

# *The Medical Debt Crisis In Indianapolis: A Snapshot*



**A Report by the Hospital Accountability Project  
An Initiative of  
Citizens Action Coalition Education Fund  
And  
Indiana Legal Services  
With support from Community Catalyst**

**Embargoed until 11:30 a.m. July 26, 2010**



## About the Indianapolis Hospital Accountability Project

The **Citizens Action Coalition Education Fund (CACEF)** was established in 1976. CACEF's mission is "To improve the quality of life of all inhabitants of the State of Indiana by conducting research, public education and development efforts to conserve natural resources, protect the environment and provide affordable access to essential human services." CACEF is a 501(c)3 organization. Often CACEF partners with the Citizens Action Coalition of Indiana (CAC), a 501(c)4 membership organization that works statewide on consumer, health and environmental issues. Over the last thirty years these organizations have contributed measurably to improving the lives of Hoosiers from all socioeconomic spheres.

Incorporated more than forty years ago, **Indiana Legal Services, Inc. (ILS)** is the largest poverty law firm in Indiana, serving clients in all 92 Hoosier counties. Its mission is to provide poor people with a wide variety of aggressive, quality legal services which will effectively help them to gain equal access to the courts; empower them to control their lives; and impact on the major causes of poverty. ILS attorneys provide free legal counsel on a wide range of civil legal matters; however, consumer law, income maintenance (public benefits) and health care are among the most often raised.

**Community Catalyst** is a national non-profit advocacy organization dedicated to making quality, affordable health care accessible to everyone. Since 1997, Community Catalyst has worked to build consumer and community leadership to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone—especially vulnerable members of society. Community Catalyst's **Hospital Accountability Project** works with advocates across the country to implement state and local hospital practices that regularly involve the community in health planning, protect families from financial devastation due to medical debt, and allow the uninsured and underinsured to seek and receive needed health care services. *For more information, visit [www.communitycatalyst.org](http://www.communitycatalyst.org).*

The **Indianapolis Hospital Accountability Project** is a collaborative effort of the Citizens Action Coalition Education Fund and Indiana Legal Services. This report is first in a series that will examine the impact of hospital debt and the strength of the hospital safety net in Indianapolis. We intend these reports to serve as the basis for ongoing dialogue among nonprofit hospitals, community members, and consumer advocates to ensure that community needing help are able to access information and hospital services. Funding for this Project comes from a grant from Community Catalyst.

*Hospital Accountability Project: Working to ensure that nonprofit hospitals in Indianapolis earn the tax breaks they receive by providing an adequate amount of charity care to underinsured and uninsured citizens.*

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## Executive Summary

The Hospital Accountability Project is working to ensure that nonprofit hospitals in Indianapolis earn the tax breaks they receive by providing an adequate amount of charity care to underinsured and uninsured citizens. This report is the first in a series and examines the impact of hospital debt on individuals and families in Indianapolis and provides an overview of Federal and State statute related to charity care and community benefits.

Nonprofit hospitals receive significant federal, state, and local tax breaks and are expected, in return, to provide “benefit to the community.” These community benefits include a certain amount of care to uninsured and/or underinsured patients in the form of charity care. Charity care - also called free care or financial assistance - is care that is offered at no cost or a reduced cost to individuals who are unable to pay. Charity care and community benefit programs are important components of the health care safety net, often serving as the only alternative for low- and moderate-income individuals who lack affordable health insurance coverage to receive appropriate care.

National studies have found a link between families’ financial health and medical debt. For example, a study published in the American Journal of Medicine concluded that medical bills and illness contributed to 62 percent of all US bankruptcies, and bankruptcies attributed to medical problems rose almost 50 percent between 2001 and 2007.<sup>1</sup> For most, hospital bills were the largest medical expense.<sup>2</sup> A Commonwealth Fund report also shows the growing impact of medical debt on bankruptcies. It states that “...the proportion of working-age Americans who struggled to pay medical bills and accumulated medical debt climbed from 34 percent to 41 percent, or 72 million people, between 2005 and 2007.”<sup>3</sup> At the same time, national uninsured and underinsured rates remain high. According to Families USA, one in four people in Indiana under age 65 were uninsured for all or part of 2007-2008. Remarkably, most of the uninsured are in working families.<sup>4</sup>

The high number of uninsured and underinsured in the state and the strong connection between medical debt and bankruptcies demonstrates the need for effective, well-communicated and well-structured hospital community benefit programs – including free or reduced-cost care. Both Indiana statute and Federal law set requirements for nonprofit hospitals to provide charity care and community benefits. For example, Indiana’s community benefit law (IC 16-21-9) sets parameters and requirements that nonprofit hospitals must meet for providing free and/or reduced cost care to patients, conducting community assessments to identify health care needs, creating community benefit plans for meeting those needs and evaluating the effectiveness of the community benefit plan. But while the requirement to provide community benefits is clear, it is not clear how Marion County nonprofit hospitals – St. Vincent, Indianapolis; St. Francis; Community Hospital East, South and North; and Clarian Health (Indiana University, Riley and Methodist) – are fulfilling these requirements.

To try to determine public awareness of hospital community benefit programs and begin to understand the extent of the hospital debt problem in Indianapolis, a survey tool was created. With 547 responses to date, we have found that:

1. **Insurance does not protect one from hospital debt.** The majority of our respondents – 333 – had insurance, yet 440 individuals reported owing money to a hospital.
  - a. 249 respondents had insurance when they received treatment that resulted in debt;
  - b. 177 reported that insurance covered a portion of the costs and 59 report insurance did not cover any of the costs.
2. **The amount of debt owed by respondents ranged significantly from \$750,000 to \$20.**
  - a. The average owed for the 51 individuals with Medicaid and/or Medicare was \$22,228.
  - b. The average owed for the 389 others was \$22,652.
  - c. The average amount owed for those with \$100,000 or less in debt was \$13,250.
3. **Almost half of respondents marked that they had not been told of any financial assistance or other programs when they were at the hospital.** In addition, anecdotal reports to HAP canvassers and staff included:
  - a. Reports of a financial aid office but no one was available to provide assistance;
  - b. Reports that hospital staff were told the patient was uninsured and they were never told that they might be eligible for financial assistance;
  - c. Reports that individuals called to ask for help with bills, were asked questions by phone, and then told they were not eligible; and
  - d. Requests made for applications for financial assistance and applications were never received or multiple application forms were completed and returned with no response from the hospital(s).
4. **Even though state law requires hospitals to post notices of community benefits and financial assistance, the majority of people HAP staff spoke with and responded to the survey were surprised to hear that they might have been eligible for financial assistance.**

For many, Indiana's community benefit programs remain a best kept secret.

### **Recommendations**

#### **Public Notification**

1. Information that services are available at no or low cost must be clearly posted in a variety of places throughout the hospital, on the hospitals website, and throughout the community. This should include:
  - a. Posting in all waiting rooms

- b. Provided verbally and in writing at the time an individual registers or pre-registers with the hospital.
  - c. Provided verbally when an individual contacts the hospital requesting an appointment, and in any documents that are sent to the individual prior to the appointment.
  - d. The hospital employee responsible for getting signatures on discharge papers should be required to remind the patient and/or their family that the hospital has a financial assistance program, and application papers should be provided in the discharge packet.
  - e. Post relevant information at local community organizations and/or faith based organizations and the township trustee.
  - f. Prominently posted on the hospital website
  - g. Include information on the types of discounts that are available and detailed information on eligibility guidelines.
2. Areas that have information posted on community benefit programs should also contain applications for all relevant government insurance programs such as Medicaid, Medicare, Healthy Indiana Plan, and Hoosier Healthwise with assistance provided in filing for benefits as needed.
  3. Information posted should be available in alternate languages as well as alternate formats for individuals with disabilities.
  4. Staff working in areas such as hospital clinics, billing departments, emergency rooms and other relevant areas should be provided adequate information on the types of charity care and community benefits available at the hospital. These individuals should be able to explain the programs and services to anyone when asked and be able to answer all questions or direct the questions to someone who can provide an accurate answer within a short period of time.
  5. Details should be available via the hospital's website.

**Billing/Payment Plans for Community Benefits** – All billing must be clear, concise and easy to understand.

1. Upon discharge from care, the patient must be reminded that the hospital has a financial assistance program that may be able to help with payment of bills.
2. Any and all bills sent to a patient must include information on available payment plans as well as other assistance that may help with the payment of outstanding debt.
3. If there is no response following multiple written correspondence, protocol should be established for attempting to contact the individual in person or by phone prior to sending unpaid bills to a debt collection service.
4. Payment plans **MUST** be designed with cooperation between the hospital and the patient. Payments must be reasonable based on the individual income and expenses and not based on a rigid pre-determined pay scale.
5. Individuals who have trouble paying for care should be provided applications to appropriate health insurance such as Medicaid, Medicare, HIP and Hoosier Healthwise. As appropriate these individuals should also be provided assistance in completing these application forms.

6. Establishing partnerships with local community and faith based organizations to help with providing education and information on payment plans and community benefits.

**Additional items to consider:**

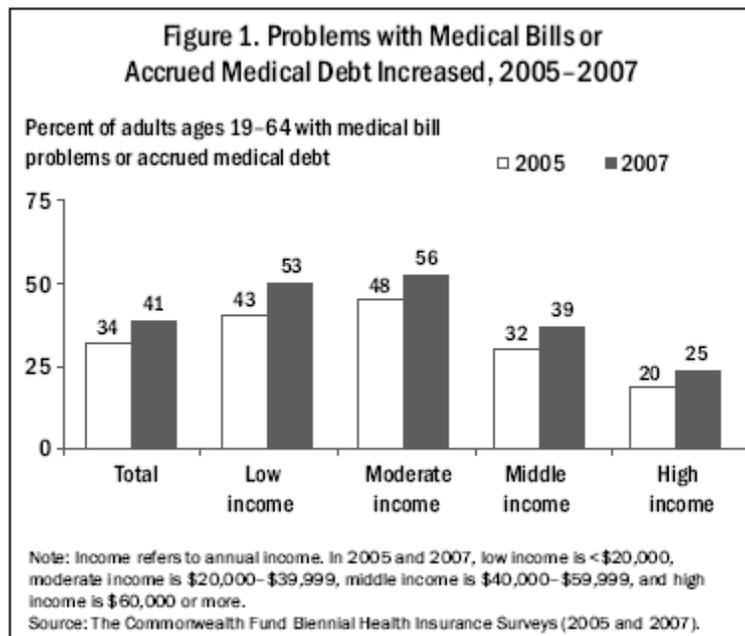
1. At all “Health Fairs” and other community outreach events information should be available in the form of brochures or other written materials that inform attendees of financial assistance that is available from the hospital.
2. All staff who may answer the phone – whether in billing or general operators – must have information on who to contact when individuals call asking for financial assistance and/or community benefits and should have basic information on the type of financial assistance that may be available.
3. Financial assistance counselors/appropriate staff must be available at all times in the emergency room to provide information on financial assistance and to answer questions.

## Background

### The Impact of Medical Debt

Medical debt and its lasting impact on financial stability is a growing problem across the country and in Indiana. A quick review of newspaper articles and an online search provide some information on medical debt and the negative impact on families, while a more in-depth review of research demonstrates that the impact of medical debt, even for those with insurance, can be devastating. A study published in the American Journal of Medicine concluded that medical bills and illness contributed to 62 percent of all US bankruptcies and that “For 92% of the medically bankrupt, high medical bills directly contributed to their bankruptcy.” The study also shows that bankruptcies attributed to medical problems rose almost 50 percent between 2001 and 2007.<sup>5</sup> Remarkably, this study found that most of the medically bankrupt families were middle class, and that most individuals who file for bankruptcy had some form of health insurance when they got sick. Furthermore, among medical debtors, hospital bills were the largest medical expense.<sup>6</sup>

A Commonwealth Fund report further demonstrates the growing impact of medical debt on bankruptcies. It states that “...the proportion of working-age Americans who struggled to pay medical bills and accumulated medical debt climbed from 34 percent to 41 percent, or 72 million people, between 2005 and 2007.” The report goes on to state: “Because of medical bills or accumulated medical debt, an estimated 28 million adults reported they used up all their savings, 21 million incurred large credit card debt, and another 21 million were unable to pay for basic necessities.”<sup>7</sup>



Seeing Red: The Growing Burden of Medical Bills and Debt Faced by U.S. Families P. 2

**Lack of Access to Affordable Coverage**

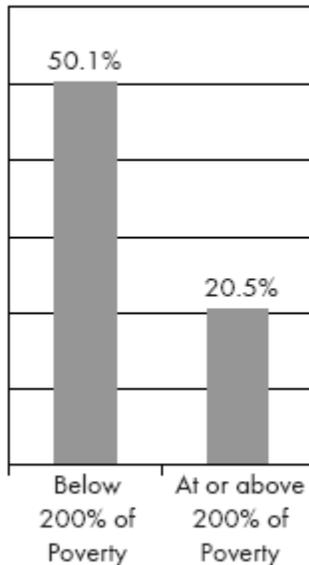
Many across the country and in Indiana lack access to affordable medical treatment, even when they have insurance. Lack of access to affordable health care and affordable health insurance is a national emergency and contributes to the problems of medical debt. A March 2009 Families USA report shows that one in three (or 86.7 million people) under age 65 were uninsured for some or all of the two year period 2007-2008. The study also shows that 79.2% (four out of five individuals) who were uninsured during 2007-2008 were from working families. Many that are uninsured or underinsured are more likely to forgo or delay necessary treatment, go without screenings or preventive care, and are likely to pay more for care. <sup>8</sup>

People in Families with High Health Care Costs, 2000 to 2009 <sup>9</sup>

Share of Family Pre-Tax Income Spent on Health Care	People with High Health Care Costs		Increase 2000-2009	
	2000	2009	Number	Percent
More than 10 Percent	41,701,000	64,374,000	22,673,000	54.4%
More than 25 Percent	11,647,000	18,710,000	7,063,000	60.6%

In Indiana it is estimated that more than 29 percent - or one in four people under age 65 – were uninsured for all or part of 2007-2008 and that 70 percent were uninsured for six months or longer. In Indiana, almost 78 percent of the uninsured were in working families; and, families with incomes below 200 percent of the federal poverty line were more likely to be uninsured than families with incomes above 200 percent of the federal poverty line. <sup>10</sup>

Percent Uninsured during 2007-2008, by Income



The Uninsured: A Closer Look. Hoosiers without Health Insurance

Another group with limited access to affordable health care are those who are underinsured. The number of underinsured adults has increased – up 60 percent between 2003 and 2007 – an estimated 25 million adults. Much of this increase is among middle

class adults. About 53 percent of the underinsured and 68 percent of the uninsured went without needed care, compared to only 31 percent of insured adults who report going without care. About 45 percent of the underinsured and 51 percent of the uninsured reported problems paying bills, being contacted by collection agencies, or changing their way of life to pay medical bills, compared to 21 percent of insured adults who reported financial stress related to medical bills:<sup>11</sup>

Some of the issues faced by uninsured and underinsured families will be addressed by the Affordable Care Act (ACA) but for many, coverage will not be available until 2014 and what is available at that point will not cover everyone. The remaining gaps in care and challenges faced by uninsured and underinsured will continue to be a challenge for all of us to address.

### **Role of the Hospital Safety Net**

Hospital charity care and community benefit programs are important pieces of the health care safety net. There is an expectation that hospitals, especially nonprofit hospitals, will provide a certain amount of free or reduced-cost care, along with other community benefits, to eligible patients. This expectation is based on a number of factors, including:

- Nonprofit hospitals receive significant federal, state, and local tax breaks. In return, there is an expectation that they will provide a certain amount of “community benefits” - that is, unreimbursed goods, resources and services that address health needs identified by the hospital’s community, particularly those who are uninsured, underinsured or underserved. Charity care, or free care, is an important kind of community benefit.<sup>12</sup> It is care provided to uninsured and underinsured patients at reduced or no cost.
- Indiana specifically requires nonprofit hospitals to provide unreimbursed community benefit programs, including charity care (free and/or reduced cost services). The law outlines what hospitals must do to notify patients of available programs and requires annual reporting.
- Indiana also operates a separate program, known as the Health Care for the Indigent Program, which uses state funds to reimburse hospitals for low-income individuals requiring emergency hospital care.
- Most, if not all, nonprofit hospitals include in their mission statements that they provide services to all in need, regardless of their ability to pay.
- Many hospitals receive reimbursement for the free care they provide including funds from Medicare for teaching hospitals to train physicians, as well as from charitable donations directly to the hospital or to foundations connected to the hospital.<sup>13</sup>

### **Existing State and Federal Standards for Private Nonprofit Hospitals**

Both Indiana law and federal law include additional charity care and community benefit requirements for certain hospitals that qualify for tax-exempt status. This next section summarizes those provisions.

### Indiana's Community Benefits Law

**Indiana state law** defines both charity care and community benefits (IC 12-16 and IC 16-21-9). The charity care statute outlines the Health Care for the Indigent program (HCI) which pays for both inpatient and outpatient care that is directly related to emergency treatment. The community benefit statute outlines requirements that nonprofit hospitals must meet. While these terms are used interchangeably, for the purposes of this report they will be used to define two separate programs as defined by Indiana law. See Appendix I for the full text of both statutes.

Indiana's **Community Benefits** law (**IC 16-21-9-1**) establishes the community benefit requirements that all nonprofit hospitals in the state must meet. The law defines community benefit as:

“...the unreimbursed cost to a hospital of providing charity care, government sponsored indigent health care, donations, education, government sponsored program services, research, and subsidized health services. The term does not include the cost to the hospital of paying any taxes or other governmental assessments.”

In addition to defining the term “community benefit,” the statute outlines other requirements that nonprofit hospitals must follow. The law requires that all nonprofit hospitals:

- Develop a mission statement that the hospital is committed to serving the health care needs of the community and create a community benefits plan with a budget, goals and measurable objectives for providing community benefits, as well as a way to evaluate effectiveness;
- Conduct a community needs assessment to identify the health care needs of the community and develop a community benefit plan that includes a way to evaluate the effectiveness of the plan and has measurable objectives.
- Prepare a detailed annual report of the community benefits plan to be filed annually with the state department of health. This section also requires that each hospital develop a written statement notifying the public of the annual report and requires them to develop a written notice about any charity care program and the application process for such program operated by the hospital. It also requires that the notices be posted in the general waiting area, emergency services waiting area, the business office and other areas that may be appropriate.<sup>14</sup>

### Indiana's Health Care for the Indigent Program

In addition to specifying nonprofit hospitals' charity care and community benefit requirements, Indiana also operates a separate program which reimburses hospitals for emergency care they give to low-income patients who are unable to pay for their care. The **Health Care for the Indigent program** (HCI) (**IC 12-16**) has different requirements for participating hospitals, in addition to the charity care and community benefit programs listed above. The statute includes information on program administration, eligibility requirements, application process and rates of payment HCI pays for both inpatient and outpatient care that is directly related to emergency treatment.

In Marion County, expenses at hospitals other than Wishard Memorial Hospital are covered only to a limit determined by a state medical review team. Applications must be filed within 30 working days of admission and a decision is made within 45 days of application. The HCI program should be considered separately from community benefits which are covered in this report.

### **New Federal Requirements for Charity Care and Community Benefit**

In addition to state law, there are federal community benefit requirements that nonprofit hospitals must follow. Federal tax-exempt status is based on the community benefit standard, a test applied by the IRS to determine whether a hospital is "...operated to promote health in a manner that serves a charitable purpose and, accordingly, merits tax-exempt status."<sup>15</sup> The original statute dates back to the 1960's and is widely regarded as outdated as a tool for accurately measuring nonprofit hospitals' contributions to their community, given the changes that have occurred in the health care marketplace over the past fifty years. More recently, however, the IRS has shown some interest in re-examining the community benefit standard. Its most notable change to date includes the 2009 addition of Schedule H, a new reporting form that will capture unprecedented amounts of data on hospital charity care and community benefit.

#### **After the trauma - Navigating the billing maze**

C.S. of Indianapolis was airlifted to Methodist Hospital in Indianapolis following a car accident in September 2009. While all of the bills clearly state that C.S. is uninsured and unemployed, she has been billed over \$150,000 for surgeries, emergency services and treatment, and follow-up services she has received. Nine months after the accident C.S. is still trying to get assistance for over \$150,000 in bills.

Even though the emergency services, surgeries and treatment were done at Methodist Hospital (part of Clarian Health) there are separate bills from the anesthesiologists, radiologist and others making the process of figuring out who to talk to about getting financial aid very hard. C.S. has filed a request for financial assistance a few times with both Clarian Health and Clarian Home Care providers as well as with the respiratory and critical care providers, the anesthesiologist and the air ambulance. C.S. is grateful for the assistance she's received to date but has stated that the process could be easier if billings were more clearly written and the process of applying for assistance more clearly defined.

In addition to unpaid bills, C.S. has been given conflicting information from different providers. At discharge, someone at the hospital told that her she would get the items she needed, including a walker, and that there would be no charge. Imagine her surprise when she received a bill for these items, including one with a monthly rental fee. When she contacted the provider to ask about the charges and explained that she had been told they would be "given" to her at no cost, she was informed that the person who told her that shouldn't have, and that hospital staff did not have the authority to determine what is "free" and what is billed.

For C.S., the lack of clarity in financial assistance policies and the lengthy process of getting a decision from the hospital has delayed additional surgeries, her recuperation and added to her stress as she wonders how she will pay for medical expenses, daily living expenses or even find a job. C.S. believes if it wasn't for the financial and emotional support from her family, this would be impossible to handle.

But while Schedule H simply requires hospitals to report additional information about their community benefit and charity care activities, the recently passed federal health reform law, the *Patient Protection and Affordable Care Act* (PPACA) adds new requirements that nonprofit hospitals must meet to keep their federal tax-exempt status. Specifically, Section 9007 of PPACA amends section 501(c)3 of the Internal Revenue Code by adding four new conditions hospitals must meet to qualify as tax-exempt under the federal tax code. The hospitals must:

1. Develop written financial assistance policies which must state:
  - a. Whether they offer free or discounted care;
  - b. Eligibility criteria and how to apply for financial assistance;
  - c. How they decide how much patients are charged for care;
  - d. How the hospital might collect payments, unless the hospital already has a separate billing/debt collection policy in place;
  - e. How the hospital will publicize the policy in the community.
2. Limit what they charge for services:
  - a. Hospitals are prohibited from using “gross charges.” The term “gross charges” is not defined by law but is generally accepted to mean the hospital’s list price for services without any negotiated discounts.
  - b. If a patient qualifies for financial assistance and is in need of emergency or other medically necessary care, he or she may only be charged the “amounts generally billed” to insured patients for the same services.
3. Observe fair billing and debt collection practices. Nonprofit hospitals need to make a “reasonable effort” to determine if a patient qualifies for financial assistance before pursuing “extraordinary” debt collection activities.
4. Conduct regular community needs assessment at least every three years, seek input from community members, make the assessments available to the public and adopt strategies for meeting needs identified.<sup>16</sup>

These new requirements are in effect in 2010, with one exception; the community needs assessment becomes effective in March 2012.

### **Statement of the Problem: Lack of Transparency, Consistency, and Compliance**

While it is clear that uninsured and underinsured individuals may have difficulty paying their medical bills and that nonprofit hospitals are required to provide a certain amount of free or reduced cost care, most people are unaware that these programs are available. The recently released *Best Kept Secrets: Are Non-Profit Hospitals Informing Patients About Charity Care Programs*, confirms the need for hospitals to do a better job of providing information to patients and communities. The Access Project surveyed 99 randomly selected nonprofit hospitals – checking hospital websites and calling hospital representatives to see if they complied with the American Hospital Association (AHA) guidelines regarding charity care/community benefits. They found that:

- 85 hospitals mentioned the availability of charity care.
- Fewer than half of these (41) provided application forms

- Only about a quarter of the hospitals (26) provided information about who qualified for charity care.
- Only about a third (34) provided information in a language other than English.<sup>17</sup>

In addition to people being unaware that financial assistance programs exist, the lack of a clear definition of how much a nonprofit hospital should invest in financial assistance and a lack of consistent rules regarding notification of patients means many patients are unaware that assistance is available and many end up bankrupt or with their credit ruined.

### **Purpose of the Survey**

In our work to understand whether nonprofit hospitals in Indianapolis were communicating their policies and providing an adequate amount of charity care to underinsured and uninsured citizens, the Indianapolis Hospital Accountability Project (HAP) created a survey to:

1. Help understand the scope of the medical debt problem in Indianapolis; and
2. Determine how well nonprofit hospitals provide patients with information about community benefits/financial assistance programs.

A copy of the survey tool can be found in Appendix II.

The survey tool has been distributed at neighborhood block parties, through community centers and multi-service centers, community meetings, and at other events including area farmers' markets and health fairs. In addition, canvassers have knocked on thousands of doors in different areas of Indianapolis talking to people about medical debt and hospital issues and asking people to complete surveys. Through these venues, HAP has collected 547 surveys. The highlights of the HAP survey results are listed below along with comments from canvassers and respondents. A summary of all responses is available in Appendix III. Please note that every respondent did not respond to every section of the survey.

### **Survey Findings**

Demographic breakdown shows that 388 of the respondents were women and the average age was 44. In addition, 66 respondents were covered by Medicaid or Medicare, with 10 covered by both programs, the average age for this group was 52. Family incomes ranged from \$0 to \$100,000 with 121 saying they are working full-time; 52 working part-time; and 167 stating they are unemployed. There were also 105 who checked an "other" category for employment. This included individuals seeking disability, on disability or temporary disability as well as individuals receiving help from friends and family.

Numerous national studies and reports show that insurance does not protect one from hospital debt. Our HAP survey results support similar findings in Indianapolis. Of the 547 individuals responding, 267 reported having insurance and 211 reported being uninsured, with 66 covered by Medicaid and/or Medicare. Of those with insurance, 183

reported that they utilize the insurance, while 19 say they do not. Reasons given for not using insurance included:

- Co-pay too high – 34
- Deductible too high – 28
- Insurance not covering what is needed - 35
- Other reasons – 19

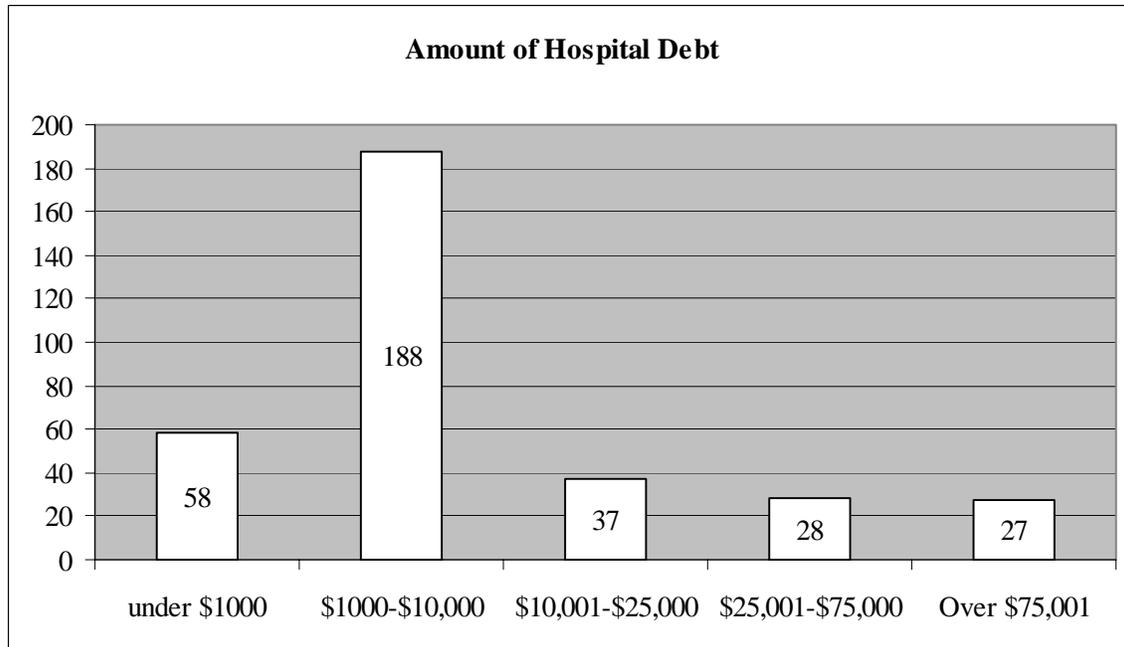
**Insurance doesn't guarantee financial security:**

S.S. has insurance for herself and her family yet currently owes approximately \$6,000 in hospital bills for services they received from Riley Hospital (a part of Clarian Health) and St. Francis. The money owed is from co-pay and deductibles. When S.S. contacted Clarian Health about assistance with the bills from Riley Hospital, she was told she could apply for financial assistance over the phone. After answering a few questions on income and some expenses (house, utilities, car payment and insurance), she was told that they are not eligible for assistance because they can make payments. S.S. again requested an application be sent so that she could provide more complete information about income and expenses and is waiting to receive the application

In dealing with St. Francis SS is experiencing other frustrations with debt ranging from 2007. S.S. has attempted to contact the billing office at St. Francis to ask for assistance. She has had difficulty obtaining help because many of the bills have been sent to collections, and each is a separate account with the collection agency. S.S. believes that if she had been notified before the hospital sent the bills to a collection agency she might have been able to negotiate an affordable payment plan and possibly received some financial assistance with the bills. Without a payment plan or financial assistance, S.S. is not sure how she will pay these bills and continue to cover the daily living expenses for herself and her family. Her credit rating has already been damaged.

Despite the fact that more than half of the respondents reported having insurance either private or Medicaid/Medicare, 440 individuals reported owing money to a hospital. Furthermore, 249 respondents reported that they had insurance when they received treatment that resulted in debt. And, 177 reported that insurance covered only a portion of the costs, while 59 report insurance did not cover any of the costs. The amount owed to hospitals ranged from \$750,000 to \$20.

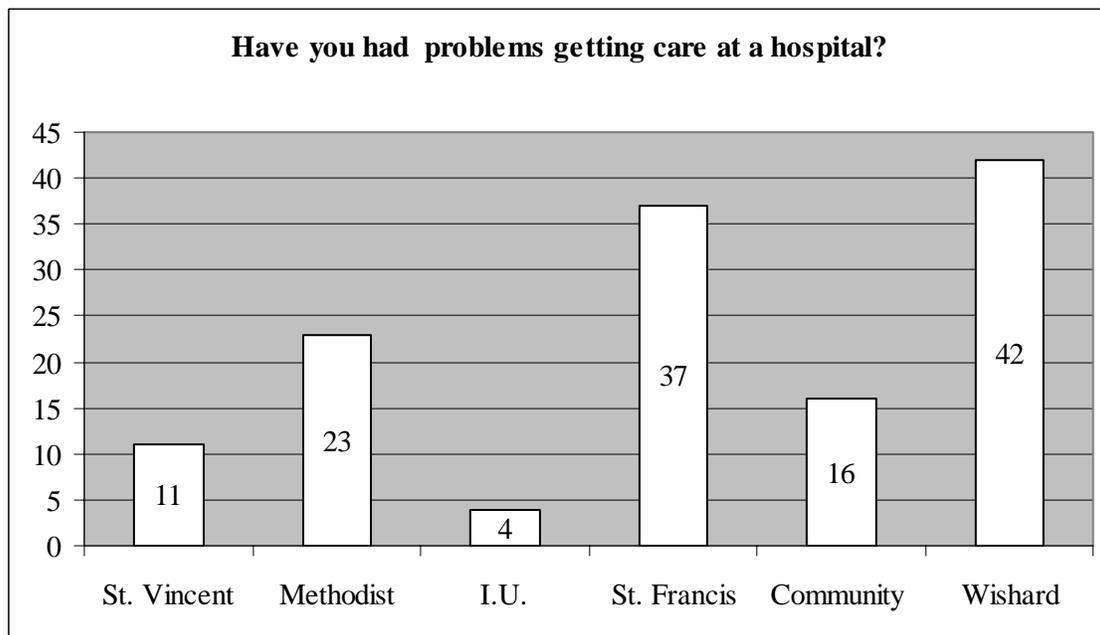
- Of the 51 individuals with Medicaid and/or Medicare that owed money to hospitals, the averaged owed was \$25,669. The amounts owed by all ranged from \$200,000 to \$100.
- Of the 389 others who owed hospital debt, the averaged owed was \$22,724 and ranged from \$750,000 to \$20. The average amount owed for those with \$100,000 or less in debt was \$13,250.



Does not include Medicaid and/or Medicare debt.

Respondents also reported having difficulties accessing care, in addition to having hospital debt:

- 95 respondents reported having trouble getting care at a hospital;
- 250 reported not going to the hospital because they are scared of the cost; and
- 110 reported being asked to pay before receiving medical care. This includes being asked to pay co-payments prior to treatment. Some report that they were able to make payments on these charges, while others were told to come back when they had the money.



We also asked respondents to state whether they had been told about any help or financial assistance programs while at the hospital. Specifically, we asked respondents:

While at the hospital were you told about (check all that apply)

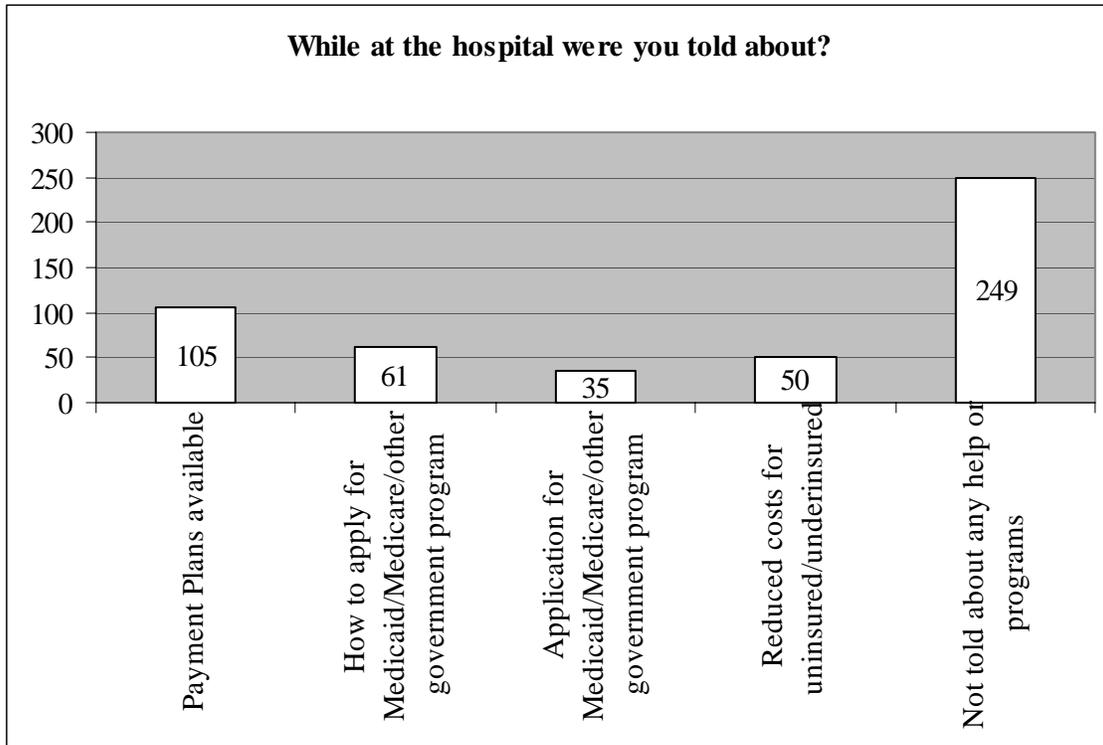
105 - Payment plans are available

61 - How to apply for Medicaid/Medicare or other government program

35 - An application for Medicaid/Medicare or other government program.

50 - Reduced costs for uninsured or underinsured

249 - Not told about any help or programs



These results are troubling since state law requires nonprofit hospitals to develop a written notice about any charity care program and the application process for such programs and posts notices in various locations in the hospital. Our survey suggests that such programs are not being communicated effectively to patients and the public. In fact, almost half of our respondents marked that they had not been told of any help or programs.

In addition, anecdotal reports to HAP canvassers and staff included:

- Reports of a financial aid office that was never staffed.
- Statements that individuals told hospital staff that they had no insurance and were never told that they might be eligible for financial assistance.
- Reports that individuals had called to ask about help with bills, were asked question by phone, and then told they were not eligible for programs.

One respondent reported that when she called to ask about financial assistance, she was told she did not qualify and that, based on the hospital calculation, she could pay. When

she insisted she could not, the hospital staff told her to get a loan to pay off the bill. The individual reports that she did take out a loan and is now paying off the bank instead of the hospital.

These findings support much of what has been reported nationally: in Indiana, hospital charity care is a secret to many patients who are truly in need of safety net services. While the findings from the surveys are disturbing to review, they do begin to demonstrate that improvements need to be made. Indiana nonprofit hospital community benefit programs should not be a “Best Kept Secret.”

### **Recommendations and Next Steps**

The following are initial recommendations and most center on stricter monitoring and enforcement of current state and federal law. Based on HAP survey findings and conversations with individuals around the city, it is clear that many parts of current state law are not being implemented consistently at each hospital. While this inconsistency and lack of compliance with state law is problematic in its own right, it has further implications as Indiana hospitals prepare to comply with new IRS reporting standards and federal requirements geared toward increasing transparency and protecting consumers from poor billing practices. We welcome the opportunity to work together with hospitals and state official to adopt notification, billing and debt collection standards that meet the needs of Indiana residents, and we recommend that hospitals be required to meet the following standards:

#### **Public Notification**

1. Information that services are available at no or low cost must be clearly posted in a variety of places throughout the hospital, on the hospitals website, and throughout the community. This should include:
  - a. Posting in all waiting rooms
  - b. Provided verbally and in writing at the time an individual registers or pre-registers with the hospital.
  - c. Provided verbally when an individual contacts the hospital requesting an appointment, and in any documents that are sent to the individual prior to the appointment.
  - d. The hospital employee responsible for getting signatures on discharge papers should be required to remind the patient and/or their family that the hospital has a financial assistance program, and application papers should be provided in the discharge packet.
  - e. Post relevant information at local community organizations and/or faith based organizations and the township trustee.
  - f. Prominently posted on the hospital website
  - g. Include information on the types of discounts that are available and detailed information on eligibility guidelines.
2. Areas that have information posted on community benefit programs should also contain applications for all relevant government insurance programs such as Medicaid, Medicare, Healthy Indiana Plan and Hoosier Healthwise with assistance provided in filing for benefits as needed.

3. Information posted should be available in alternate languages as well as alternate formats for individuals with disabilities.
4. Staff working in areas such as hospital clinics, billing departments, emergency rooms and other relevant areas should be provided adequate information on the types of charity care and community benefits available at the hospital. These individuals should be able to explain the programs and services to anyone when asked and be able to answer all questions or direct the questions to someone who can provide an accurate answer within a short period of time.
5. Details should be available via the hospital's website.

**Billing/Payment Plans for Community Benefits** – All billing must be clear, concise and easy to understand.

1. Upon discharge from care, the patient must be reminded that the hospital has a financial assistance program that may be able to help with payment of bills.
2. Any and all bills sent to a patient must include information on available payment plans as well as other assistance that may help with the payment of outstanding debt.
3. If there is no response following multiple written correspondence, protocol should be established for attempting to contact the individual in person or by phone prior to sending unpaid bills to a debt collection service.
4. Payment plans **MUST** be designed with cooperation between the hospital and the patient. Payments must be reasonable based on the individual income and expenses and not based on a rigid pre-determined pay scale.
5. Individuals who have trouble paying for care should be provided applications to appropriate health insurance such as Medicaid, Medicare, HIP and Hoosier Healthwise. As appropriate these individuals should also be provided assistance in completing these application forms.
6. Establishing partnerships with local community and faith based organizations to help with providing education and information on payment plans and community benefits.

**Additional items to consider:**

1. At all "Health Fairs" and other community outreach events information should be available in the form of brochures or other written materials that inform attendees of financial assistance that is available from the hospital.
2. All staff who may answer the phone – whether in billing or general operators – must have information on who to contact when individuals call asking for financial assistance and/or community benefits and should have basic information on the type of financial assistance that may be available.
3. Financial assistance counselors/appropriate staff must be available at all times in the emergency room to provide information on financial assistance and to answer questions.

Future HAP reports will look more specifically at each nonprofit hospital/hospital system in Marion County and the community benefit programs they run as well as the amount of money invested in community benefits. In addition, we will be working to better identify areas where compliance with state and federal law could be improved to benefit uninsured and underinsured Hoosiers.

## **Conclusion**

This first report provides a general overview of state and federal law related to community benefits and charity care. It also outlines the results from our survey, which demonstrate that many individuals—including employed persons and those with insurance coverage—have difficulty finding affordable care and accessing information about available charity care programs when they cannot afford to pay. These initial results suggest that some Indianapolis residents may struggle to receive appropriate care while avoiding medical debt. This, in turn, has implications for the overall health and financial stability of people living in our community.

Our findings also raise questions about the adequacy of state oversight of hospital community benefit programs, as well as the effectiveness of the strategies hospitals may currently be using to communicate these programs to patients. For example, if state law requires hospitals to post notices of community benefit programs, why are so many respondents unaware of the programs? Given the number of respondents who reported that they struggle with significant hospital debt, are existing hospital charity care programs adequately structured to meet the needs of community members?

Finally, we recognize that the issues faced by the uninsured and underinsured are complex. Many factors have contributed to the rise of medical debt. While nonprofit hospitals cannot fix these problems on their own, there are things that they are uniquely positioned and expected to do to ensure that community members in need of care do not continue to fall through the cracks.

## **Appendix I**

### **IC 12-16-2.5-1: Hospital Care for the Indigent And IC 16-21-9: Provision of Charitable Care by Nonprofit Hospitals**

## **IC 12-16-2.5**

Chapter 2.5. Hospital Care for the Indigent; Administration and General Provisions

### **IC 12-16-2.5-1 Administration of program**

Sec. 1. The division shall administer the hospital care for the indigent program under this article. *As added by P.L.120-2002, SEC.18.*

**IC 12-16-2.5-2 Repealed** (*Repealed by P.L.146-2008, SEC.819.*)

**IC 12-16-2.5-3 Repealed** (*Repealed by P.L.145-2005, SEC.31.*)

### **IC 12-16-2.5-4 Disproportionate share of low income patients; calculating allowable disproportionate share additional payments**

Sec. 4. To the extent permitted under federal statutes or regulations, patient days for patients under the hospital care for the indigent program shall be included in calculating allowable disproportionate share additional payments under 42 U.S.C. 1395 ww(d). *As added by P.L.120-2002, SEC.18.*

### **IC 12-16-2.5-5 Program not applicable to inmates and patients of certain institutions**

Sec. 5. The hospital care for the indigent program does not apply to inmates and patients of institutions of the department of correction, the state department of health, the division of mental health and addiction, the division of aging, or the division of disability and rehabilitative services.

*As added by P.L.120-2002, SEC.18. Amended by P.L.141-2006, SEC.57.*

**IC 12-16-2.5-6 Repealed** (*Repealed by P.L.255-2003, SEC.55.*)

### **IC 12-16-2.5-6.3 Definitions**

Sec. 6.3. For purposes of this article, the following definitions apply to the hospital care for the indigent program:

- (1) "Assistance" means the satisfaction of a person's financial obligation under IC 12-16-7.5-1.2 for hospital items or services, physician services, or transportation services provided to the person.
- (2) "Claim" means a statement filed with the division by a hospital, physician, or transportation provider that identifies the health care items or services the hospital, physician, or transportation provider rendered to a person for whom an application under IC 12-16-4.5 has been filed with the division.
- (3) "Eligible" or "eligibility", when used in regard to a person for whom an application under IC 12-16-4.5 has been filed with the division, means the extent to which:
  - (A) the person, for purposes of the application, satisfies the income and resource standards established under IC 12-16-3.5; and
  - (B) the person's medical condition, for purposes of the application, satisfies one (1) or more of the medical conditions identified in IC 12-

16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3). *As added by P.L.145-2005, SEC.3.*

**IC 12-16-2.5-6.5 Repealed** (*Repealed by P.L.212-2007, SEC.31; P.L.218-2007, SEC.52.*)<sup>18</sup>

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**IC 16-21-9 Chapter 9. Provision of Charitable Care by Nonprofit Hospitals**

**IC 16-21-9-1 "Community benefits" defined**

Sec. 1. As used in this chapter, "community benefits" means the unreimbursed cost to a hospital of providing charity care, government sponsored indigent health care, donations, education, government sponsored program services, research, and subsidized health services. The term does not include the cost to the hospital of paying any taxes or other governmental assessments. *As added by P.L.94-1994, SEC.17.*

**IC 16-21-9-2 "Government sponsored indigent health care" defined**

Sec. 2. As used in this chapter, "government sponsored indigent health care" means the unreimbursed cost to a hospital of Medicare, providing health care services to recipients of Medicaid, and other federal, state, or local indigent health care programs, eligibility for which is based on financial need. *As added by P.L.94-1994, SEC.17.*

**IC 16-21-9-3 "Nonprofit hospital" defined**

Sec. 3. As used in this chapter, "nonprofit hospital" means a hospital that is organized as a nonprofit corporation or a charitable trust under Indiana law or the laws of any other state or country and that is:

- (1) eligible for tax exempt bond financing; or
- (2) exempt from state or local taxes. *As added by P.L.94-1994, SEC.17.*

**IC 16-21-9-4 Organizational mission statement; community benefits plan**

Sec. 4. A nonprofit hospital shall develop:

- (1) an organizational mission statement that identifies the hospital's commitment to serving the health care needs of the community; and
- (2) a community benefits plan defined as an operational plan for serving the community's health care needs that:
  - (A) sets out goals and objectives for providing community benefits that include charity care and government sponsored indigent health care; and
  - (B) identifies the populations and communities served by the hospital.*As added by P.L.94-1994, SEC.17.*

**IC 16-21-9-5 Health care needs of community**

Sec. 5. When developing the community benefits plan, the hospital shall consider the health care needs of the community as determined by communitywide needs assessments. *As added by P.L.94-1994, SEC.17.*

### **IC 16-21-9-6 Elements of community benefits plan**

Sec. 6. The hospital shall include at least the following elements in the community benefits plan:

- (1) Mechanisms to evaluate the plan's effectiveness, including a method for soliciting the views of the communities served by the hospital.
- (2) Measurable objectives to be achieved within a specified time frame.
- (3) A budget for the plan. *As added by P.L.94-1994, SEC.17.*

### **IC 16-21-9-7 Annual report for community benefits plan**

Sec. 7. (a) Each nonprofit hospital shall prepare an annual report of the community benefits plan. The report must include, in addition to the community benefits plan itself, the following background information:

- (1) The hospital's mission statement.
- (2) A disclosure of the health care needs of the community that were considered in developing the hospital's community benefits plan.
- (3) A disclosure of the amount and types of community benefits actually provided, including charity care. Charity care must be reported as a separate item from other community benefits.

(b) Each nonprofit hospital shall annually file a report of the community benefits plan with the state department. The report must be filed not later than one hundred twenty (120) days after the close of the hospital's fiscal year.

(c) Each nonprofit hospital shall prepare a statement that notifies the public that the annual report of the community benefits plan is:

- (1) public information;
- (2) filed with the state department; and
- (3) available to the public on request from the state department.

This statement shall be posted in prominent places throughout the hospital, including the emergency room waiting area and the admissions office waiting area. The statement shall also be printed in the hospital patient guide or other material that provides the patient with information about the admissions criteria of the hospital.

(d) Each nonprofit hospital shall develop a written notice about any charity care program operated by the hospital and how to apply for charity care. The notice must be in appropriate languages if possible. The notice must also be conspicuously posted in the following areas:

- (1) The general waiting area.
- (2) The waiting area for emergency services.
- (3) The business office.
- (4) Any other area that the hospital considers an appropriate area in which to provide notice of a charity care program. *As added by P.L.94-1994, SEC.17.*

### **IC 16-21-9-8 Failure to file annual report**

Sec. 8. The state department may assess a civil penalty against a nonprofit hospital that fails to make a report of the community benefits plan as required under this

chapter. The penalty may not exceed one thousand dollars (\$1,000) for each day a report is delinquent after the date on which the report is due. No penalty may be assessed against a hospital under this section until thirty (30) business days have elapsed after written notification to the hospital of its failure to file a report.

*As added by P.L.94-1994, SEC.17.*

**IC 16-21-9-9 Other rights and remedies retained**

Sec. 9. The rights and remedies provided for in this chapter are in addition to other statutory or common law rights or remedies available to the state or a nonprofit hospital. *As added by P.L.94-1994, SEC.17<sup>19</sup>*

## **Appendix II**

# **Hospital Accountability Project Survey Tool**



The Citizens Action Coalition Education Fund (CACEF) is the research and education arm of the Citizens Action Coalition (CAC), Indiana's oldest and largest consumer lobbying group. Both CAC and CACEF work for fair utility rates, affordable health care and a clean environment.

CACEF is working on a Hospital Accountability Project (HAP) in Marion County. The project's goal is to ensure that nonprofit hospitals in Indianapolis earn the tax breaks they receive by providing an adequate amount of charity care to underinsured and uninsured citizens.

Your responses to this survey will help us understand how local hospital practices are affecting individuals and families in Marion County. If you have problems with hospital bills, please complete the survey below. No personal information provided will be used without obtaining your permission first.

---

**Do you have health insurance?** \_\_\_ Yes \_\_\_ No

**If Yes: Do you use it?** \_\_\_ Yes \_\_\_ No

**If you don't use your insurance why?**

\_\_\_ Co-pay too high      \_\_\_ Deductible too high      \_\_\_ Doesn't cover what I need  
\_\_\_ Other \_\_\_\_\_

---

**Do you owe money to a hospital?**

\_\_\_ Yes – approximately how much? \_\_\_\_\_

\_\_\_ No

**What hospital(s) do you owe?**

\_\_\_ St. Vincent

\_\_\_ St. Francis

\_\_\_ Methodist

\_\_\_ Community Hospital

\_\_\_ IU

\_\_\_ Other \_\_\_\_\_

**Did you have insurance when you received treatment that resulted in the debt?**

\_\_\_ Yes \_\_\_ No

**If Yes, did the insurance cover any of the costs?**

\_\_\_ Yes \_\_\_ No

**Have you had problems getting care at a hospital?**

\_\_\_ Yes **What Hospital – please mark all that are appropriate**

\_\_\_ St. Vincent

\_\_\_ St. Francis

\_\_\_ Methodist

\_\_\_ Community Hospital

\_\_\_ IU

\_\_\_ Other \_\_\_\_\_

**Have you or someone in your family not gone to the hospital because you were scared of the cost?** \_\_\_ Yes \_\_\_ No

## Hospital Accountability Survey

Did the hospital ask you to pay before you received medical care?

Yes  No

While at the hospital were you told about (check all that apply)

- Payment plans are available  Not told about any help or programs  
 How to apply for Medicaid/Medicare or other government program  
 An application for Medicaid/Medicare or other government program.  
 Reduced costs for uninsured or underinsured

---

### DEMOGRAPHIC INFORMATION

We are collecting this information to help with our data collection – we appreciate you providing the information requested, however it is not required.

Gender:  Male  Female

Age: \_\_\_\_\_

Ethnicity:

Black/African American

Hispanic

White/Caucasian

Other

Total family income (before taxes): \$ \_\_\_\_\_

Current employment status:

Full time

Unemployed

Part-time (how many jobs? \_\_\_\_)

Student

Self-Employed

Retire

Other (please describe) \_\_\_\_\_

Zip Code: \_\_\_\_\_

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Another part of HAP will include community meetings which will provide information on current health reform proposals and provide information and training in consumer advocacy and managing debt. In addition we will build teams of citizens who will work together to improve hospital policies. Please provide your contact information so we can invite you to these meetings.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone # \_\_\_\_\_ Alternate # \_\_\_\_\_

e-mail \_\_\_\_\_

Is there an alternate way to reach you? \_\_\_\_\_

---

Completed surveys can be returned to the location where you received it or mailed to: CACEF at the address listed below.

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Citizens Action Coalition Education Fund  
603 E. Washington St., Suite 502  
Indianapolis, Indiana 46204  
317-205-3535; Fax 317-205-3599

August 2009

## **Appendix III**

### **HAP Survey Results**



## HAP Survey Findings

### Coverage:

- 267 have insurance.
- 211 do not have insurance.
- 34 have coverage from Medicaid and 42 have coverage from Medicare - 10 are covered by both.

### Do you use your insurance? Does not include Medicaid/Medicare recipients

Yes – 183                      No – 19

### Reasons for not using insurance that is available:

- Co-pay too high – 34
- Deductible too high – 28
- Does not cover what I need – 35
- Other reasons – 19

### Do you owe money to a Hospital?

- 389 individuals/families owe money to hospitals
- Average owed: \$22,652. Range from \$750,000 to \$20
- 51 individuals with Medicaid/Medicare owe money to hospitals. Average owed is \$22,228 - ranges from \$200,000 to \$100.

### What Hospitals do you owe?

40 - St. Vincent	101 - Community Hospital
113 - Methodist	157 - Wishard
36 - I.U.	35 - Other
206 St. Francis	

### Did you have insurance when you received treatment that resulted in the debt?

YES –249                      NO –202

### If Yes, did the insurance cover any of the costs?

YES – 177                      NO –59

### Have you had problems getting care at a hospital?

YES – 95

11 - St. Vincent	4 - I.U.	16 - Community Hospital
23 - Methodist	37 - St. Francis	42 - Wishard

### Have you or someone in your family not gone to the hospital because you were scared of the costs?

YES – 250                      NO – 191

### Did the hospital ask you to pay before you received medical care?

YES –110                      NO – 338

**While at the hospital were you told about:**

- Payment plans are available – 105
- How to apply for Medicaid/Medicare or other government programs – 61
- An application for Medicaid/Medicare or other government program – 35
- Reduced costs for uninsured/underinsured – 50
- Not told about any help or programs – 249
- No response – 112

**Demographics from Surveys**

Male – 190

Female – 388

Average age – 44 (Medicaid/Medicare responses average age is 52)

African American – 104

Caucasian – 396

Hispanic – 8

Other – 4

Family Income ranges from \$0 to \$100,000

Full time employment - 121

Part-time employment – 52

Self-employed – 16

Unemployed – 167

Student – 13

Retired – 64

Other – 105 (includes individuals seeking disability or on disability or temporary disability, individuals receiving TANF and receiving help from family and friends)

Information from 547 surveys returned. Information compiled July 11, 2010

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- <sup>3</sup> M. Doty, S. Collins, S. Rustgi, and J. Kriss, *Seeing Red: The Growing Burden of Medical Bills and Debt Faced by U.S. Families*, The Commonwealth Fund, August 2008. [http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2008/Aug/Seeing%20Red%20The%20Growing%20Burden%20of%20Medical%20Bills%20and%20Debt%20Faced%20by%20U%20S%20Families/Doty\\_seeingred\\_1164\\_ib%20pdf.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2008/Aug/Seeing%20Red%20The%20Growing%20Burden%20of%20Medical%20Bills%20and%20Debt%20Faced%20by%20U%20S%20Families/Doty_seeingred_1164_ib%20pdf.pdf)
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