in three Americans state that they have trouble affording premiums and cost-sharing.<sup>56</sup> Affordability itself has been decreasing as costs rise and wages remain stagnant. Furthermore, as the new administration attempts to repeal and replace the ACA, it is extremely likely that access to Medi-Cal and health insurance subsidies will be diminished drastically. The new administration proposes rolling back Medi-Cal expansion and block granting the program. They also propose cuts to Medicare. Charity care remains an important program for vulnerable folks today, and will continue to be in the event of new healthcare reform. Though there has been an overall decline in the amount given in charity care

over the years, it is still a vital component to California's vulnerable.

## Findings and Analysis

Federal and state guidelines set the minimum standards for charity care, but the eligibility criteria and procedure through which it is delivered is at the discretion of hospitals. Analyzing each hospital's respective policy can elucidate the nuances in eligibility criteria and how hospitals disseminate information to their patients about the policy. Knowledge about charity care policy variations can help advocates at HERA and other places to better aid patients, and advocate for policy change to protect consumers. At HERA, a number of clients with medical bill issues had medical debts at two or more hospitals. Analysis of client data demonstrated that clients often had medical bills from different hospitals, and had to meet different eligibility criteria to qualify for charity care. This can be difficult for both patients and advocates assisting patients with medical bills. However, this flexibility and hospital governance over their own charity care policies is not necessarily negative, or actionable at the policy level; there are many reasons hospitals should be able to devise their own charity care policies since they have varying financial needs based on the communities they serve. For example, county hospitals and other safety net hospitals are known to serve a greater share of Medicare, Medi-Cal and medically indigent populations therefore could be expected to pay less in charity care, since their community benefits are in part accomplished through the community they serve.

Government-sponsored health programs typically pay lower rates for services than private insurance companies, and often, hospitals that serve these populations experience shortfalls in their accounts – meaning that they receive less in reimbursements than the cost of the service itself.

Nonetheless, charity care remains a crucial part of the safety net for low-income individuals, and understanding the variance in policies can shed a light on groups that may be systematically left behind. In these findings, I analyze how hospital policies differ on various components of charity care, as required under federal and state law.

Charity care policies submitted to OSHPD on their website System for Fair Price Hospital Reporting<sup>57</sup> were used to analyze hospital policies in Alameda and Contra Costa counties (see methods). The hospitals in Table 1 are required to have and to submit charity care policies to maintain licensure.<sup>58</sup> Analysis of each policy demonstrated that subsidiaries of Kaiser Permanente, John Muir Health, Sutter Health and Kindred Health all shared the same policy. Therefore, the policies for those hospitals are reported as one entity in upcoming analysis. Table 1 shows which hospitals are part of larger chains. In the case of Alameda County Health System, Alameda Hospital had a different charity care policy than Highland Hospital and Fairmont, the latter two which shared the same policy. While it was assumed that all county hospitals would share the same policy, that was decidedly not the case. Furthermore, San Leandro Hospital, which is part of Alameda County Health System, did not have a hospital policy link that functioned. Valley Memorial Hospital was included in OSHPD's website, but the policy on their OSHPD page was for a different hospital entirely, indicated some error, and a hospital website could not be found. It is therefore excluded from most analysis. In total, the analysis will focus on thirteen different policies for hospitals that have their own policy, or system-wide policies. For example, while there are seven separate Kaiser Foundation hospitals, they all operate under the same charity care policy, and therefore it only counts as one systems-wide policy. Generally, analysis is provided at the level of the hospital, or hospital system if multiple different hospital centers share

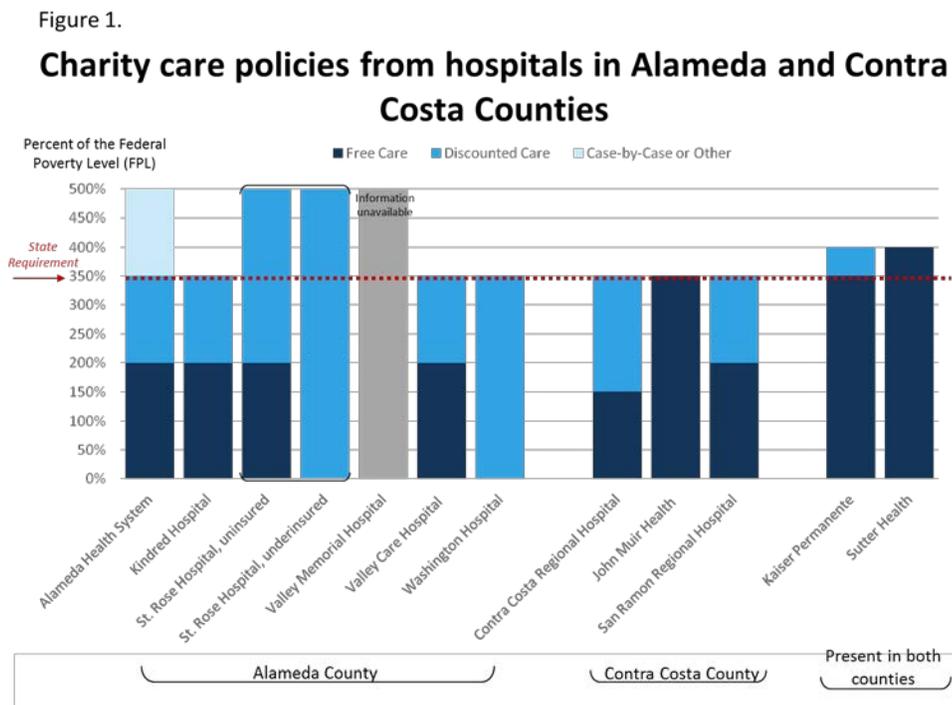
the same main website, which is the case for Kaiser Permanente, Sutter Health, and John Muir Health.

<b>Table 1: Hospitals Included in Analysis , by Name, Ownership Status and Type of Hospital</b>			
<b>Hospital System/Ownership Status</b>	<b>Hospital Name</b>	<b>Type of Hospital</b>	
<b>Alameda County: 15 Hospitals</b>			
<b>Alameda Health</b> <i>City/County</i>	Alameda Hospital (DSH)	General acute care	
	Fairmont Hospital	Acute rehabilitation center	
	Highland Hospital (DSH)	General acute care	
	San Leandro Hospital*	General acute care	
<i>Private</i>	Fremont Hospital	Acute psychiatric hospital	
<b>Kaiser Permanente</b> <i>Nonprofit</i>	Kaiser Foundation Hospital – Fremont	General acute care	
	Kaiser Foundation Hospital – Oakland/Richmond	General acute care	
	Kaiser Foundation Hospital – San Leandro	General acute care	
<b>Sutter Health</b> <i>Nonprofit</i>	Alta Bates Medical Center	General acute care	
	Eden Medical Center	General acute care	
<b>Kindred Health</b> <i>Private</i>	Kindred Hospital San Francisco Bay Area	Long term acute care	
	<i>Nonprofit</i>	St. Rose Hospital (DSH)	General acute care
	<i>Nonprofit</i>	Valley Memorial Hospital*	General acute care
<b>Stanford Health</b> <i>Nonprofit</i>	Valleycare Medical Center	General acute care	
	<i>District</i>	Washington Hospital	General acute care
<b>Contra Costa County: 10 Hospitals</b>			
<i>City/County</i>	Contra Costa Regional Hospital (DSH)	General acute care	
<b>John Muir Health</b> <i>Nonprofit</i>	John Muir Behavioral Health Center	Acute psychiatric hospital	
	John Muir Medical Center – Concord	General acute care	
	John Muir Medical Center	General acute care	
<b>Kaiser Permanente</b> <i>Nonprofit</i>	Kaiser Foundation Hospital – Martinez/Walnut Creek	General acute care	
	Kaiser Foundation Hospital – Antioch	General acute care	
	Kaiser Foundation Hospital – Richmond Campus	General acute care	
	Kaiser Foundation Hospital – Walnut Creek	General acute care	
<b>Tenet Health</b> <i>Private</i>	San Ramon Regional Hospital	General acute care	
<b>Sutter Health</b> <i>Nonprofit</i>	Sutter Delta Medical Center	General acute care	
<b>Totals:</b>			
<b>6 City/County/District; 16 Nonprofit; 3 Private</b>			
<b>21 General acute Care; 2 Acute psychiatric hospital; 1 Acute rehabilitation center; 1 Long term care center</b>			
NOTE: *Indicates that while these hospitals were intended for analysis, their policies on charity care were not available on OSHPD. They have been left of further analysis.			

## Goals of Analysis

Overall, I hoped to understand the differences between hospital policies to understand what patients are eligible for financial assistance, and to perhaps see what aspects of the policy contribute to the lack of clarity and knowledge about these policies.

- Establish eligibility criteria
- Determine whether policies are complying with the written guidelines of federal and state law
- Determine what the notification standards are, and how hospitals inform consumers on their policies.



## Eligibility

Eligibility criteria varied widely between policies. The following represents the context, the findings, and analysis behind the policy review.

### Eligibility based on income thresholds

Analysis of hospital policies on OSHP demonstrates that the 23 out of 25 hospitals that published their policies meet California requirements to provide free or discounted care to individuals below 350% FPL in some capacity, at least in their written standards (Figure 1). However, the variation comes in how the hospitals are setting eligibility standards (see Appendix C). Most hospitals require a financially qualified individual to earn less than 350% FPL, but others like Kaiser Permanente and St. Rose Hospital give some type of discounted care up to 500% of federal poverty. For St Rose, the type of charity care (free versus discounted, and at what rate) varies based on the insurance status of the individual (Figure 1 and Appendix C & D).

### Free care and discounted care

Examining the nuances between what income thresholds qualify for free care and which for discounted care demonstrated the analysis demonstrated that larger hospital systems – John Muir, Kaiser Permanente, and Sutter – are more likely to offer free care versus discounted care to eligible populations up to a higher income threshold (Appendix D).

Overall, the income thresholds are useful when attempting to understand if consumers would

meet the first step of qualification for these policies. For Fremont Hospital, which sets the threshold for free care at 100% FPL, and others that set the threshold at 200% FPL, it is unclear how many individuals this serves – presumably, a share of this population would be eligible for Medicaid, which uses a means-tested eligibility criteria at or below 138% FPL. The population of people generally qualifying for free care would likely be undocumented, but still able to provide proof of income, or ineligible for Medicaid for other reasons. In order to meet income thresholds, individuals are required to submit pay stubs, IRS tax forms, and/or more.

The discounted rates available under each policy generally follow California and federal law. Most policies stipulated that costs would be equivalent to the greatest of the reimbursement they

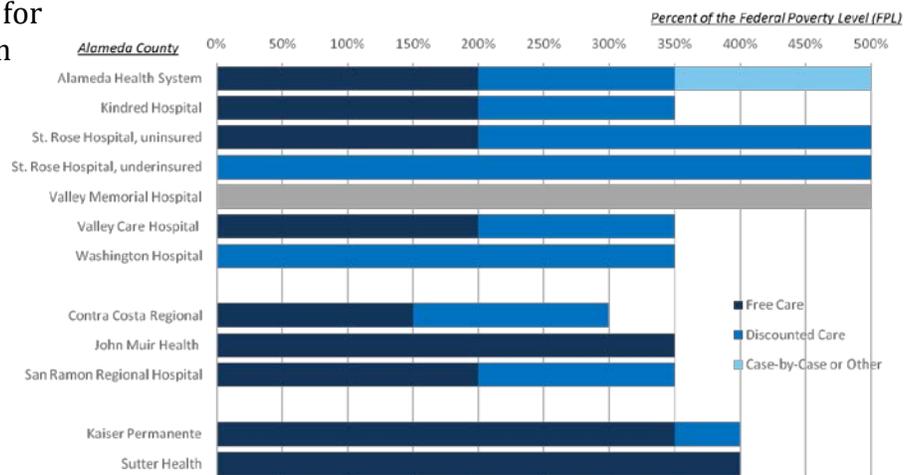
would expect from a government sponsored insurance, such as Medicare or Medi-Cal. Alameda hospital specifically stated that Medicare rates would be used as the standard for a discount, while Kindred Hospital uses Medi-Cal reimbursement rates. Four hospitals present specific percent discounts or offer sliding scales, but also state that the amount billed cannot be greater than that received from government programs. This aspect of the law seems largely followed in the written policy, despite the variability.

As depicted in Appendix D, there is much variability as to the specifics on who gets free or discounted care, and how that is calculated. It is difficult to make sense of this variability in income thresholds as it plays out to consumers without further data on how many people apply for charity care compared to how many receive it.

### *Definition of a high medical cost patient, or underinsured patient*

Eligibility under income thresholds is often also broken down based on if a patient was uninsured, or underinsured. The definition of underinsured matters as it determines who is eligible to receive discounts or free care. As mentioned in the background, the original AB 774 defined a high medical cost patient as one “whose family income does not exceed 350% of the [FPL] and who does not receive a discounted rate from the hospital or physician as a result of 3rd party coverage.”<sup>59</sup> The law set an income eligibility floor that hospitals can choose to surpass. However, the rollout of the ACA and the health insurance marketplaces demonstrated an increase in high-priced, high deductible plans. In 2015, the passage of SB 1276 revised definition of “high medical cost patient” under the Hospital Fair Pricing Act to *include* those who may receive discounts from third party coverage in their payments.

**Charity care policies from hospitals in Alameda and Contra Costa Counties, cont'd**



- Not all policies have updated their policies to comply with this change in the law. Three hospital policies still use the AB 774 definition of high medical cost patient (Appendix C).
- Another three policies did not provide a definition for this group.
- Seven define underinsured patients in other ways, with Kaiser Permanente going above the minimum standards and not including an income cutoff for underinsured patients.

The findings follow national research results that demonstrate low compliance of hospitals with ACA requirements on providing discounted care at the amount generally billed to insured patients. A study looking at IRS data demonstrated that approximately 37% of hospitals are limiting charges for those who qualify for financial assistance to Medicare rates.<sup>60</sup>

### *Income and asset calculations*

An additional component of high medical cost patients is that their expenses generally need to be at or greater than 10% of their or family income. Many policies outline how to calculate income based on certain factors such as income, assets, number of people in household, employment status and more. The cost of medical care is often calculated by adding in eligible charges from an individual or their family for a 12-month period, compared to the income for that same period of time. Assets can factor in to the income, though according to California law, hospitals may not consider retirement plans or deferred compensation plans part of an asset calculation. The first \$10,000 of assets and 50% thereafter must not be included in calculations. Alameda Hospital is in apparent violation of this, as they only ignore the first \$10,000.

Policies are generally in congruence on using recent pay stubs or tax returns to verify income. Others also included proof of asset calculations, as part of income.<sup>5</sup> Some indicate verbal acknowledgement.

- Two policies from Kaiser Foundation hospitals and Valleycare Memorial Hospital have clearly defined methods of auto-enrolling individuals into free care.
  - Kaiser Foundation hospitals pre-enroll individuals for free care if they are uninsured, have a scheduled appointment for eligible services, have not indicated they have health coverage, and is presumed ineligible for Medicaid. Or, if they have prior history of demonstrating financial hardship at a Kaiser Foundation hospital. In either of these cases, Kaiser administrators will enroll them into the financial assistance program and provide them with the option of opting out.
  - Valleycare Memorial (part of Stanford University Health Care) uses a third-party vendor to determine a patient's income tool at the time of registration for uninsured Emergency Department and Urgent Care visits to determine if their income is below 200% FPL, and if so, they will be advised for a free, cost-less visit. If they are not within the income threshold, then they must

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<sup>5</sup> "Qualifying Assets" generally mean 50% of the patient's monetary assets in excess of \$10,000, including cash, stocks, bonds, savings accounts or other bank accounts, but excluding IRS qualified retirement plans and deferred-compensation plans. Certain real property or tangible assets (primary residences, automobiles, etc.) are not included. However, additional residences in excess of a single primary residence will be included, as will recreational vehicles. "Qualifying Assets" will not include the principal amounts of funds contained within an IRS recognized retirement account, such as an IRA, 401K or 403B retirement accounts.

complete an application.

- Four also include asset thresholds as criteria for free and discount care (Appendix D).
  - Highland Hospital: caps eligible patients at the same level as Medi-Cal does for beneficiaries.
  - Fremont Hospital: for uninsured individuals to be eligible for free care, their assets must be less than \$10,000.
  - Contra Costa caps assets for the uninsured to qualify for free care: the first \$10,000 are not counted, and 50% of assets above that must be at or below \$2000 per person or \$3000 per family to qualify for free care.
  - John Muir Health requires charges to be a specific ratio to charged costs in order to receive free or discounted care. For free care, a person's qualifying assets have to be at or less than 200% of billed charges. For discounted care, the charged bills must be greater than an individual's qualifying assets, and even then, the discount is provided at a sliding scale.

Assets generally factor into income calculations, though the four hospital policies listed above elevate eligibility standards and make it more difficult to get charity care. While more stringent regulations on eligibility would point to making the delivery of charity care more difficult, it is unclear how these requirements impact consumers. Further research and data on the applicants and beneficiaries of charity care at these hospitals is needed to draw further conclusions.

### *Ineligibility based on insurance*

Analysis of the charity care policies elucidated that hospitals often enforce extra criteria for eligibility that is not defined under the law. Most hospital policies had provisions that mandated consumers either provide proof of being ineligible for government sponsored insurance programs (such as through a denial), or that they exhaust all other possible insurance resources before applying for charity care (Appendix C). Others noted that application for Medicaid or insurance on Covered California could occur at the same time as a charity care application. Alameda Hospital and Kindred Hospital deemed individuals with government sponsored insurance ineligible. This policy could adversely impact seniors with Medicare who are responsible for 20% of costs, leaving them in the cracks of a policy aimed to help the lower-income. Certain hospitals specifically exclude Medicaid or Medicare patients by states that those who are eligible for, or receive, government sponsored insurance are not eligible for charity care.

In theory, hospital policies that promote enrollment in government sponsored insurance can be mutually beneficial for consumers and hospitals, as the former would have access to insurance coverage and decreased financial responsibility in the future, and hospitals would receive some reimbursement for services rendered. While most hospitals have patient advocates that assist individuals in signing up for coverage, it is still possible that individuals would fall through the cracks.

### *Ineligible services and charges*

California law does not specify which services are eligible, though federal law requires that financial assistance policies cover all emergency and medically necessary care. Most of the policies studied in this report appear to comply with this requirement by explicitly stating that medically necessary services and emergency services are covered, or through the lack of a statement on ineligible services. Services

ineligible for charity care include medical expenses coming from elective procedures or special or complex.

In terms of ineligible charges, premiums are generally not counted in the calculation of medical expenses incurred by a patient. Four hospital policies specifically excluded deductibles from eligible charges, which does not ideologically support the definition changes of high cost uninsured patients in SB 1276. Often, the out-of-pocket costs that amount to be greater than 10% of an individual’s income are due to high deductibles. While the ACA instituted a cap for covered out-of-pocket expenses, that cap sits at \$7,150 for individuals and \$14,300 for families.<sup>61</sup> In comparison, a family of three earning exactly 350% of the FPL earns \$71,470 per year,<sup>62</sup> pointing to how the family cap for out-of-pocket expenses including deductibles is at 20% of income. If deductibles are not counted, then individuals earning less than 350% could seemingly be held accountable to expenses well over 10% of their income.

Increasing enrollment in high deductible plans precipitates the reality of individual’s facing high out-of-pockets costs. For plans on Covered California in 2017, the deductibles for a bronze plan were set at \$6,300 for an individual and 12,600 for a family<sup>63</sup>– which is well above 10% of income for people at 350% FPL. While it is possible that individuals may receive subsidies for their premium payments or cost-sharing, that amount varies by income between 138% and 400% FPL.

Inclusion of deductibles into covered expenses in charity care policies would greatly benefit insured patients who face high medical costs, and remain in line with the Hospital Fair Pricing Act in providing protections for people who face unexpected high costs.

## Timeline for application and debt collections

Policies vary in the length of time patients have to apply for charity care.

- Four hospital policies do not explicitly state any deadline to apply for charity care.
- For the remaining nine, the timeframe to apply for charity care varies from 10 days’ post-discharge to one year (table 2).

Table 2:	Timeframe to apply for financial assistance					
	1 year	240 days	150 days/ 6 months	60 days	10 days	Unclear/ unstated
Number of hospital policies	1	2	6	1	1	2

NOTE: This time frame beings at discharge or from the first billing statement. See Appendix E.

- Once submitted and approved, financial assistance can be given either for the services mentioned in the application, or for all services for a period of time (Table 3). Extending the duration of time an application is valid for could be useful in cases where patients need a series of treatments for their medical condition.

Table 3:	How long an application is valid for					
	1 year	180 days	Current month	That application period	Varies*	Unclear/ unstated
Number of hospital policies	3	2	1	2	1	4

NOTE: Kaiser Permanente’s standard time frame is 1 year, but varies based on services rendered

Policies are also unclear on whether applications could be made to retroactive accounts, once individuals had determined if they were incorrectly billed or if they had unpaid bills sent to debt collections past the deadline. This opacity is particularly salient for organizations like HERA and patient advocates. Established timelines for applications can ease the process of applying and receiving financial assistance for health care costs. Patients have clear medical need for time and notice to pay for medical bills. One interviewee reported that the onslaught of medical bills she received after her diagnosis of breast cancer was extremely stressful. The additional stress of paying for medical bills and the fear of collections while sick adds to the burden of the condition. Studies show that stress can impact the time of recovery and healing.<sup>64</sup>

As mentioned before, surveys show that individuals do not know about hospital financial assistance policies, and are often surprised to find that they have medical bill debt. In consumer complaints logged at the Consumer Finance Protection Bureau (CFPB), researchers find that medical collections are more likely to be about the existence of medical bills, their amount, or information than with other non-medical debt collections.<sup>65</sup>

The hospital policies in this study generally appear to comply with the written policies that debt cannot be sent to collections agencies if an individual is qualified or potentially qualified for financial assistance. Appendix E demonstrates the time window between when an individual can apply for charity care, and when a hospital states they will send the unpaid bills to collections absent knowledge regarding a patient's financial status. However, hospital policies were not clear as to how they would ascertain knowledge about an individual's financial status. Client work at HERA clearly demonstrates that individuals who are qualified for charity care are often falling through the cracks.

## Notification Standards

Consumers remain largely unaware of the hospital charity care policies, despite the standards in federal and state laws that require notification of financial assistance policies to individuals. Hospital written policies generally stated that they would post information about charity care in high trafficked areas of the hospital. Since it was difficult in this study to determine if that was actually true, the policies were instead examined for language on when they stated they would inform patients. Federal law requires nonprofit hospitals to provide statements in at least three bills.

➤➤ Out of the 13 policies examined, only one hospital policy (John Muir Health) claimed that they would include a standardized message on charity care in patient bills.

Table 4 below demonstrates how many hospital policies.

➤➤ Five policies were not clear on if or when they would provide patients with charity care information.

➤➤ None of the policies directly sent applications without requests.

<b>Table 4</b>	
<b>When the hospital send information on charity care policies in a bill or statement</b>	<b>Number of hospital policies</b>
Information is given in a bill without a patient's request	5
<i>On every bill</i>	1
<i>On the first bill</i>	2*
<i>On another bill or final bill before collections</i>	3*
Information given at the time of registration, pre-admission, or when the patient does not indicate a third-party coverage.	3
<i>Information given when an individual is covered with health insurance,</i>	0
Unclear or unstated in policy	5
NOTE: Kaiser Permanente is counted twice since they give a notice on the first bill and another within 120 days of discharge, as part of their reasonable notification standards.	

The provision of information about the policy is a critical step in accessing charity care. Nearly half (47%) of people who experience trouble paying medical bills also report that they did not know about their hospital's financial assistance policies.<sup>66</sup> A study looking at the hospital compliance side also demonstrated low levels of notification of charity care policies, finding that about six in ten hospitals notify patients of their policies before turning to collections actions.<sup>67</sup> The evidence demonstrates a lack of information transfer: while the policies and assistance do exist, it is not clear the patients are receiving the information in the most beneficial way, despite clear policies aimed to increase awareness.

In general, policies indicated that the primary step is to provide information and application assistance for private and public insurance coverage. There has been a long history of helping enroll uninsured folks for health care at the site of care, a measure that is seen as effective in increasing coverage rates. However, hospital policies are not strong in assisting those who *do* have insurance but face high costs. While this is not entirely unreasonable, as the uninsured are a much more vulnerable group that face larger threats to financial security, it is still necessary to provide supports to high medical cost patients. SB 1276 was passed because of the unexpected high costs individuals faced with privately purchased insurance on the healthcare insurance exchange, but compliance with that law is low.

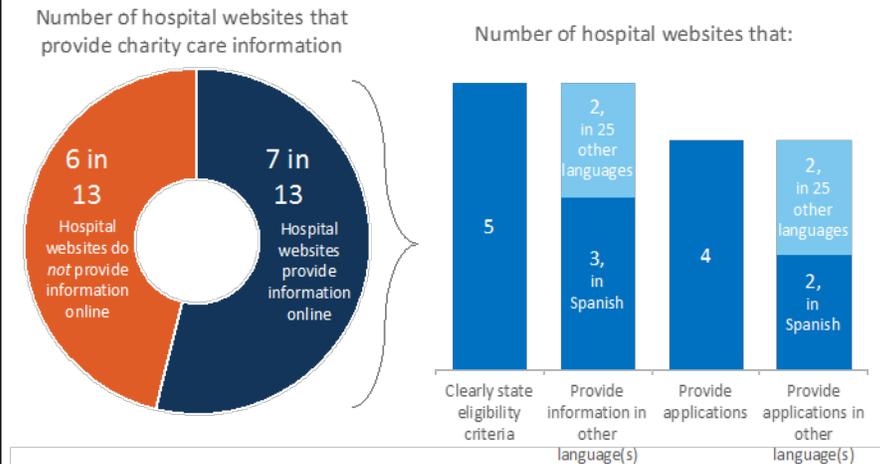
## **Publicly available information**

Providing policy information through bills and statements is one direct way of getting information directly to consumers. However, publicly available information plays a huge role in access to care. Patients potentially eligible for financial assistance may be of both the policies and their eligibility, leading them to delay care until it is a more serious and costly medical procedure, or seek care and attempt to pay taking out more loans, such as credit card or interpersonal loans. Having the information readily available helps people financially and let them know that the application process is not arbitrary.

➤➤ Only seven of the 13 hospital websites provided any information online, and some with more difficulty than others (Figure 2). Certain websites had easy access to billing and payment pages that clearly labelled their policies, such as John Muir Health. Others, namely Kaiser Permanente required longer searches (see Methodology for more information).

Figure 2

### Publicly available information on charity care



SOURCE: Analysis of hospital websites

➤➤ Out of these seven, only five clearly stated the income eligibility factors.

➤➤ Five provided information in different languages, and the two that provided information *and* applications in 25 other languages than English were Kaiser Permanente and Sutter Health, two large nonprofit health systems have the resources to do so.

➤➤ Five websites provide contact information for patient advocates or for the financial assistance office.

The provision of information online is one critical way that information can be disseminated to large audiences. Accessibility to information online can increasing awareness and utilization of programs that can mutually benefit hospitals and consumers. Consumers can more readily access financial assistance before medical bills become debt. Receiving applications before a bill goes unpaid and into collections also can increase the efficiency of hospitals and decrease financial assistance appeals. However, the findings indicate that hospitals are not complying with federal IRS rules that mandates that the financial assistance policy, its “application form, and a plain language summary of the FAP must be made widely available on a website.”<sup>68</sup>

## Findings Summary

This case study of hospital policies combined with the in-house data, multiple reports and articles on the execution of charity care policies demonstrates that a significant number of hospitals are not following the federal and state guidelines to provide information or notifications to consumers. Low-income consumers face greater repercussions from this than just unpaid medical bills – medical debt reported on their credit report affects access to credit, loans, housing, and basic life needs.

When combining the analysis on seniors to charity care provisions, we see that charity care leaves out one of the most vulnerable populations who have fixed incomes and still face rising costs. (Most seniors have Medicare, and those who don’t and are poor are likely to qualify for Medicaid, or charity care). Some hospitals qualify anyone who receives government sponsored insurance as ineligible for charity care. However, seniors on average face thousands of dollars in

out of pocket costs per year; in 2010, their out-of-pocket expenses approximated \$4700.<sup>69</sup> While a discounted policy would not be beneficial, since seniors on Medicare already receive the Medicare rate, they likely would benefit from reasonable payment plans that are available to high medical cost patients under the HOPA. The issue of affordability for seniors is not likely to go away, considering the current administration's desire to repeal the ACA and cut back millions from Medicare and Medicaid. Repeal of ACA and passage of AHCA could see seniors' costs increase by \$2000- \$3000 per year, a 25% increase.<sup>70</sup> Furthermore, the issue of payment for expensive cancer treatments and long term care for Medicare enrollees is of growing concern, as mentioned before. Medicare often does not pay for these necessary yet expensive treatments, and seniors who live on fixed incomes are less likely than others to be able to afford them, despite having the greatest need.

## Part II Limitations

This analysis is a preliminary part of research by HERA aimed to increase available information and understanding of the context for charity care policies and practices. The findings demonstrate the pitfalls in written policy at the hospital level, but there are multiple levels of analysis that must be conducted to better understand how hospitals can 1) improve notification and 2) do so in a way that does not negatively impact their finances and resources. Hospitals have a social obligation to provide for the communities they serve, but they also need to be sustainable to be able to continue doing so. While this analysis demonstrated that a number of hospitals are not complying with federal and state law, even through their policies, the impact could be different in practice. Anecdotal reports from consumers, advocates, and experts in the field point to the understanding that these charity care policies are not effectively being disseminated, through notification or publicly available postings. However, it is unclear if their public postings are even useful. Furthermore, it is possible that certain hospital websites had more information about their charity care policies on their own bill pay systems, which are not accessible to non-members.

Most of all, the biggest limitation exists with data. To better understand if hospitals follow the guidelines in their charity care policies, it would be valuable to have data on the applications submitted to understand who is applying, and who is being awarded free or discount care. This analysis lacked information on the breakdown of charity care – are individuals more likely to receive discounts or free care, and if so, why? What are the characteristics of the individuals receiving care?

In that same vein, we do not know if hospitals are tracking information on who has high medical costs or who is uninsured. While they are required to obtain information on insurance status, and likely do so for the purposes of getting reimbursed, it is not clear that patient income data is being utilized to help vulnerable populations access this care.

The limitations also exist in that the hospitals examined have very different characteristics. Some serve primarily medically indigent and Medicaid patients, and therefore contribute to the community in that financial regard. Charity care is simply one way of meeting a hospital's community health needs assessment. Understanding charity care in the context of other work – such as the share of patients that get signed up for health insurance instead of remaining uninsured – could add depth to the question of what purpose charity care policies serve.

## Recommendations and Next Steps

This policy analysis is intended as a foundational investigation project into client needs and policies that impact HERA's client population. Therefore, the recommendations are not intended to be preliminary suggestions to further explore. These recommendations will be more explicitly defined as we understand the root of the problem better through next steps.

## Recommendations for Advocates

- ***Engage staff to discuss possible medical debt issues with clients and raise the question, even if clients have not presented with that issue.***

Findings point to the fact that most HERA clients have multiple different types of debt. Identifying themes from client interviews, beginning to code for the problem, and then undertaking the internal data review that HERA chose to do were important first steps for identifying ways to improve internal systems to improve client outcomes.

## State and County Recommendations

California has a commitment to expanding opportunities for the most vulnerable populations. There is room for state and county-based policy advocacy, but this is largely dependent on the direction national health care reforms takes. Repeal of the ACA, a truncated Medicaid budget, or a decrease in federal subsidies in health care for low-income folks could lead to a rise in the uninsured population. This would make charity care more crucial as a safety net measure. Furthermore, it is necessary to have protections in place to protect consumers against the loss of insurance and the threat of decreased financial security.

### *State Level Policy Changes*

- ***Explicitly allow Medicare enrollees to participate under the Hospital Fair Pricing Act***

Seniors are disproportionately impacted by high medical costs. The HFPA should be amended to give seniors the option of participating in reasonable payment plans if their costs exceed 10% of their income.

- ***Notification Requirements: hospitals must include an easy to read, one page information sheet on charity care policies and the application process***

The sheet would contain information on financial assistance, eligibility, how to apply for financial assistance, and how to apply for private and public health insurance programs in each billing statement. Since part of the problem is that consumers are unaware that hospitals have financial assistance policies and what the eligibility criteria is, it would be useful to have information in *each* billing statement, rather than an arbitrary one that a reasonable consumer could easily overlook. The statement should specifically address high medical cost patients, and point out eligibility criteria. It should address SB 1276 in that individuals who receive a discount from a third-party insurer are still eligible. The statement should be provided in both English and Spanish.

- Precedent at the state level: Maryland<sup>71</sup> and Connecticut<sup>72</sup> law requires that each bill contain an easy to read information sheet on financial assistance.

Connecticut specifically states that the one-page summary must be available in English and Spanish.

- Federal law that applies: The Truth in Lending Act<sup>73</sup> requires disclosures as well, and is intended to ensure that credit terms are presented in a way that is easy to understand for the reasonable consumer. It has requirements on format and language, and provides consumers with rights. As medical bills are also associated with credit and have an impact on one's financial future, state law on providing easy to read information on payment plans and options for financing is very much in a similar vein.

➤➤ ***Expansion of reasonable payment plans under the Hospital Fair Pricing Act***

Under California Health and Safety Code §127400, hospitals are required to provide reasonable payment plans that do not exceed 10 percent of a patient's family income, minus cost of living expenses. Under the HFPA, this type of plan should be extended to individuals above 350% FPL who face costs at 10% of their income or higher.

A second part of this law should establish the benchmark that collections agencies that contract or affiliate with a hospital in any way relating to the sale of patient medical debt would be contractually obligated to follow hospital law. This would require collections agencies to set up reasonable payment plans that do not exceed 10% of a person's income, minus cost of living expenses.

- Precedent: There is precedent under the HFPA. Extension to collections agencies is possible, since evidence demonstrates their predatory nature. There would be less political pushback. Furthermore, medical debt is involuntary, which is in part why hospitals as a type of creditor must follow debt collection rules. Extension of those rules to an agency it is tied with is within the realms of HFPA.

➤➤ ***Assignment of a patient advocate to uninsured individuals and those who are underinsured***

At the time of billing, it is possible to establish the insurance status of an individual. At this point, hospitals should be required to assist individuals who are uninsured through the provision of a patient advocate who helps uninsured individual sign up for insurance or apply for financial assistance.

- Precedent: Certain hospitals like Sutter Health already have such provisions in their policies and have the staff to assist patients. In Sutter's charity care policy, they state the following: "Patients who may be Uninsured Patients shall be assigned Financial Counselors, who shall visit with the patients in person at the hospital. Financial Counselors shall give such patients a Financial Assistance application, as well as contact information for hospital personnel who can provide additional information about this Financial Assistance policy, and assist with the application process." This can be used as a basis for drafting policy language.

## *County Policies*

➤➤ ***Require reporting of charity care policies and levels of financing to county***

A county-level policy that requires hospitals to report their financial assistance policy and the levels of charity care given to patient, annually. The governing county

agency, the Alameda Department of Public Health, would be required to compile and prepare a report on charity care provisions in the county. The heightened transparency would allow individuals to compare hospitals, and encourage greater enforcement of policy.

- Precedence: San Francisco passed a city/county ordinance that requires greater transparency and reporting from hospitals on their charity care policies in 2001. The ordinance has been effective in elucidating information on charity care.<sup>74</sup>

➤➤ ***Community Involvement***

Have a place for community representatives of medically underserved communities to be present in the community health needs assessment processes. Charity Care is simply one part of the assessment, and greater community involvement could strengthen the care that is delivered back to communities.

## Appendices

Appendix A: Interviews with Select HERA Clients (names have been replaced to protect identities)	
	Interview Summaries
<p><b>Kim, female, 66 years old</b>            Medical bills: none</p> <p>Relation to medical bills: as a caregiver and financial support for her mother</p> <p>Currently employed.</p>	<p>Kim does not personally have medical debt issues. However, for a portion of her adult life, she was the primary caregiver for her mother. She mother had Medicare and Medi-Cal, but also needed in-home care. Kim assisted paying for her mother’s care, by paying for in-home care, prescription drugs, and a nursing facility. She paid on average \$500-\$600 per month on care, and took a second job to help pay for her mother’s expenses and her tightened budget. Many of these jobs were informal – babysitting, or extra help.</p> <p>She also had a sister-in-law who suffered from early onset Alzheimer’s. Kim helped take care of her, and helped setting her debts as well. She helped her sister-in-law apply and receive SSI, though it was a 3-year process.</p> <p>Personally, she does not yet have medical bills or debt. She works for the City, and receives good employer-based health insurance.</p>
<p><b>Regina and George Goodman, 65-69 years old.</b></p> <p>Medical bills: ~\$5,800, some in collections</p> <p>Insurance at the time of billing: Medicare/Medi-Cal</p> <p>Retired.</p>	<p>The Goodmans originally came to HERA with mortgage –related issues, and were looking for assistance to keep their house of 30 years. HERA advocates were able to assist them in keeping the property. At this time, they also faced health issues – George was diagnosed with cancer. He later needed heart surgery for a pacemaker. Regina has to take blood pressure medicine, which she can’t afford. They currently have about \$5800 in unpaid medical bills, and some of that is in collections. They receive almost daily mail from Sutter Health regarding their unpaid bills. They currently only make around \$1800 per month, from Social Security, and most goes towards their housing. On top of that, their Medi-Cal deductible is set at \$900, which is a mistake, and so for the past year, they have had to make tradeoffs in health care. Medicare coverage is consistent and full, but the problem lay with Medi-Cal. Regina has skipped doses and spacing them out to make prescriptions last longer. She does not pay for Medicare Part D, and is concerned that if she tried to purchase it, she will be charged extra for the gap in coverage. She does not receive her breathing treatment, which costs \$120 per treatment, and so she forgoes care.</p> <p>They have faced much difficulty in speaking with someone to update their income information on Medi-Cal to get the proper cost-sharing rates. However, multiple trips to social services and phone calls has not led them anywhere. George stated that he has struggled communicating with people at hospitals, insurance</p>

	<p>companies, and at social services who treat him differently because he is a senior. One of the biggest problems, it seems, is getting their cost-sharing to be at the same rate. They would then be able to afford prescription drugs.</p> <p>She once had a treatment that required out-of-pocket payment, followed by reimbursement She mentioned she would not have gotten this treatment if were not thanks to a friend who was able to cover the \$6000 fee. Reliance on family support was emphasized.</p> <p>In terms of the medical debt and impact on credit, they do not worry about it as much since they were able to secure their house thanks to HERA advocates, and they should not have those bills to begin with. However, they still don't like having debt and are making payments when possible.</p> <p>While they have a caseworker at Social services, they would find it more useful for both social services and their own financial security to have access to one who is actually able to help them. They currently do not receive any assistance from their caseworker, though they have made many efforts to do so.</p>
<p><b>Mr. Tom Feldman, 65- 69 years old</b></p> <p>Medical bills: unknown amount, all in collections</p> <p>Insurance at the time of billing: Medicare/Medi- Cal</p> <p>Retired, homeless.</p>	<p>Tom is currently homeless. Despite being employed for most of his life and being financially stable, his situation has changed drastically in the last few years. He lost his home to foreclosure three years ago. Since then, his wife was diagnosed with breast cancer and died, and he has been living in a storage facility. He earns some from social security (\$1228) and from a small pension (\$147) but was not able to secure housing. He knows he has certain medical conditions that need tending to: he needs hearing aids, new glasses with a prescription, prescription drugs for his blood pressure, and back surgery. However, despite having Medicare and Medical, he doesn't think he can afford the copays. He has to pay for most of the cost of the hearing aids and glasses, and can't afford to do so. More importantly, he doesn't want to receive treatment without having access to housing.</p> <p>His medical debt comes from a time when he was unexpectedly hospitalized in Arizona. He has Medi-Cal, and was once told by a patient advocate at Alameda Alliance that he should not have these bills or debt. Tom also did not think he should have those bills, since he has coverage, but nonetheless received collections notices. He mentioned that he was bombarded with questions from financial services at the hospital, but was not medically able to do more than provide his insurance information. He was also on pain medication at the time, and therefore could not remember or comprehend the information he received.</p> <p>He thinks greater coordination with a patient advocate and someone to help him along the way could help him get back on his feet.</p>

<p><b>Barbara Atwood, 66 years old</b></p> <p>Medical bills: \$3000-\$4000, some in collections</p> <p>Insurance at the time of billing: private insurance</p> <p>Retired.</p>	<p>A couple years ago, Barbara didn't have Medicare. While she had good private coverage, it was very expensive amounting to 25-30% of her own income. At the time, she was diagnosed with breast cancer, and wanted to go out of network for experimental treatment. It took huge efforts and multiple appeals letters, but was able to have her insurance company pay for much of her \$20,000 treatment.</p> <p>It could have devastated her financially, but she mentioned her hard work in being her own patient advocate, despite the stress of having cancer and going through treatments at the same time. She mentioned having an advocate would have been helpful. Had a nurse to give information, but not necessarily advocating. This ordeal put a financial strain on her.</p> <p>Her experience with medical bills is that it exacerbates other financial issues and places a massive strain on daily living. Due to breast cancer, she was no longer able to work, could afford insurance, and couldn't pay for her mortgage. She had her home for 30 years, but faced loss due to foreclosure and unmet payments. Her unpaid medical bills, some of which were mistakes, had adversely impacted her credit score, and she wasn't able to take out a loan.</p> <p>"[It was] overwhelming to deal with the disease, having to pay for the medical insurance....and then having problems paying for housing."</p> <p>She was able to keep her home thanks to the help from HERA.</p> <p>She currently has \$3000-\$4000 dollars in medical bills from the period of time before Medicare set in, some in collections. For some of the bills, she was under the impression that insurance would cover it, and for others, insurance simply took more time to pay back the hospital.</p> <p>Currently, her financial concern is regarding an accident. She was hit by a car in May 2016, and Medicare didn't kick in until June when she turned 65. Has \$70,000 in medical charges. Has to pay for everything, but is pending lawsuit. Have had to change lifestyle to pay for insurance – before Medicare. Had to make major life changes.</p>
<p><b>Mr. Robert Thomas, 73 years old</b></p> <p>Medical bills: none</p> <p>Relation to medical bills:</p>	<p>Robert's experience with medical bills has primarily been as acting as a caregiver for his mother. Hi mother was having mobility issues, had to be at home. She wasn't comfortable cooking due to medical issues, and had to hire an in-home support or caregiver. Initially, he would pay out-of-pocket for these care supports, at about \$13-18/ hour, about four hours a day. She didn't need help every day, as he would go and take care of her on certain days. However, her needs only got worse. She had a small pension, but that wasn't enough to pay for her care. He would buy groceries, and keep the household going. Initially, the cost of care wiped out his and his mother's savings. He had to re-prioritize costs to pay for his mother, and that has decreased the</p>

<p>assisting mother and serving as a primary caregiver to her</p> <p>Currently employed.</p>	<p>potential savings he could currently have. Most baby boomers are going to have this issue.</p> <p>Finding more long term care supports - “That was my first dilemma”, he stated. However, he then found another company to manage Medicare and Medi-Cal accounts, that was financially affordable and that took care of the coverage aspect of care. The company, CEI, was able to send individuals in-home, and also took care of the financial aspect of making sure they were covered under Medicare/Medi-Cal policies.</p> <p>His mother also received government funding to assist in home living, such as payments for bars around the house and new toilets. Once people get older, and are still managing well, would like something like CEI – trained people, who come into homes and manage expenses. Found it very helpful, especially because his mother’s income was very confined.</p> <p>As for his future, he thinks about the important of continued care supports. He thinks having some access to both medical and domestic assistance would be helpful at the state level. The need may vary, as some older folks will move in with siblings, others go to institutions. But some will need extra support, especially given the drain on resources that the cost of living in the Bay Area has for people on fixed incomes.</p> <p>He does not have medical bills. He works for the city and has had good health insurance and coverage.</p>
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<b>Appendix B: Summary of Key Requirements for Charity Care under Federal and State Law</b>		
	<b>California Standard</b>	<b>Federal Standard</b>
<b>Applicability</b>	All licensed hospitals, including general acute care hospitals, acute psychiatric hospitals, and specialty hospitals. Rural hospitals may qualify to lower eligibility requirements for charity care, based on financial need of hospital. Hospitals operated by the California Department of Corrections and Mental Health are exempt.	501(c)(3) nonprofit hospitals that are tax exempt
<b>Written Policy Requirement</b>	Each hospital is required to have a written policy on free and discounted payments and eligibility standards for patients. The written policy must: Clearly state income criteria with respect to federal poverty guidelines Discount payment policy must include extended payment plan information (as well as how patients can negotiate the terms of the payment plan) and that emergency physicians providing emergency care are required to provide discounted payment options to financially qualified patients.	Hospitals must have written financial assistance policies for hospital care as well as emergency medical care. Must: Mention how individuals can obtain information. Whether the assistance is free or discounted State that a qualifying individual may not be charged greater than the amount generally billed to insured patients. Must include calculation methods. In the case where the hospital does not have its own billing and collections procedure, in the event of nonpayment certain actions that are not extraordinary collections actions may be taken.
<b>Eligibility Criteria for Financial Assistance and Discount Payment Policy</b>	Uninsured patients or high medical cost patients who are at or below 350% FPL. Required documentation to establish income: recent pay stubs, income tax returns, and asset information. May not include statements on retirement or deferred compensation plans. Ineligible items to calculate assets: the first \$10,000 of a patient's monetary assets and 50% over \$10,000 may not be counted in determining eligibility.  Discounted payment must be at the rate a hospital would be the greater of the amount the hospital would otherwise receive from Medicare, Medi-Cal, Healthy Families, or other government sponsored program. If there is no established payment by a public insurance	Hospitals can use their discretion to maintain eligibility criteria.  The discounted care cannot be more than the normal amount charged to insured patients, and the policy must include the method to calculate the amount charged.

	program, then the hospital can establish its own discounted rate.	
<b>Billing and Collections Requirements and Restrictions</b>	<p>Hospitals must make “reasonable efforts” to determine whether the individual qualifies for private or public health insurance to cover costs.</p> <p>If the patient does not provide proof of insurance, or requests charity care, the hospital must provide an application for Medi-Cal, Healthy Families, or another governmental program to the patient.</p> <p>Statement of charges must be provided, including requests for insurance, information about private/public health insurance options, and more.</p> <p>For uninsured or underinsured patients, the hospital cannot report unpaid bills or information to collections agencies or credit reporting agencies until 150 days after the initial bill. This timeline can be extended if there is a lengthier application and an appeals process for charity care.</p> <p>Wage garnishments and liens on primary residencies are prohibited as collections practices for charity care-eligible patients.</p>	<p>Hospitals must make “reasonable efforts” to determine whether an individual is eligible for the hospital’s financial assistance policy.</p> <p>Hospitals are prohibited from engaging in extraordinary collection activities, including wage garnishment, liens on an individual’s property, foreclosing on property, seizing personal financial or other information, or commencing civil action against an individual.</p>
<b>Applicable Services</b>	Unspecified	Medically necessary care and emergency care.
<b>Notification and Publication Requirements</b>	<p>Notification requirements: Provide patients with a written notice regarding free and/or discount policies, eligibility, and contact information for a hospital employee or office. The notice must also be provided for patients who receive emergency or outpatient care, but are not admitted.</p> <p>Publication requirements: Notices on free and discount care must be clearly</p>	<p>Notification requirements: FAP, application form, and plain language summary must be available on a website and by request, either in person, or through mail.</p> <p>Notices on policy must be in conspicuous public displays Plain language summary to be provided prior to discharge and in at least 3 billing statements.</p>

	posted in locations that are visible to public, including the emergency department, billing office, admissions office, and other.	
<b>Application in different languages</b>	In addition to English, application must be available in any non-English language spoken by a substantial number of people served by hospital (>5%)	All notices must be provided in the language of populations with limited English proficiency that make up more than 10% of people served by the hospital.
<b>NOTE:</b> This table is not comprehensive of all the requirements, and only lists key requirements from federal and state law.		

## Appendix C: Eligibility and Ineligibility Standards for Hospitals in Alameda and Contra Costa Counties

Hospital/Health System	Eligibility	Definition of “High Medical Cost Patient”	Ineligible charges
<b>Alameda County</b>			
<b>Alameda Hospital</b>	<p><b>Eligible:</b> Self-pay patients and underinsured with incomes at or below 350% FPL.</p> <p><b>Ineligible:</b> Those with or eligible for government health care benefit program.</p>	A person whose family income does not exceed 350% FPL, does not receive a discounted rate from the hospital as a result of third-party coverage, and whose medical expenses for themselves or family exceed 10% of family income in past 12 months.	Copays, deductibles, indemnity balances, Medi-Cal share of cost, and balances due from workers' compensation or auto insurance's coverage. Elective services or work that is not medically necessary.
<b>Highland Hospital</b>	At or below 350% FPL and assets do not exceed level set by Medi-Cal. Patients must be screened for other insurance	no definition	not stated
<b>Fairmont Hospital</b>	At or below 350% FPL and assets do not exceed level set by Medi-Cal. Patients must be screened for other insurance	no definition	not stated
<b>Fremont Hospital</b>	Uninsured or underinsured, at or below 350% FPL	A person whose family income does not exceed 350% FPL, does not receive a discounted rate from the hospital as a result of third-party coverage, and whose medical expenses for themselves or family exceed 10% of family income in past year in past 12 months.	not stated
<b>Kindred Hospital San Francisco Bay Area</b>	<b>Eligible:</b> Uninsured and underinsured, at or below 350% FPL. Must provide proof of ineligibility for government sponsored health programs, including Medi-Cal, Health Families, Medicare, or CA	At or below 350% FPL; the costs relative to share of income are not specified, but the policy states that staff will review eligible expenses to determine eligibility.	Co-pays, deductibles, indemnity balances or share of cost. Elective procedures and medically unnecessary care.

	<p>Children's Services. May need to provide denial.</p> <p><b>Ineligible:</b> Those with or eligible for government health care benefit program.</p>		
<b>St. Rose Hospital</b>	<p><b>Eligible:</b> Uninsured, and underinsured patients. Income up to 500% FPL</p>	<p>A person whose family income does not exceed 500% FPL, does not receive a discounted rate from the hospital as a result of third-party coverage, and whose medical expenses for themselves or family exceed 10% of family income in past 12 months.</p>	<p>Co-pays, deductibles, indemnity balances or share of cost. Elective procedures and medically unnecessary care. complex/specialized services (e.g. transplants, experimental or investigational procedures);</p>
<b>Valleycare Health System</b>	<p><b>Eligible:</b> Uninsured or underinsured patients at or below 350% FPL. Uninsured individuals must be determined to be ineligible for other medical assistance programs, through denial.</p>	<p>Those who are at or below 350% FPL. Specifically points to SB 1276 and includes those who receive a discounted rate due to third party coverage.</p>	
<b>Washington Hospital</b>	<p><b>Eligible:</b> At or below 350% FPL. Uninsured must provide proof of ineligibility for government sponsored insurance, such as a denial.</p>	<p>A person whose family income does not exceed 350% FPL, and whose medical expenses for themselves or family exceed 10% of family income.</p>	<p>Co-pays, deductibles, indemnity balances or share of cost. Elective procedures and medically unnecessary care.</p>
<b>Contra Costa County</b>			
<b>Contra Costa Regional Medical Center</b>	<p><b>Eligible:</b> At or below 350% FPL. Uninsured patients, and underinsured patients who do not receive a discounted rate on their medical bills from coverage. Those unqualified for other health coverage programs.</p> <p><b>Ineligible:</b> People who own additional property on top of an individual's primary residence</p>	<p>A person whose family income does not exceed 350% FPL, and whose medical expenses for themselves or family exceed 10% of family income.</p>	

<b>John Muir Health</b>	<b>Eligible:</b> At or below 350% FPL	No definition	
<b>San Ramon Regional Hospital</b>	Uninsured and underinsured with incomes at or below 350%. Only after all other payment sources have been exhausted (no further information given on application for other programs).	A person whose family income does not exceed 350% FPL, and whose medical expenses for themselves or family exceed 10% of family income.	
<b>Present in both counties</b>			
<b>Kaiser Permanente</b>	<b>Eligible:</b> Means tested at or below 350% FPL, or high medical cost patient.  No exclusions based on insurance	A patient of any income level whose medical expenses for themselves or family exceed 10% of family income. Does not include premiums, but may include expenses incurred outside KP.	Cosmetic surgery or services, infertility treatments, retail medical supplies, prescriptions and supplies not considered emergent or medically necessary include. Prescriptions for Medicare Part D enrollees eligible/enrolled in the LIS program.
<b>Sutter Health</b>	<b>Eligible:</b> Individuals earning at or below 400% FPL  <b>Ineligible:</b> Medi-Cal recipients	An insured individual who is not covered by Medi-Cal, have income at or below 400% FPL, and medical expenses for themselves or family exceed 10% of family income.	Uninsured patients seeking complex/specialized services (e.g. transplants, experimental or investigational procedures), cosmetic procedures.

## Appendix D: Policies for Free and Discounted Care

Hospital/Health System	Free care	Discounted care	Case-by-case basis
<b>Alameda County</b>			
<b>Alameda Hospital</b>	At or below 200% FPL	201% --- 350% FPL: Discounted to Medicare rates	351%---500%FPL:case---by---casebased on circumstance. 351%--- Unlimited: uninsured patients making cash payments can receive discounts under Policy No. 83 A
<b>Highland Hospital</b>	At or below 200% FPL	Patients between 200%---350% FPL receive a 60% discount off total charged. No less than that average discount recorded for the current Medicare and Medi---Cal programs	
<b>Fairmont Hospital</b>	At or below 200% FPL	Patients between 200%---350% FPL receive a 60% discount off total charged. No less than that average discount recorded for the current Medicare and Medi---Cal programs	
<b>Fremont Hospital</b>	Uninsured with assets < \$10,000 and income at or below 100% FPL	Uninsured with incomes between 101% and 250% FPL: Discount of no higher than 50% of greatest rate between Medicare or Medicaid. For uninsured and underinsured between 251% --- 350% FPL: discounted to highest rate of Medicare and Medicaid.	Uninsured with monetary assets greater than \$10,000, and underinsured who don't qualify by income
<b>Kindred Hospital San Francisco Bay Area</b>	Uninsured at or below 200% FPL	Uninsured at 201%---350% FPL and underinsured up to 350% FPL: Medi---Cal rates apply, or if unavailable, 75% reduction in charges.	
<b>St. Rose Hospital</b>	Uninsured at or below 200% FPL	Uninsured at 201%---350% FPL: 10% of gross billed charges, or no greater than the highest amount expected from a government sponsored health insurance program. Uninsured between 350%---500%:	Income eligible Medicare/Medi---Cal patients may apply for denied care

		15% of gross billed charges, or no greater than the highest amount expected from a government sponsored health insurance program. Underinsured: Expected payments will be limited to 20% of gross billed charges.	
<b>Valleycare Health System</b>	Individuals at or below 200% FPL	Between 201%---350% FPL --- will receive Medi---Cal rate.	The payment plan will require that monthly payments do not exceed 10% of a patient's familial income for one month excluding deductions for "essential living expenses" (defined as expenses for any of the following: rent or house payments including maintenance expenses, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child and spousal support, transportation and automobile expenses including insurance, fuel, and repairs, installment payments, laundry and cleaning expenses, and other extraordinary expenses.
<b>Washington Hospital</b>		Uninsured and underinsured at or below 350% FPL: Discounted to greatest charge expected from government sponsored insurance (Medicare, Medi---Cal, Healthy Families, etc.)	
<b>Contra Costa County</b>			
<b>Contra Costa Regional Medical Center</b>	Uninsured or underinsured individuals who do not receive a discounted rate through insurance: at or below 150% FPL, and net assets (exempting first \$10,000	Uninsured and underinsured individuals between below 350% FPL who don't qualify for free care. Uninsured individuals: Medi---Cal rates equates to 35% discount. Underinsured individuals who don't receive a discount based off third party	

	and 50% above that) do not exceed \$2,000 for an individual or \$3,000 for a family.	coverage: difference between Medical payment and insurance payment. No assets test.	
<b>John Muir Health</b>	At or below 350% FP, if qualifying assets do not exceed 200% billed charges	If medical expenses are greater than 20% of income, AND must be greater than qualifying assets: sliding scale on discount.	
<b>San Ramon Regional Hospital</b>	Patients with income under 200% FPL	Uninsured and underinsured between 201% --- 350% FPL, on a sliding scale, but no more than that expected from the greater of the Medi---Cal, Medicare, or other government---sponsored insurance programs.	
<b>Present in both counties</b>			
<b>Kaiser Permanente</b>	Uninsured under 350% FPL, and for underinsured patients, the patient responsibility portion is covered.		High Cost Medical Patients, unclear what exactly they are eligible for
<b>Sutter Health</b>	Uninsured patients at or below 400% FPL	High medical cost patients with incomes at or below 400% FPL can get write---off for patient responsibility amount of hospital services.	Special circumstance: when insured patient's third party coverage pays only a portion of expected reimbursement for the patient's stay because the patient exhausted their benefits during the stay, the Hospital should collect from the patient the balance of the expected reimbursement that would have been due from the third---party coverage if the benefits were not exhausted.

<b>Appendix E: Timeline for Charity Care Applications</b>			
<b>Hospital/Health System</b>	<b>Deadline for application</b>	<b>Application valid for:</b>	<b>Policies on when hospitals will send unpaid bills to debt collections</b>
<b>Alameda County</b>			
<b>Alameda Hospital</b>	10 days after discharge	180 days	After 60 calendar days of non-payment of an established payment plan or 90 calendar days of non-payment on an account
<b>Highland Hospital</b>	6 months; unclear what the start date is	One year	not stated
<b>Fairmont Hospital</b>	6 months; unclear what the start date is	One year	not stated
<b>Fremont Hospital</b>	unclear	unclear	150 days after nonpayment. Will inform patients of credit-counseling nonprofit organization and summary of rights.
<b>Kindred Hospital San Francisco Bay Area</b>	60 days	180 days	120 from final bill with nonpayment
<b>St. Rose Hospital</b>	150 days from initial billing	unclear	150 days after initial billing if there if nonpayment
<b>Valleycare Health System</b>	1 year from discharge date of accounts	unclear	Unclear in policy. Website states that if payments or arrangements are not made within 90 days, a final notice will be delivered, and then collections actions will be pursued.
<b>Washington Hospital</b>	150 days from initial billing	Month of service	Unclear; perhaps after 150 days.
<b>Contra Costa County</b>			
<b>Contra Costa Regional Medical Center</b>	150 days of first billing; explicitly state that applications after this time will be denied.	unclear	Not prior to 150 days if patient indicates inability to pay or lacks coverage.
<b>John Muir Health</b>	6 months post first patient statement date = 150 days	That application period, retroactive for 6 months	Not stated
<b>San Ramon Regional Hospital</b>	Not stated; mentions that determination of eligibility for charity	That application period.	Not stated

	care will be made "at the time of admission, or shortly thereafter"		
<b>Present in both counties</b>			
<b>Kaiser Permanente</b>	240 days from first billing statement	Varies; standard is 1 year	Unclear how many days; reasonable efforts to be made
<b>Sutter Health</b>	240 days from discharge bill	1 year	After a reasonable effort has been made.

<b>Appendix G: Information Available on Hospital Websites</b>						
<b>Hospital/Health System</b>	<b>Any information posted online</b>	<b>Information available in different languages</b>	<b>Eligibility criteria are clearly stated</b>	<b>Contact information or person listed</b>	<b>Application posted online</b>	<b>Application available in difference languages</b>
<b>Alameda County</b>						
<b>Alameda Hospital</b>	No	N/A	N/A	N/A	No	N/A
<b>Highland Hospital</b>	No	N/A	N/A	N/A	No	N/A
<b>Fairmont Hospital</b>	No	N/A	N/A	N/A	No	N/A
<b>Fremont Hospital</b>	No; no search option	N/A	N/A	N/A	No	N/A
<b>Kindred Hospital San Francisco Bay Area</b>	No	N/A	N/A	N/A	No	N/A
<b>St. Rose Hospital</b>	Yes	No	No	Yes; patient advocate	No	
<b>Valleycare Health System</b>	Yes	Yes; Spanish	Yes	Yes; billing department	Yes	Yes; Spanish
<b>Washington Hospital</b>	No	N/A	N/A	N/A	No	N/A
<b>Contra Costa County</b>						
<b>Contra Costa Regional Medical Center</b>	Yes	No	Yes	No, but number for financial counselors are on other pages.	No	N/A
<b>John Muir Health</b>	Yes	Yes; Spanish	Yes	Yes; patient financial services	Yes	Yes; Spanish
<b>San Ramon Regional Hospital</b>	Yes	Yes; Spanish	No	Yes; financial assistance office	No	N/A
<b>Present in both counties</b>						
<b>Kaiser Permanente</b>	Yes, but not on main page. Found through google search	Yes; 25 different languages	Yes	Yes; patient financial advisor	Yes	Yes; 25 different languages
<b>Sutter Health</b>	Yes	Yes; 26 different languages	Yes	Yes	Yes	Yes; 26 different languages

## Appendix H: Policy Regarding When Information Will be Delivered

Hospital/Health System	Written statement in bill or mailed separately
<b>Alameda County</b>	
<b>Alameda Hospital</b>	Statement in bill; unclear when
<b>Highland Hospital</b>	Unclear
<b>Fairmont Hospital</b>	Unclear
<b>Fremont Hospital</b>	At the time of admission or as soon after, for patients with no third-party coverage or with a potential deductible or copay.
<b>Kindred Hospital San Francisco Bay Area</b>	Written statement and application IF patient indicates they are uninsured.
<b>St. Rose Hospital</b>	Unclear
<b>Valleycare Health System</b>	Unclear
<b>Washington Hospital</b>	At the time of registration, and before a bill is sent to collections, and for patients who have not provided proof of insurance.
<b>Contra Costa County</b>	
<b>Contra Costa Regional Medical Center</b>	Statement in initial billing
<b>John Muir Health</b>	Yes; standardized message on bill
<b>San Ramon Regional Hospital</b>	Not stated
<b>Present in both counties</b>	
<b>Kaiser Permanente</b>	Yes; one written statement within 120 days of discharge, and one summary of the financial assistance program on the first hospital bill.
<b>Sutter Health</b>	Yes

## Appendix I: Hospital Financials on Charity Given in Fiscal Year 2015

Hospital/Health System	Charity care	Uncompensated care (charity care + bad debt)	Charity care	Uncompensated care	Uncompensated care (charity care + bad debt + county indigent programs) as a share of net patient revenue	Charity care	Uncompensated care	Medi-Cal shortfall	Medicare shortfall
	Dollar Amount*cost-to-charge ratio	Dollar Amount*cost-to-charge ratio	Share of operating expenses	Share of operating expenses		Share of net patient revenue	Share of net patient revenue		
<b>Alameda County</b>									
Alameda Hospital	\$118,935	\$4,531,140	0.11%	4.25%	6.04%	0.15%	5.77%	---\$12,956,655	---\$9,832,182
Alta Bates Summit Medical	\$2,879,181	\$4,572,154	0.61%	0.97%	0.98%	0.65%	1.04%	---\$27,869,458	---\$77,554,596
Eden Medical	\$3,831,985	\$7,338,287	1.23%	2.36%	2.36%	1.14%	2.18%	\$1,416,755	---\$53,641,179
Fremont Hospital	\$16,312	\$430,826	0.05%	1.40%	1.40%	0.03%	0.86%	\$1,522,133	\$3,490,892
Highland Hospital	\$1,464,916	\$21,931,821	0.25%	3.75%	8.37%	0.40%	6.06%	---\$139,360,552	---\$63,945,448
Kindred Hospital San Francisco Bay Area	\$0	\$171,814	0.00%	0.39%	0.39%	0.00%	0.37%	---\$1,587,279	\$1,385,025
San Leandro	\$704,496	\$3,438,041	0.76%	3.69%	3.69%	1.28%	6.25%	---\$24,011,589	---\$16,062,520
St. Rose Hospital	\$1,017,674	\$2,936,091	0.73%	2.12%	2.12%	0.72%	2.09%	---\$16,526,349	---\$18,294,259
Valleycare Health System	\$1,345,282	\$5,556,877	0.55%	2.27%	2.27%	0.52%	2.15%	---\$2,119,516	---\$30,656,614
Washington Hospital	\$1,604,445	\$7,756,724	0.40%	1.94%	1.94%	0.37%	1.81%	---\$46,231,766	---\$79,817,671
<b>Contra Costa County</b>									
Contra Costa Regional Medical Center	\$0	\$61,214	0.00%	0.01%	1.44%	0.00%	0.02%	\$12,792,753	---\$41,557,579

John Muir – behavioralHealth Center	\$0	\$162,150	0.00%	0.44%	0.44%	0.00%	0.46%	---\$361,205	---\$2,063,604
John Muir Medical – Concord	\$4,025,986	\$11,622,465	1.01%	2.90%	2.90%	0.95%	2.76%	---\$47,400,437	---\$71,993,063
John Muir Medical – Walnut Creek	\$4,716,777	\$18,048,601	0.65%	2.50%	2.50%	0.57%	2.19%	---\$2,179,592	---\$176,793,008
San Ramon Regional Hospital	\$92,724	\$932,926	0.06%	0.64%	0.64%	0.06%	0.58%	---\$2,648,703	---\$24,854,479
Sutter Delta Medical Center	\$2,121,892	\$4,253,789	1.14%	2.28%	2.28%	1.09%	2.18%	---\$8,908,967	---\$19,985,612

**NOTE: No financial data for KP or Fairmont Hospital**

## **Appendix I: Survey Questionnaire**

### *(Current Financial Situation)*

1. How would you describe your household's current financial situation?
  - Live comfortably
  - Meet your basic expenses with a little left over for extras
  - Just meet your basic expenses
  - Don't have enough to meet basic expenses
  - Don't know
  - Refused
  
2. In the past 12 months, did you or anyone in your household have difficulty paying any non-medical bills? (Y/N)
  - a. 2.a.: If yes: What kind of bill? (I will list out a few different types of bills, and say yes if you had trouble with that type of bill)
    - Phone
    - Utilities, such as bills for electricity, water, or garbage.
    - Rent/mortgage
    - Credit card bills
    - Other (please list)
    - None
    - Don't know
    - Refuse
  
3. In the past 12 months, have you or anyone in your household experienced difficulty paying for medical bills for doctors, dentists, medications, home care, or other hospital visits? (Y/N)
  
4. In the past 10 years, have you or anyone in your household experienced unpaid medical bills or debts? (Y/N)
  
5. Who in your household experienced these bills?
  - Self
  - Spouse
  - Parent
  - Child
  - Grandparent
  - Sibling
  - Other
  
6. How have these medical bills or debts affected how you felt about the future? (open ended question)

### *(Experience with Medical bills)*

I received your name from a list that showed you previously had experience with medical bills and worked with HERA on financial issues. I'd like to talk to you about your experience with medical bills and how it impacted your financial situation.

7. What year or years did these bills occur? (open ended question)
  
8. How many different medical situations led to the medical bills you had when you contacted HERA?

9. Which of the following describes the source of medical bill problems? (please stop me when I read a medical service that applies to this question)
- Doctor visits
  - Emergency room
  - Hospitalization
  - Outpatient fees
  - Lab fees
  - Diagnostic tests, such as x-rays or MRIs
  - Prescription drugs
  - Nursing home or long-term care services
  - Dental care
  - Other type of medical service
10. Did the illness that cause the medical bills cause you or anyone in your household to lose a job, take a cut in pay or hours ? This can be either as a result of the illness itself or in order to care for the person who was sick. (Y/N) If yes, will inquire as to who in household was impacted.
11. At the time of the medical bills, were you covered by insurance?
- a. If yes, what type of insurance?
- Medicare
  - Medi-Cal
  - Medicare AND MediCal
  - Private insurance
  - Individually purchased insurance
  - Uninsured
  - Don't know
  - Refused

*(Impact of bills on finances)*

12. Did you take out a loan to pay for your bills? (Y/N)
13. Did you pay for your bills through credit card loan? (Y/N)
14. Did the medical bills make it harder to pay other bills? (Y/N) 15.a: *If yes:* Which bills?
- Phone
  - Utilities, such as bills for electricity, water, or garbage.
  - Rent/mortgage
  - Credit card bills
  - Other (please list)
  - None
  - Don't know
  - Refuse
15. Did your medical bills influence in any way your housing situation?
- If yes:*
- a. Did you have to refinance your home?
- b. Did you have to sell your home?

c. Did you move homes?

16. Overall, how much of an impact have these medical bills had on you and your family? (Open ended question)

*(Charity care questions)*

17. At the time of your medical bills, were you aware of charity care or discount care or payment programs at hospitals? (Y/N)

*If yes, the following:*

- a. How were you informed? (open ended)
- b. Did you know if you were eligible for discount or charity care? (Y/N)
- c. Did you receive discount or charity care? (Y/N)
  - If yes, then did you feel you had enough time to accept the program? (Y/N)

18. Did you participate in a payment plan set up with the hospital, insurance company, collections agency, or any other institution? (Y/N)

- a. If yes, did you feel you had enough time to understand the terms and enroll in the payment plan? (Y/N)

19. Did you receive other financial help for these bills?

*If yes: what kind of help? (open ended)*

*(Collections Agency related questions)*

20. Have you been contacted by a collections agency for these medical bills? (Y/N)

21. How many times did the collections agency contact you per week?

- 1-5
- 6-10
- 11-15
- 16-20
- 21+

22. How did the collections agency contact you?

- Phone
- Letter
- Email
- In-person
- Don't know
- Refused

23. Have you be contacted by a collections agency for other non-medical bills? (Y/N)

*If yes:*

Which bills?

24. Have you experienced an adverse impact on your credit score because of the medical bills or medical debt?

*(Medical Bills Questions)*

25. What was the TOTAL amount owed for the medical bills you have had problems paying? Please estimate the total amount that you or a family member personally owed for medical bills, not including any amount paid for by health insurance. Please include the total amount that was owed, even if you have paid off part of that amount.

- Less than \$500
- 500 to less than \$1,000
- \$1,000 to less than \$2,500
- \$2,500 to less than \$5,000
- \$5,000 to less than \$10,000
- \$10,000 or more
- Don't know/not sure
- Refused

**Demographic Questions**

26. What is your current age? (open ended)

27. What gender do you identify with?

28. Please specify your ethnicity

- a. Hispanic/Latino
- b. Black
- c. White
- d. Asian/Pacific Islander
- e. Native American or American Indian
- f. Other
- g. Multiple
- h. *Refused*

29. Employment status:

- a. Employed full time
- b. Employed part-time
- c. Self-employed
- d. Out of work and looking for work
- e. Out of work but not looking for work
- f. Retired
- g. Homemaker
- h. Military
- i. Unable to work

30. Question on household income

a. What is your yearly income? (open ended).

If you wish not to specify, I can present income brackets, or we can skip this question.

# Endnotes

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<sup>1</sup> Kaiser Family Foundation. The Burden of Medical Debt: [Results from the Kaiser Family Foundation/New York Times Medical Bills Survey](#). January 2016.

<sup>2</sup> Ibid.

<sup>3</sup> Kaiser Family Foundation. Press Release. Average Annual Workplace Family Health Premiums Rise. September 2016.

<sup>4</sup> Kaiser Family Foundation. The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey. January 2016.

<sup>5</sup> Kaiser Family Foundation, Employer Health Benefits Survey. 2015.

<sup>6</sup> Kaiser Family Foundation, see *supra* note 3.

<sup>7</sup> Commonwealth Fund. Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families—Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007.

<sup>8</sup> Kaiser Family Foundation, see *supra* note 3.

<sup>9</sup> Ibid. Inability to pay medical bills can lead to debt, which is a contributing factor to bankruptcy. The KFF survey found that 11 percent of individuals with medical bill issues declared bankruptcy at some point, and medical bills were a contributor to their bankruptcy.

<sup>10</sup> Dranove, D and Millenson M. Health Affairs. Medical Bankruptcy: Myth Versus Fact.

<sup>11</sup> The American Medical Association estimated that 20% of claims are processed inaccurately. The American Medical Association, 2010 National Health Insurer Report Card.

<sup>12</sup> Press Release, American Medical Association. New AMA Health Insurer Report Card Finds Need for More Accuracy. June 14, 2010.

<sup>13</sup> U.S. Governmental Accountability Office, GAO-11-269, Private health Insurance, Data on Application and Coverage Denials 8. 2011.

<sup>14</sup> Kaiser Family Foundation. Preventive Services Covered by Private Health Plans under the Affordable Care Act. August 2015.

<sup>15</sup> Commonwealth Fund 2012 Biennial Report, see *supra* note 1.

<sup>16</sup> Rukavina, M. Suffolk Law Review. Medical Debt and its Relevance Assessing Creditworthiness.

<sup>17</sup> In 2013, the Center for Medicare and Medicaid Services released data on hospital charges for the most common inpatient procedures, which demonstrated how much discretion hospitals have over pricing. A joint replacement in Ada, Oklahoma, for example, cost \$5,300, but \$223,000 in Monterey Park in California.<sup>17</sup> Consumers are not informed about these costs until they receive a bill.

<sup>18</sup> Brown, E. Houston Journal of Health Law and Policy. Irrational Hospital Pricing. Vol. 14

<sup>19</sup> Reinhardt UE. The pricing of US hospital services: chaos behind the veil of secrecy. Health

Affairs. 2006.

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<sup>20</sup> Health Access. Preventing Overcharging, Surprise Bills, and Medical Debt.

<sup>21</sup> See supra note 18.

<sup>22</sup> See supra note 19.

<sup>23</sup> 26 U.S.C. § 501(r)(1)(B) (Supp. 2011).

<sup>24</sup> 26 U.S.C. § 501(r)(4)(A)(i).& § 501(r)(4)(A)(v)

<sup>25</sup> Reasonable efforts refer to providing notice and time for the patient to apply for financial assistance. The length of time is undefined.

<sup>26</sup> 26 U.S.C. § 501(r)(6) (Supp. 2011).

<sup>27</sup> 26 U.S.C. § 501(r)(1)-501(r)(7)

<sup>28</sup> Hall M, Schneider C. Mich Law Review. Patients as Consumers: Courts, Contracts, and the New Medical Marketplace. 2008.

<sup>29</sup> Consumer Financial Protection Bureau, Data point: Medical debt and credit scores, May 2014

<sup>30</sup> Avery, R. Calem, P. Canner G. Federal Reserve Bulletin. Credit Report Accuracy and Access to Credit. Summer 2004.

<sup>31</sup> Ibid.

<sup>32</sup> FICO Blog. The Impact of Medical Debt on FICO Scores. July 13, 2015.

<sup>33</sup> McKinsey. Revisiting Healthcare Payments: An Industry Still in Need of Overhaul. <sup>34</sup> CFPB. Data Point: Medical debt and credit scores. May 2014.

<sup>35</sup> U.S.C. § 1681s-2(a)(5)(A)

<sup>36</sup> California Health and Safety Code. § 127425(d)

<sup>37</sup> See supra note 15.

<sup>38</sup> Wu, Chi Chi. Strong Medicine Needed: What the CFPB Should Do to Protect Consumers from Unfair Collection and Reporting of Medical Debt. National Consumer Law Center.

<sup>39</sup> 15 U.S.C. § 1692g

<sup>40</sup> National Council on Aging. [Older Adults & Debt: Trends, Trade-offs, and Tools to Help](#).

<sup>41</sup> Provisions in the ACA aim to close this coverage gap by 2020.

<sup>42</sup> Internal Revenue Service. [Instructions. 1990](#).

<sup>43</sup> The Commonwealth Fund. Health Care Coverage and Access in the Nation's Four Largest States.

<sup>44</sup> Kaiser Family Foundation. [Distribution of Total Population by Federal Poverty Level](#).

2015.

<sup>45</sup> Internal Revenue Service. [New Requirements for 501\(c\)\(3\) Hospitals Under the Affordable Care Act.](#)

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<sup>46</sup> Rosenbaum, s. Health Affairs Blog. [Additional Requirements For Charitable Hospitals: Final Rules On Community Health Needs Assessments And Financial Assistance.](#) January 2015.

<sup>47</sup> Adreima. [A Brief Guide to 501\(r\) Compliance.](#)

<sup>48</sup> New York Attorney General's Office. [A.G. Schneiderman announces Groundbreaking Consumer Protection Settlement with the Three National Credit Reporting Agencies.](#) March 2015.

<sup>49</sup> Health and Safety Code §127400

<sup>50</sup> California Hospital Association, prepared by Hooper, Lundy & Bookman, PC. Community Health Needs Assessment, Charity Care, Financial Assistance Policies, and Billing and Collection Activities. February 2014.

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[D5FB6BDB6801](https://sfgov.legistar.com/View.ashx?M=F&ID=2597930&GUID=AB6E2FC7-4C3F-455B-B17F-D5FB6BDB6801) See Also, San Francisco Hospitals Charity Care Report San Francisco Department of Public Health April 2017 at

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