Institute for Healthcare Improvement

**INSTITUTE FOR HEALTHCARE IMPROVEMENT**
**SUMMARY REPORT: 90-DAY PROJECT**

# Wave 51: Reducing the Burden of Debt from Healthcare Cost

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## II. Intent:

This is the second cycle of research on health care toxicity/ affordability as measured by consumer debt. While IHI has done extensive research in the past on the untenable rise of health care cost more broadly, this set of cycles focused specifically on the cost of care as experienced by patients and families. The goal of this cycle was to identify measures and a set of change ideas (including an advocacy agenda) that health systems can use to decrease the amount of debt that consumers incur.

## III. Background:

This is the second 90-day cycle of activity on this topic. In Wave 50 we identified a set of consumer issues around:

- Billing: inaccurate bills, uncoordinated bills, balance bills, and surprise bills
- Insurance and Networks: providers out of network, narrow network insurance products and high deductible plans
- Cost transparency and pricing: transparency of system/care delivery prices, and rising high cost pharmaceuticals

The impact these problems are having on consumers is manifested in the following examples. In 2017, $365 billion was spent on out-of-pocket health care cost.[1] The West Health Gallup survey[2] estimated that consumers borrowed $88 billion to pay for health care. Therefore, about 1/4 of consumer spending for health care is debt. In addition, 18% of consumers in the US are now in collection for medical debt.[3] In a recent settlement in the state of Washington, "Attorney General

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[1] Centers for Medicare & Medicaid Services. (Accessed June 2019). NHE Fact Sheet. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html

[2] West Health/Gallup. (2019). The U.S. Healthcare Cost Crisis. https://news.gallup.com/poll/248081/westhealth-gallup-us-healthcare-cost-crisis.aspx

[3] Urban Institute. (2018). Debt in America: An Interactive Map. https://apps.urban.org/features/debt-interactive-map/?type=medical&variable=perc_debt_collect

Bob Ferguson today announced that, as a result of his lawsuit, St. Joseph Medical Center in Tacoma and seven other CHI Franciscan hospitals will forgive as much as $20 million in debt, pay $2.22 million in refunds, pay the Attorney General's Office $2.46 million, and rehabilitate the credit of thousands of patients who qualified for charity care between 2012 and 2017 but did not receive it…." Medical debt is one of the leading reasons why families get trapped in poverty," Ferguson said. "Hospitals are required to inform low-income patients about the availability of charity care. St. Joseph failed to live up to its duty, and imposed obstacles on vulnerable Washingtonians trying to access affordable care. Today's resolution rights a wrong committed against thousands of patients across Washington."[4]

Based on these consumer issues and the impact they are having, we have identified a set of opportunities that we will discuss in this report.

1. Building on some early exploration and consideration, we produced a measurement set for health care cost toxicity and affordability. All measures that we chose have readily available databases to support them or they are feasible for health systems to monitor.

2. Built a set of interventions that health systems can use to protect consumers from health care cost toxicity, i.e., medical debt. We worked to understand which interventions serve as a "win" for the system in addition to being a "win" for the patient (i.e., a positive impact on revenue cycle, bad debt, etc.). The goal will be to test and refine these ideas with health systems and eventually share with the industry at large. The test bed for this work will be determined by the opportunities we have with health systems.

3. Federal and State policy and regulation impacts consumers' health care debt. We chose two states with one of the lowest and one of the highest amounts of medical debt and analyzed the policy differences at the state level. We chose Texas with 26% of the adult population in collection for medical debt and Minnesota with 3%. We hope this will lead health systems toward advocacy.

**IV. Description of Work to Date:**
This work was built on the consumer health care cost problems we identified in wave 50 of IHI research titled, "Financial Toxicity/Affordability of Health Care for Patients." During this present cycle we looked at literature, compared outcomes between Texas and Minnesota, and conducted interviews.

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[4] Washington State Office of the Attorney General. (2019). Following AG's Charity Care Lawsuit, St. Joseph Parent Company CHI Franciscan Will Provide Up To $25 Million in Restitution, Deb Relief and Fees. https://www.atg.wa.gov/news/news-releases/following-ag-s-charity-care-lawsuit-st-joseph-parent-company-chi-franciscan-will

We were able to accomplish all three parts of the deliverables that we outlined in the charter: measures, change ideas and advocacy ideas.

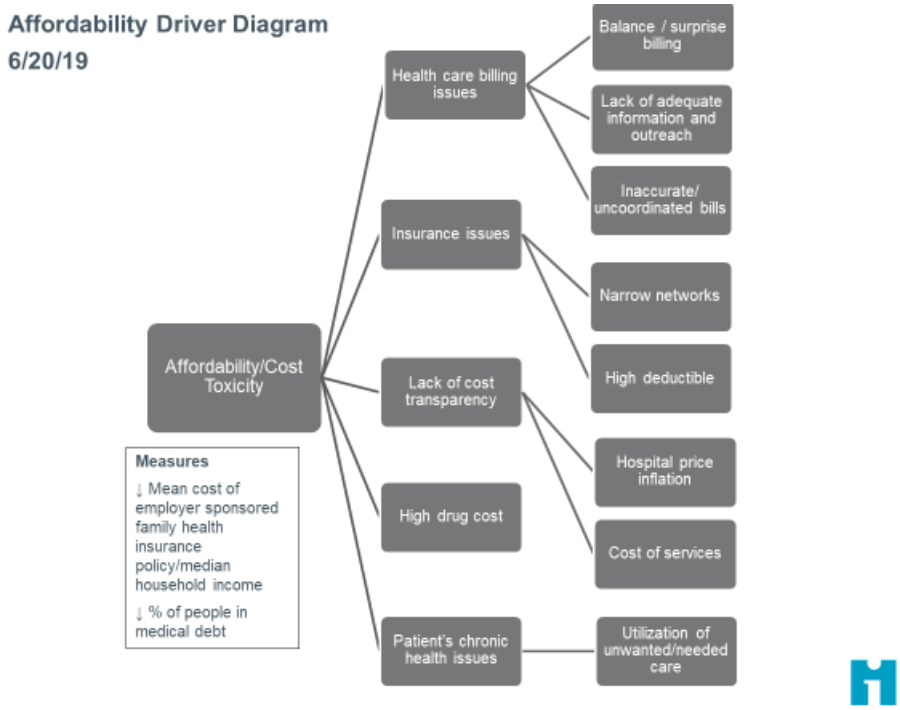
**V. Results of the 90-Day Scan:**

**Development of Content Theory**
Based on our work from the first cycle of research activity, we created the following driver diagram.

In this diagram there are five primary drivers along with a set of secondary drivers. For more information on these drivers, please read IHI's Innovation Project Wave 50: Financial Toxicity / Affordability of Health Care for Patients, March 31, 2019.

We selected a subset of these drivers to assemble change ideas that providers and health systems can use to keep consumers out of debt. We want to specifically site Dr. Rishi Manchandas' work on the Campaign to End Medical Debt[5] and Bellin Health system for many of the ideas we list below

[5] The Campaign to End Medical Deb https://www.endmedicaldebt.org




**Healthcare Billing Issues**

1. Insurance and network issues: ensure all providers are in-network; if providers cannot be in-network, bill the amount that reflects the cost of providing care (e.g., "usual and customary" fees for the treatment in your area)
2. Improve billing: simplify and make bills complete and understandable; provide multiple ways to pay; ensure a clear process for patients to dispute or challenge bills with sufficient time to respond and increase time to 120 days prior to collection
3. Reduce financial hardships: consider bill reductions, bill forgiveness, flexible payment plans, and longer-term interest free loans; screen patients to ensure insurance companies have been billed, ensure patients eligible for financial assistance receive the free/ discounted care; provide or link to financial counselors; raise level of debt before sending to collectors.

**Cost and transparency**

1. Provide consumers estimates of their cost and total cost before elective procedures.
2. Address hospital price inflation – hospital boards review price inflation and debt collection practices.
3. Financial risk prediction: Consider using social determinants of health (SDOH) screenings as tool for identifying individuals who need more financial support and link them to appropriate resources.

4. Advise patients before signing financial responsibility forms to add the following: “as long as the providers are in my insurance network.”

**Patients with Chronic Health Issues**

1. Limit how much self-paying individuals have to pay out-of-pocket according to their income.
2. Care coordination
3. Educate patients on insurance, consumer rights, community resources and health system resources
   Contribute to employee HSAs, especially for low-wage employees.

We are including some change ideas and thoughts that are related to advocacy as we discussed in the background section.

**Advocacy at state and federal level**

During our research we looked at two states that had different outcomes on the number of people who are being sent to collectors for medical debt. In Texas, 26% of the population is in medical collection and in Minnesota it is only 3% (compared to a national average of 18%).[6] We spent time looking for potential differences that might explain this data. For a detailed report, see Appendix B. In summary, we see more insurance coverage, rare for-profit healthcare hospitals, little surprise billing, greater consumer protection and higher income in Minnesota than Texas. These factors all contribute to the difference between Minnesota and Texas on medical debt and provide us clear examples on what can make a difference. We do not believe that we have exhaustively covered all possible differences between these states but we do believe that we have enough to make a few recommendations. ( For more details see appendix B)

Therefore, from a policy standpoint, to decrease medical debt, we recommend the expansion of health care coverage, the elimination of surprise billing and the implementation of more consumer protection around medical billing practices. The IRS outlines the basic consumer protections that any not for profit health system needs to do[7] and a state such as Minnesota is a good model on how to extend those protections.[8]

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[6] Urban Institute. (2018). Debt in America: An Interactive Map. https://apps.urban.org/features/debt-interactive-map/?type=medical&variable=perc_debt_collect

[7] IRS. (2018). Requirements for 501(c)(3) Hospitals Under the Affordable Care Act – Section 501(r). https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r

[8] The Office of Minnesota Attorney General. (2019). Medical Billing Pointers. https://www.ag.state.mn.us/consumer/Publications/MedicalBillingPointers.asp

**Measures**

Coupled with these change ideas are the following set of affordability measures:

National Level: Affordability Measures

- Affordability Index: Mean cost of employer sponsored family health insurance policy (employer and employee contribution) / median household income[9]
- % of people in collection for medical debt

Health System Level Affordability Measures

- % of employees that health systems sent to collectors
- % of patients that health systems sent to collectors
- % of physicians not in the same network as rest of health system
- Bad debt/charity care
- % of employee paycheck spent on healthcare premium

Consumer Level Affordability Measures

- Patient affordability = out of pocket costs / household budget[10]
- % patient screening positive for financial burden (Use SDOH screening tool to identify individuals at financial risk for health care cost.)

The measures look at three levels: national, health system, and consumer. Most of the measures are related to health care debt/collection and fit well with the change ideas and advocacy that are recommended. Two measures: 1) mean cost of employer sponsored family health insurance policy and 2) Patient affordability = out of pocket costs / household budget are to continue to remind us of the bigger issues than just debt.

**Execution Theory**

1. Consider working with your own employees first.
2. Create a patient financial experience team with key stakeholders, including rep from billing revenue cycle and patients.
3. Get the following baseline data
    a. % of employees that health system sent to collectors
    b. % of patients that health system sent to collectors

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[9] Emanuel, E.J., Glickman, A. and Johnson, D. (2017). Measuring the burden of health care costs on US families: the Affordability Index. Jama, 318(19), pp.1863-1864. https://jamanetwork.com/journals/jama/fullarticle/2661699

[10] National Quality Forum. (2014). Measuring Affordability from the Patient's Perspective. https://www.qualityforum.org/Publications/2014/09/Measuring_Affordability_from_the_Patient_s_Perspective.aspx

   c. % of physicians not in the same network as rest of health system
   d. Bad debt/charity care
4. Interview 10 employees who are in collection and try to understand the issues that they are facing. Note: This may be a sensitive topic and some may not be willing to share with co-workers. Be transparent about who gets access to the information, what the information will be used for, and how their information will be kept confidential.
   a. Why did they end up in collection?
   b. What changes might surface to the collection process that would reduce the # in collection, etc.
5. Track a set of affordability/toxicity measures (e.g., set goal for ratio of dollars in bad debt/dollars in community care, look at stratified data (age/REAL) to see which population is disproportionately being sent to debt collection.) Consider using some of the health system level and consumer level measures suggested above.
6. Co-design a set of change ideas to test. Consider some of the change ideas suggested above (e.g., bill reductions, bill forgiveness, and longer-term interest free loans, raising the level of debt before sending to collections).

**Business Case**

A final consideration before we concluded was: why should a health system be motivated to do this work?

First, consider the following examples that deal with the image of a health system in their community along with following the laws of the land for a nonprofit health system:

*"Attorney General Bob Ferguson today announced that, as a result of his lawsuit, St. Joseph Medical Center in Tacoma and seven other CHI Franciscan hospitals will forgive as much as $20 million in debt, pay $2.22 million in refunds, pay the Attorney General's Office $2.46 million, and rehabilitate the credit of thousands of patients who qualified for charity care between 2012 and 2017 but did not receive it. CHI Franciscan entered into a legally enforceable agreement to reform its charity care practices across all eight of its acute care hospitals. Attorney General Ferguson sued St. Joseph Medical Center, but the resolution involves charity care reforms for eight CHI Franciscan hospitals and provides restitution for patients withheld charity care at all eight hospitals.*

*"Medical debt is one of the leading reasons why families get trapped in poverty," Ferguson said. "Hospitals are required to inform low-income patients about the availability of charity care. St. Joseph failed to live up to its duty, and imposed obstacles on vulnerable Washingtonians trying to access affordable care. Today's resolution rights a wrong committed against thousands of patients across Washington."*

*Today's resolution, filed in Pierce County Superior Court, affects thousands of Washington consumers who sought care at eight CHI Franciscan acute care hospitals.*

*The resolution requires a multi-faceted strategy to ensure any Washingtonian who qualified for charity care but did not receive it will get the relief they deserve. Every patient from January 2012 to December 2017 will have the opportunity to receive debt forgiveness or refunds if they qualified for charity care, whether they had insurance or not.*

*So far, at least 5,451 patients have been identified who will receive automatic refunds totaling $2.22 million. In addition, the Attorney General's Office anticipates that several thousand patients will receive automatic debt relief, totaling as much as $20 million.*

*The Sisters of St. Francis of Philadelphia founded St. Joseph Hospital in 1891. According to St. Joseph's website, the sisters "ministered to all people, regardless of race, religion or financial status." The hospital's stated vision is to "lead the transformation of healthcare to achieve optimal health and wellbeing for the individuals and communities we serve, especially those who are poor and vulnerable."*[11]

What type of image does this situation portray to the residents of the state of Washington? How active is the attorney journal in your state with nonprofit health systems? The ACA added the following general requirements for tax exemption under Section 501(c)(3):[12]

1. Community Health Needs Assessment (CHNA) - Section 501(r)(3),
2. Financial Assistance Policy and Emergency Medical Care Policy - Section 501(r)(4),
3. Limitation on Charges - Section 501(r)(5), and
4. Billing and Collections - Section 501(r)(6).

Items 2, 3 and 4 specifically deal with issues related to consumer debt for nonprofit hospitals both in Washington and across the US.

A second example is a conversation one of the authors had with a consumer from Bloomington, Illinois who uses OSF Healthcare. This consumer is a self-pay individual. He described a recent

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[11] Washington State Office of the Attorney General. (2019). Following AG's Charity Care Lawsuit, St. Joseph Parent Company CHI Franciscan Will Provide Up To $25 Million in Restitution, Deb Relief and Fees. https://www.atg.wa.gov/news/news-releases/following-ag-s-charity-care-lawsuit-st-joseph-parent-company-chi-franciscan-will

[12] IRS. (2018). Requirements for 501(c)(3) Hospitals Under the Affordable Care Act – Section 501(r). https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r

episode in which he needed a colonoscopy and mentioned that normally anesthesiology would have been around $1300 dollars for the procedure, but he paid approximately $250 for the service. He went on to say how helpful OSF had been to them in providing substantial discounts as a self-pay consumer. He also knew of another family where OSF had provided discounted care.

The second consideration deals directly with consumers' present ability to pay and insurance deductibles. In the Federal Reserve report on economic well being, 40% of adults said they would have difficulty paying a $400 emergency expense.[13] Another survey said that 61% of adults had less than $1000 in savings.[14] "The average deductible among covered workers in a plan with a general annual deductible is $1,573 for single coverage."[15] This leads to a challenge for health systems in patient collections. Some of the ideas that we suggested earlier under health care billing and cost and transparency may be helpful. Some health systems are using vendors to manage payment plans for patients to improve their revenue cycle performance.

Another creative example to improve revenue was done in 2019 by Ohio Valley Medical Center.

*"Under the limited-time offer, if a patient pays half of a medical bill from 2018 or earlier, the hospitals will write off the remaining half of the bill.*

*The hospitals have received a lot of positive feedback from patients who were happy their medical debt was reduced by half. Officials said the offer has helped the hospitals collect on overdue accounts.*

*"It's a really good way to collect on old accounts," Jose Guevara, the hospitals' revenue cycle director, told The Intelligencer."*[16]

**VII. Conclusions and Recommendations:**

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[13] Report on the Economic Well-Being of U.S. Households in 2017 - May 2018 https://www.federalreserve.gov/publications/2018-economic-well-being-of-us-households-in-2017-dealing-with-unexpected-expenses.htm

[14] Most Americans don't have enough savings to cover a $1K emergencyhttps://www.bankrate.com/banking/savings/financial-security-0118/

[15] KFF 2018 Employer Health Benefits Survey https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/

[16] https://www.beckershospitalreview.com/finance/why-2-hospitals-are-slashing-medical-bills-by-50.html

Through this wave, we have developed a draft content theory, execution theory, a set of measures, and ideas for advocacy. Moving forward, we would like to identify one or more partners to further refine the ideas and begin testing.

## VIII: Appendices

***Appendix A. Observations from Bellin Health System based on an interview this year and presentation that they gave at IHI's 2018 National Forum.***

Their work starts in the first quarter of 2016.
**"**AIM: Reduce the ratio of bad debt to community care from 2.63 to 1.32 by 12/31/2018."

Their first steps were to create a team and invite key stakeholders

The Bellin Health Team Members

- Heart and Vascular Senior Leader
- Care Coordination
- Billing Representative
- Patient Financial Services
- Human Resources
- Data Analyst

PDSA #1: Their first PDSA was to get the voice of the customer.

1) Interviewed patients sent to bad debt.
2) Interviewed employees sent to bad debt.
3) Interviewed House of Hope residents.

Key Findings

- Their patients do not understand the resources available to them.
- Patients do not understand their insurance.
- There is an opportunity to improve understanding of access points in healthcare as it relates to cost.
- Patients want to know what resources Bellin has.
- Patients want to pay their bills.

PDSA #2:

1. In this PDSA, they interviewed more patients, tested concepts and developed a "Healthcare 100" presentation. The goal of this presentation was to increase Awareness to Employees for Financial Health Resources.

2. The next step was Validating Voice of Customer by assessing Awareness to Employees for Financial Health Resources.
3. The next step was Validating Voice of Customer by asking about knowledge of Bellin Employees surrounding their financial health. They provided a survey monkey that employees could use for two weeks. There were 192 participants.

Goal: Assess the knowledge of Bellin Employees surrounding their financial health and identify key areas of focus.

- Question: Which areas of financial health would you like additional information on to help improve your understanding?
- The results
    - How does my insurance work?
    - How do I save for my medical bills?
    - What are my options to pay bills?
    - Is there someone who can help me pay my bills?
    - What resources are available for Bellin employees to avoid collections?

Co-Designing Healthcare 100

- Interactive way to reach our employee population
- Connected access to healthcare with financial cost
- Highlighted financial resources unique to Bellin and available in our community.
- Basics of insurance
- This created discussion around the topic of " Financial Health" within the organization.

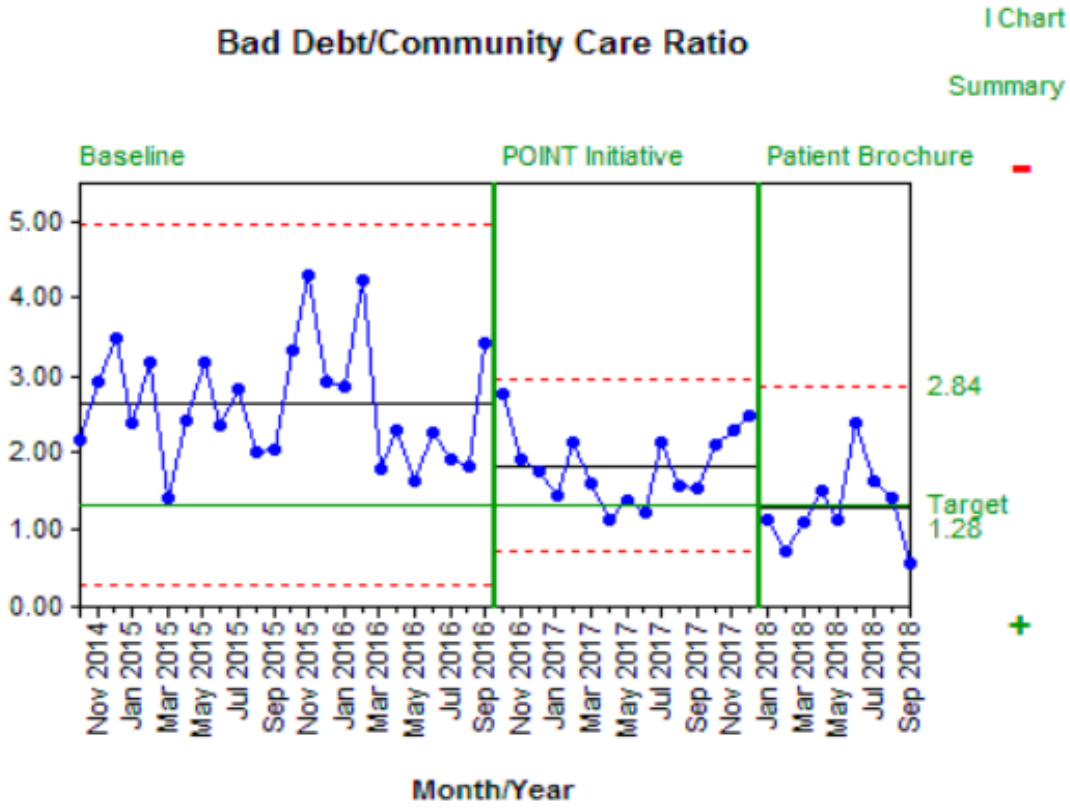
PDSA # 3 Financial Health Matters Brochure


**Results of work**

Bad debt is defined as the net amount of dollars sent in and out of bad debt status within a 30 day period of time.

Community care is a health system's financial assistance program. Patients need to qualify for this program based on their financial need. As little as 10% or as great as 100% of their medical bill could be forgiven. Community care defined on our income statements which is the actual dollar amount written off to community care. We take those eligible dollars for community care and apply what would be our self-pay discount and the remainder of those billed services is written off.

The ratio of bad debt to community care is calculated by ratio of the dollars in bad debt divided by the dollars in community care.




**3 Wins for this work**

- Financial health is now being measured at a strategic system level.
    - Bad Debt to Community Care Ratio
    - POINT Evolves into System Wide *Campaign*
    - Redesigning Bills
    - Simple application to obtain financial assistance
    - ED utilization team
- Empowering People
    - Financial Health Brochure
    - Healthcare 100

**Our Next Steps**

- Patient Financial Experience
- Payment Plans
- MyChart
- Price Transparency
- Equity
- Community Engagement

***Appendix B. Differences between Texas and Minnesota***

During our research we took two states that had different outcomes on the number of people who are being sent to collectors for medical debt. In Texas, 26% of the population is in medical collection; in Minnesota it is only 3% (compared to a national average of 18%).[17] We spent time looking for potential differences that might explain this data.

| | % of all in collection | % White | % Non White | Median $ In Collection | White | Non White |
|---|---|---|---|---|---|---|
| Texas | 26% | 23% | 29% | $850 | $821 | $875 |
| Minnesota | 3% | 3% | 7% | $342 | $335 | $402 |
| National | 18% | 16% | 21% | $681 | $653 | $720 |

**Observations**

1.Insurance coverage:[18]

- Minnesota - expanded Medicaid coverage in 2013 - uninsured rate is 4.5% in 2017
- Texas did not expand Medicaid - uninsured rate is 17.3% in 2017 (the highest rate in the U.S.)

Insurance coverage can have an impact on medical debt:[19]

*"Multiple studies found larger declines in trouble paying as well as worry about paying future medical bills in expansion states relative to non-expansion states. For example:*

- *One study found that, among those residing in areas with high shares of low-income, uninsured individuals, Medicaid expansion significantly reduced the number of unpaid bills and the amount of debt sent to third-party collection agencies. Similarly, other studies have found that Medicaid expansion has significantly reduced the percentage of people with medical debt, reduced the average size of medical debt, reduced the average number of collections, improved credit scores, reduced the probability of having one or more medical bills go to collections in the past 6 months, and reduced*

[17] Urban Institute. (2018). Debt in America: An Interactive Map. https://apps.urban.org/features/debt-interactive-map/?type=medical&variable=perc_debt_collect

[18] United States Census Bureau. (2018). Uninsured Rate by State: 2008-2017. https://www.census.gov/library/visualizations/interactive/uninsured-rate.html

[19] Antonisse, L., Garfield, R., Rudowitz, R. and Artiga, S. (2017). The effects of Medicaid expansion under the ACA: Updated findings from a literature review. https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/

*the probability of a new bankruptcy filing, among other improvements in measures of financial security.*

- *A study of Ohio's Medicaid expansion found that the percentage of expansion enrollees with medical debt fell by nearly half since enrolling in Medicaid (55.8% had debt prior to enrollment, 30.8% had debt at the time of the study)."*

2.Not-for-Profit Versus For-Profit Hospital status

Minnesota has 2 for-profit hospitals out of 145.[20]
Texas has 294 for-profit hospitals out of 366[21]

This difference may be important because the ACA created a set of requirements for not for profit hospitals around the following 4 areas: [22]

1. Community Health Needs Assessment (CHNA) - Section 501(r)(3),
2. Financial Assistance Policy and Emergency Medical Care Policy - Section 501(r)(4),
3. Limitation on Charges - Section 501(r)(5), and
4. Billing and Collections - Section 501(r)(6).

For profit hospitals do not have any similar requirements.

3. Out-of-network billing (surprise or balanced billing)[23]

Minnesota: 2% of all admissions have out-of-network billing.
Texas: 20% of all admissions have out-of-network billing.

Surprise or balanced bills are costlier to the consumer because of the higher out-of-pocket burden they place on the consumer. The odds of getting a surprise bill vary by states. In Minnesota, only

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[20] Fugate, T. (2017). Keep for-profit out of Minnesota: lessons from Michigan. https://mnnurses.org/keep-profit-minnesota-lessons-michigan/

[21] https://www.dshs.texas.gov/chs/hosp/Forms/Hspxmp16.xls

[22] IRS. (2018). Requirements for 501(c)(3) Hospitals Under the Affordable Care Act – Section 501(r). https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r

[23] Kennedy, K., Johnson , B., and Biniek, JF. (2019). Surprise out-of-network medical bills during in-network hospital admissions varied by state and medical specialty, 2016. *Health Care Cost Institute*. https://healthcostinstitute.org/blog/entry/oon-physician-bills-at-in-network-hospitals

2% of emergency room visits and 3% of in-network hospitals result in a surprise bill. In Texas, 27% of emergency room visits and 38% of in-network hospital visits result in a surprise bill.[24] Currently, there is bipartisan support to address surprise billing. In May 2019, Representatives Frank Pallone (D-NJ) and Greg Walden (R-OR) jointly drafted a bill to prevent patients from surprise charges for emergency room visits or receiving non-emergency medical care where the facility is in-network but some providers are not. Additionally, Senators Bill Cassidy (R-LA) and Michael Bennet (D-CO) have also released a "STOP Surprise Medical Bills Act."

Meanwhile, some states have acted on their own to protect consumers from surprise billing. At the end of 2018, 25 states offer some protection, and only nine states have comprehensive protection. Minnesota's law passed in 2018 and offered partial protection. Texas' law offers comprehensive protection and has been enacted but has not yet taken effect. "But not all Texans will be protected by the new law. The Texas law does not apply to people who work for large employers whose plans are regulated by the federal government. In Texas, federally regulated plans account for roughly 40% of the state's health insurance market"[25]
Even with state-level protection we see in the above example that it is better to pass a federal bill than state bills. Employer-provided health plans and other big health insurance plans that have employees in multiple states are regulated at the federal level, whereas some health insurance plans are regulated at the state level. As such, state-level protections would not apply. It would further help states that want to help protect against surprise billing, but only have the ability to regulate one subset of their population.

4. State Attorney General Activity

The Minnesota Attorney General Hospital Agreement[26]
*"The Minnesota Attorney General and most Minnesota hospitals have entered into an agreement relating to the hospitals' billing and collection practices.*
*The following are some of the provisions in the Minnesota Attorney General Hospital Agreement:*

- *The hospital cannot collect debt from the patient unless the applicable insurance company has been billed and given the opportunity to pay the claim, and there is a reasonable basis to believe the patient owes the bill.*

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[24] Pollitz, K., Rae, M., Claxton, G., Cox, C., and Levitt, L. (2019). An examination of surprise medical bills and proposals to protect consumers from them. *Peterson-Kaiser Health System Tracker.* https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them/#item-start

[25] Texas Is Latest State To Attack Surprise Medical Bills, Kaiser Health News https://khn.org/news/texas-is-latest-state-to-attack-surprise-medical-bills/

[26] The Office of Minnesota Attorney General. (2019). Medical Billing Pointers. https://www.ag.state.mn.us/consumer/Publications/MedicalBillingPointers.asp

- *The hospital must offer a reasonable payment plan to patients who are unable to pay the full amount in one payment. The hospital may not refer a debt to a collection agency if the patient makes payments in accordance with the terms of a payment plan agreed to by the hospital.*
- *A patient must be given a reasonable opportunity to submit an application for financial assistance from the hospital.*
- *A hospital's collection agency must forward all patients who object to the collection activity to the hospital. In other words, you have the right to speak with the hospital directly regarding your medical debt.*
- *The collection agency must cease collection activity, pending further review, if the patient states that: (1) he or she does not owe the bill; (2) the insurance company is obligated to pay the bill; or (3) the patient needs further documentation of the bill.*
- *For patients without insurance coverage, a hospital may not charge an uninsured patient more than the hospital would be reimbursed by its largest insurer for those with health insurance. In other words, an uninsured patient cannot be charged more than an insured patient."*

The following information was found on the web site of the Texas Attorney General[27]

*"Access to Health Care Q&A*

*In Texas, all non-profit hospitals are required to provide a certain amount of free health care to people who have no health insurance, or who cannot afford to pay for hospital care.*

***Do all hospitals have to provide charity care?***

*No. The law applies only to non-profit hospitals. For-profit hospitals are not included and public hospitals already are required to provide charity care. Under anti-dumping laws, all hospitals with emergency rooms must treat people who have emergency medical conditions, regardless of their ability to pay.*

***Who is eligible for charity care?***

*Anyone can apply, but hospitals have a right to ask financial questions to determine eligibility. The eligibility criteria are set by the hospital within the limits of the law and are based on a patient's ability to pay. Applicants are responsible for providing necessary financial information in a timely manner*

***Can I be charged an application fee?***

*The application must be offered free of charge.*

***Do hospital charity programs apply only to emergency room care?***

*No. Hospitals also offer this program in clinics and non-emergency hospital admissions.*

***How long can I receive this care?***

*You can receive care as long as you still meet the hospital criteria*

[27] Attorney General of Texas. (2019). Access to Health Care Q&A. https://www2.texasattorneygeneral.gov/faq/access-to-health-care-qa

***Do hospital charity care programs take the place of health insurance, Medicare or Medicaid?***
*No. These programs are not a substitute for health insurance or for any government health assistance programs. Hospitals will usually accept insurance first (including Medicaid or Medicare) and provide care under this program only if you have no insurance and cannot afford to pay*
***How do I know if my local hospital has a charity care program?***
*If your hospital is non-profit, information about the charity care program must be posted in the emergency room and general waiting areas, the business office, and other visible areas. If you are unsure whether a hospital offers charity care, ask an admissions clerk.*
***If I did not know about charity care when I was admitted, can I still apply for it later?***
*Yes. You can request financial assistance at any point—even after being billed by the hospital or a collection agency."*
We could not find the same level of consumer protection from medical debt in Texas as we found in Minnesota.

5. Difference in Income

Income has an impact on a patient's ability to pay their medical expenses. Median medical debt in collections for both states is less than $900, but people are unable to afford these unexpected medical bills, resulting in debt.

| State | GDP | Pop | Non Hispanic White | Hispanic | Black | Median Income | % Poverty |
|---|---|---|---|---|---|---|---|
| Texas | $53,795 | 28,701,845 | 42% | 39.4% | 12.7% | $57,051 | 14.7% |
| Minnesota | 53,704 | 5,611,179 | 79.9% | 5.4% | 6.5% | $65,699 | 9.5% |

[28],[29]

| State | Median $ In Collection | White | Non White |
|---|---|---|---|
| Texas | $850 | $821 | $875 |

[28] https://en.wikipedia.org/wiki/List_of_U.S._states_by_GDP_per_capita

[29] United States Census Bureau. (2019). Quick Facts. https://www.census.gov/quickfacts/tx and https://www.census.gov/quickfacts/mn

| | | | |
|---|---|---|---|
| Minnesota | $342 | $335 | $402 |

According to a survey conducted by the Kaiser Family Foundation and the New York Times, [30]

- 2/3 of medical debt is caused by a one-time or short-term medical expense (e.g. hospital stay or an accident).
- 1/3 of medical debt is related to treatment costs for chronic conditions.
- 55% of those with medical bill problems report debt of $2,500 or more.
- Costs related to emergency room visits (21%), hospitalization (20%), dental care (12%) and diagnostic tests like X-rays and MRIs (11%) account for the largest share of what people owe.

In summary we see more insurance coverage, rare for-profit healthcare hospitals, little surprise billing, greater consumer protection and higher income in Minnesota than Texas. These factors all contribute to the difference between Minnesota and Texas on medical debt and provide us clear examples of what can make a difference. We do not believe that we have exhaustively covered all possible differences between these states but we do believe that we have enough differences to make a few recommendations. Therefore, from a policy standpoint, to decrease medical debt, we recommend the expansion of health care coverage, the elimination of surprise billing and the implementation of more consumer protection around medical billing practices. The IRS outlines the basic consumer protections that any not for profit health system needs to do and a state such as Minnesota is a good model on how to extend those protections.

[30] Hamel, L., Norton, M., Pollitz, K., Levitt, L., Claxton, G. and Brodie, M. (2016). The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey. *Kaiser Family Foundation.* https://www.kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/view/print/#footnote-172784-2