Testimony in Support of H.B. 5320, An Act Concerning Hospital Financial Assistance

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Public Health Committee

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Dear Senator Anwar, Representative McCarthy Vahey, Senator Somers, Representative Klarides-Ditria, and esteemed members of the Public Health Committee,

Thank you for accepting this testimony in **support of H.B. 5320: An Act Concerning Hospital Financial Assistance,** on behalf of Health Equity Solutions (HES), a nonprofit organization with a statewide focus on advancing health equity through anti-racist policies and practices. Our vision is for every Connecticut resident to attain optimal health regardless of race, ethnicity, or socioeconomic status.

Medical debt is an escalating concern, disproportionately affecting Black and Latino/a individuals at rates exceeding the population average. Unlike planned debts, such as mortgages, medical debt often results from unforeseen or emergency medical needs. It's a burden carried by those seeking care in dire circumstances— 72% of people attribute their medical debt to bills from one-time or short-term medical expenses associated with acute care, such as a single hospital stay or treatment for an accident at a hospital. The unpredictability of hospital costs compounds the problem; even when prices are publicly available, patients often face unexpected out-of-pocket expenses. Even among insured individuals, healthcare costs remain a significant barrier, with 42% of those purchasing insurance from Access Health CT facing rising healthcare expenses such as copays and deductibles. No one should discover in the days or months after a hospital visit that the bill far exceeds their savings and be unaware of hospital programs designed to help.

Recognizing the urgency of this issue, the Health Equity for the People by the People coalition identified medical debt as a key priority to complement efforts to reduce uninsurance. The coalition's members (which include Health Equity Solutions, Make the Road CT, and the Ministerial Health Fellowship) reviewed research and policies from other states and prioritized hospital financial assistance policies and increasing access to HUSKY programs for immigrants as the coalition's focus. HES commends and stands firmly behind this proactive initiative, recognizing it as a promising endeavor to prevent the undue accrual of medical debt and ***strongly supports this promising effort to stop unnecessary medical debt from occurring.***

Furthermore, Health Equity Solutions conducts annual outreach to gauge the health equity priorities of Connecticut residents. To date, we have engaged over 570 participants across 47 towns and cities. Access to affordable healthcare consistently emerges as a top concern, underscoring the significant barrier that costs and medical debt pose to equitable healthcare access.

Medical Debt and Health Equity in Connecticut and the Nation

***Racial inequities in income, wealth and insurance coverage play a role in the prevalence and burden of medical debt*.** Recent data suggests that as many as 40% of U.S. adults, roughly 100 million people, are currently burdened by medical or dental bills, including an estimated 280,000 individuals in Connecticut alone. Black, Latino/a, and other households of color face disproportionately high rates of medical debt due to a number of factors rooted in systemic racism. Nationally, a staggering 68% of individuals with low incomes, 69% of Black adults, and 63% of Latino/a adults lack the financial resources to cover an unexpected $1,000 medical bill within 30 days, showcasing pervasive economic vulnerability to medical debt faced by historically marginalized communities.

Medical debt not only perpetuates economic disparities but also exacerbates a cycle of health inequity, entangling individuals in a web of financial and health-related challenges. The ramifications extend beyond mere financial burdens, with those encumbered by medical debt experiencing elevated stress levels, compromised health outcomes, and often finding themselves compelled to delay or forgo needed medical care. This dilemma is particularly distressing for individuals managing chronic conditions or requiring ongoing medical attention.

Furthermore, the consequences of medical debt ripple into various aspects of individuals' lives, transcending health concerns. Once medical debt is handed over to collections, individuals face a myriad of additional challenges, including diminished access to credit, an increased likelihood of bankruptcy, and the prospect of confronting costly and protracted collection litigation. While recent changes have been commendable in limiting the impact of medical debt on credit scores, it is imperative to acknowledge that these measures, though a step in the right direction, fall short of adequately addressing the escalating scope of this pervasive problem. The need for comprehensive solutions is paramount to break the detrimental cycle perpetuated by medical debt and ensure equitable access to healthcare for all.

Pervasive discrimination in employment and education, among other aspects of systemic racism,[1] means that Black, Indigenous, Latino/a, and other people of color in Connecticut are disproportionately likely to be uninsured or enrolled in insurance policies with out-of-pocket costs they cannot afford. Further, Connecticut has one of the nation's highest racial wealth gaps, which means Black and Latino/a people are less likely to have cash on hand to pay large, unexpected bills. Black, Indigenous, Latino/a, and other people of color in our state are already at greater risk of avoiding care and accruing medical debt. In a state where 7% of Black adults and 8% of Latino/a adults had no health insurance compared to 3% of White adults, the burden of medical debt falls disproportionately on communities of color. Likewise, a disproportionate number of Black and Latino/a adults in CT reported they had not received or had delayed medical care, including 28% citing they did so due to costs.

[1] A complex system, rooted in historical and current realities of differential access to power and opportunity for different racial groups. This system is embedded within and across laws, structures, and institutions in a society or organization. This includes laws, inherited disadvantages (e.g., the intergenerational impact of trauma) and advantages (e.g., intergenerational transfers of wealth), and standards and norms rooted in racism.
Talking-About-Anti-Racism-Health-Equity-1-of-3.pdf (shvs.org)

HEALTH EQUITY SOLUTIONS

Why Focus on Hospital Financial Assistance?

Nonprofit hospitals are required to offer financial assistance (often called "charity care") to patients who meet each hospital's financial assistance criteria. Hospital financial assistance is free or discounted health services. It is for people who do not have health insurance or cannot afford treatment. **This proposed bill would keep more Connecticut residents from incurring medical debt by setting standards for these policies, increasing awareness of and access to financial assistance, and ensuring compliance with existing state and federal requirements**.

Despite billions in tax breaks, many hospitals allocate minimal resources to financial assistance programs. Currently, 60% of nonprofit hospitals across the nation spend less than 2 cents on financial assistance for every dollar of net patient revenue. **Connecticut hospitals have been progressively spending less on financial assistance, leading to a $339 million deficit in financial assistance and community investment compared to the value of their tax exemption. This deficit amount could have wiped out medical debt for 240,612 (69%) CT residents if only hospitals had spent their "fair share" on financial assistance.**

Moreover, 45% of nonprofit hospitals routinely send medical bills to patients with incomes that make them eligible for financial assistance. Over $2.7 billion in outstanding bills from more than 1,600 hospitals nationwide were forwarded to patients who might have been eligible for financial assistance had they received adequate support in applying. An estimated 13-35% of Connecticut residents likely qualify for financial assistance depending on the hospital they visit. These national figures and state estimates suggest many Connecticut residents are unaware that financial assistance is available.

Media coverage has repeatedly uncovered aggressive billing and collection practices by hospitals. Recent reporting by Kaiser Health News and the New York Times uncovered practices such as aggressive lawsuits, collection practices, and intake practices even for patients eligible for financial assistance. In 2019, researchers in Connecticut found that 81,136 small claims lawsuits were initiated by hospitals and medical providers from 2011 – 2016. In 2003, the Wall Street Journal covered lawsuits against Yale New Haven Hospital for aggressive debt collection practices.

The prevalence of aggressive billing and collection practices by hospitals highlights the need for consistent monitoring and enforcement mechanisms. While federal tax code mandates nonprofit hospitals to address medical debt, the IRS has not revoked any hospital's nonprofit status for noncompliance in the past decade. States have a crucial role to play in closing these regulatory gaps, including strengthening penalties for noncompliance, providing patients with the right to take action against noncompliant hospitals, and devoting funding to increase oversight by state agency officials.

Transparency and accountability can lead to change. After a report showed it was Connecticut's most litigious hospital, Danbury Hospital reviewed and changed its billing and debt-collection policies.

Consistent reporting and oversight of financial assistance would ensure all hospitals are held to the same standards.

How would H.B. 5320 Help?

HES analyzed financial assistance regulations across the United States as well as relevant academic and grey literature. We then shared a list of policies in practice in other states, but not in Connecticut, with our coalition partners. The coalition agreed on a set of policy options and sees those options reflected in this proposed bill, which would:

- The creation of a **uniform financial assistance application** accepted by all CT hospitals, as in Colorado and Maryland.
- **Adopt presumptive eligibility** based on indicators of financial hardship — individuals who are enrolled in Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and with household income below 250% FPL, as already practiced in Hartford Healthcare, Illinois, and Maryland.
- **Notify patients of financial assistance options** during discharge and in every bill and collection notice in English and the top languages spoken in the hospital's community, as in Maryland, Maine, and Washington.
- **Empower the Attorney General to investigate and take action** to enforce these requirements as in Illinois and New Mexico.
- Require hospitals to **annually report on how much financial assistance they provided**, including how many people asked for help and how many got it as in Colorado.

HES respectfully urges this committee to pass this equity-focused proposal and respectfully recommends the following changes to the language in H.B. 5320:

- Provide flexibility for applicants to submit **alternative documents to verify their income** for eligibility determination, as in Illinois and Colorado. Flexibility is especially important for individuals who do not get paid with pay stubs, who may be a survivor of intimate partner violence, or may be experiencing homelessness.
- Establish a **minimum income threshold** for eligibility, aligning with the practices in Massachusetts, California, and Maryland.
- Implement **reasonable payment plans** for individuals who do not meet the eligibility criteria, as in Massachusetts, Maryland, and Colorado.
    - This measure aims to prevent patients from having to sacrifice basic necessities to settle medical bills and can ultimately reduce hospitals' burden of uncollectible debt.
- Mandate the **screening of ALL patients** for financial assistance eligibility, mirroring protocols in Colorado, Maryland, and Maine.
- Require that all hospitals have their financial assistance policies available in **braille and large print.**

- Require hospitals **to direct patients to the Office of the Healthcare Advocate** prior to initiating the collections process.
- **Increase accountability** by requiring hospitals to report race, ethnicity, and language (REL) data as it relates to how much financial assistance they offer (i.e., who receives it, how many patients are referred to collections, and how many are sued broken down by REL), as in Colorado and Maryland, which can help ensure equitable access to financial assistance. HES proposes standardizing how spending on financial assistance is reported, given the wide variation in hospital fees.
- Allow hospitals to **submit a Corrective Plan** to the Attorney General's office to rectify any identified violations, fostering a culture of compliance, ongoing communication, and continuous improvement in financial assistance practices.

Concluding Remarks

Hospital financial assistance is one key component of broader affordability efforts, including expanding access to health insurance, erasing existing medical debt, cost-growth benchmarking, addressing pharmaceutical costs, and limiting extraneous fees. We are grateful for the committee's consideration and ***respectfully urge the advancement of H.B. 5320 to address the accumulation of unnecessary medical debt by improving access to and strengthening the enforcement of hospital financial assistance policies*.** HES believes this proposal would be pivotal in addressing and alleviating the burden of medical debt for Connecticut residents.

Thank you for the opportunity to submit this testimony in strong support of **H.B. 5320, An Act Concerning Hospital Financial Policies.** We can be reached with any questions at aclarke@hesct.org or 860.937.6432.