About the Foundation:

The National Credit Union Foundation (the Foundation) is the charitable arm of the U.S. credit union movement and works as a catalyst to improve people’s financial lives through credit unions. Through Foundation grants and programs, credit unions provide widespread financial education, create greater access to affordable financial services, and empower more consumers to save, build assets, and own homes. Donations to the Foundation enable credit unions to help their members reach life-changing goals and achieve financial freedom.

The National Credit Union Foundation is a 501(c)(3) tax-exempt charitable organization. The Foundation continues to earn the Better Business Bureau seal of approval as an “Accredited Charity” for meeting all 20 BBB Wise Giving Alliance Standards for national charities.

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For the last seven years Mark has worked as a Field Coach for the Foundation’s REAL Solutions Program, a program designed to serve new target markets, including young adults, immigrants and modest income households. The most extensive REAL Solutions program he has overseen has been the training of over 1,400 certified credit union financial counselors in 390 credit unions in 25 states. He has also worked with CUNA Mutual to develop an experiential training program to help credit union members and staff to better prepare for retirement. Mark has given over 500 presentations at credit union events in 48 states on a variety of issues. Prior to moving to the US in 2004, Mark had 22 years experience as a director with Australian credit unions and was the Volunteer & Resources Manager with the Australian Credit Union Foundation

Who should use this toolkit?

This medical debt toolkit has been developed for use by credit union staff. It contains information and tools, which credit union staff will find useful when helping members who have medical debt.

Often, members with medical debt are also experiencing broader financial problems and need assistance not only to address his/her medical debt issues but also need help with other aspects of his/her finances.

Certified Credit Union Financial Counselors (CCUFC’s) have a wide range of skills to assist members address his/her financial challenges and are best positioned to use the information in this toolkit.

However, any credit union staff member with the skills to help members with a problem could use the information and tools in this toolkit to assist a member who is experiencing medical debt issues.

More information on the options available for credit union staff to become Certified Credit Union Financial Counselors can be found at - http://www.cuna.org/Training-And-Events/Training-by-Business-Area/Financial-Counseling/Credit-Union-Financial-Counseling-Certification-Program/
Introduction

Medical debt is a widespread problem that can create havoc with people's financial lives. If not dealt with, medical debt can snowball causing bigger problems. In fact, medical debt is the leading cause of personal bankruptcy in the United States. Yet medical debt tends to be talked about much less than credit card debt, mortgage debt and student loan debt. People are often so afraid of medical debt that they avoid dealing with it, which makes matters worse. In fact, medical debt is often not so difficult to address if you face it head-on and know where to start. This Toolkit provides a framework staff can use to identify medical debt issues and help members resolve his/her medical debt. This toolkit will also help you understand how you can help members quickly reduce or at least limit some medical bills and therefore make a big difference in the financial situation and members’ peace of mind.

This Toolkit contains information collected from a range of sources and is principally aimed at helping credit union staff to assist members who need help with dealing with medical debt. Staff will learn how to:

- Screen members for medical debt;
- Collect all the information that is needed to work the case; and
- Help the member choose a customized strategy to help resolve the debt and follow through on that strategy.

This Toolkit also aims to help staff become confident when talking to members about medical debt and enable staff to help members reduce his/her debt or restructure his/her debt payments to be more affordable.

Defining medical debt

Medical debt is a personal debt or money expended for medical services or medical products. It may be owed directly to a healthcare provider like a doctor’s clinic or hospital or to an agent of the provider. Sometimes the bill might get passed onto a debt collection agency. Medical debt also includes money for medical services that is owed to a third-party like a credit card company or another lender.

The extent of medical debt

According to a 2012 health insurance survey\(^1\) by the Commonwealth Fund, 75 million people or 41% of working aged adults experienced medical bill problems. The same survey found that 48 million or 26% of working age adults had a medical debt or were paying off a medical bill over time.

The problems included:

- Problems paying or unable to pay a medical bill;
- Contacted by a collection agency for an unpaid medical bill;
- Changed his/her way of life in order to pay a medical bill; and
- Paying off medical bills over time.

The same survey found that 48 million or 26% of working age adults had a medical debt or were paying off a medical bill over time.

A plethora of other research and surveys confirms the alarming amount of medical debt owed by millions of Americans.

According to the American Medical Association\(^2\)
20% of medical claims are inaccurately processed by health insurers. The Wall Street Journal in an article titled “How to Fight a Bogus Bill”, reported the following statistics. Stephen Parente, a professor of health finance at the University of Minnesota who has studied medical billing extensively, estimates that 30% to 40% of bills contain errors. The Access Project, a Boston-based health-care advocacy group, says it’s closer to 80%. Medical-billing errors mar the credit reports of roughly 14 million Americans, according to a December study by the Commonwealth Fund. According to a 2010 study by the Federal Reserve, medical bills account for more than half of all debts in collection.

A Quicken Health survey found that almost one third of Americans let a medical bill go to collections because they did not understand the bill or explanation of benefits statement.

Roughly 38 percent of Americans with employer-sponsored health insurance had a deductible of $1,000 or more in 2013—up from 10 percent in 2006, according to the Kaiser Family Foundation.

According to the Medical Group Management Association, multi-specialty practices saw his/her bad debt (money they are owed, but couldn’t collect) go up by 14 percent between 2008 and 2012. Because that number is increasing, health providers are changing the way they process payments, some medical offices have reduced the amount of time they wait until going to collection agencies, while others expect to be paid up front before they perform a procedure.

Another issue that leads to medical debt is a lack of price transparency in health spending. It is nearly impossible for consumers to know upfront how much they are going to have to pay for a particular procedure. According to a survey conducted by Harris Poll on behalf of NerdWallet Health, 73% of adults said if they knew the cost of medical care before receiving a treatment, they could make better health decisions.

Much of this data was confirmed by the Consumer Financial Protection Bureau’s (CFPB) December 2014 Report – “Consumer credit reports: A study of medical and non-medical collections.” Research performed by the CFPB demonstrated that credit scoring models that treat medical collections in the same way as other collections penalize consumers with medical debt collections by underestimating his/her creditworthiness with lower scores. The study found that consumers with medical debt were more likely to pay his/her future loan obligations on par with consumers scoring at least ten points higher. In cases where the consumer’s medical debt was paid off, the scores underestimated the consumer’s creditworthiness by an average of 22 points.

The consequences of medical debt

Medical debt can be devastating for individuals and families. It can have serious financial and psychological consequences as well as consequences for healthcare access and even employment.

Financial consequences include credit problems, housing problems and difficulty affording other necessities. Psychological consequences include depression, stress and anxiety. Health access consequences include delayed care, discontinued care and unfilled prescriptions. There may also be employment consequences such as problems stemming from wage garnishment or difficulty getting a new job because of ruined credit.

A study in 2007 titled “Medical Bankruptcy in the United States” by three professors at Harvard Law School found that 62.1% of all bankruptcies in 2007 were medical; 92% of these medical debtors had medical debts over $5000, or 10% of pretax family income. The rest met criteria for medical bankruptcy because they had lost significant income due to illness or mortgaged a home to pay medical bills. Most medical debtors were well educated, owned homes, and had middle-class occupations. Three quarters had health insurance.

Another Harvard study in 2008 titled “Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures” found that 49% of people who lost their home to foreclosure reported that their foreclosure was caused in part by a medical problem, including illness or injuries (32%), unmanageable medical bills (23%), lost work due to a medical problem (27%), or caring for sick family members (14%).
TO GIVE YOU AN IDEA OF HOW SERIOUS THE CONSEQUENCES CAN BE, HERE ARE SOME OF THE FINDINGS OF THE 2012 COMMONWEALTH FUND SURVEY:

- 28% of those with medical debt report postponing care due to cost, nearly the same percentage as those who were uninsured.
- 39% or 28 million adults under the age of 65 with medical bills or debt problems used all or most of his/her savings trying to pay off the bills.
- 29% or 19 million adults under 65 were unable to pay for basic necessities such as food, heat or rent because of a medical bill.
- 30% or 20 million adults under 65 go into credit card debt because of a medical bill.
- 10% or 7 million adults under 65 took out a mortgage against his/her home or took out a loan to pay medical bills.
- 22% or 17 million adults under 65 delayed career or educational plans due to medical bills.
- 6% or 4 million adults under 65 declared bankruptcy due to medical bills.
- 42% or 32 million adults under 65 received a lower credit rating because of medical bills.
- 68% or 51 million adults under 65 experienced at least one of these problems because of medical bills.
The impact of medical debt on credit

As already discussed, medical debt is having an enormous impact on the credit reports of consumers. However, the way in which a member’s credit is affected by medical debt is about to change. The Attorney General of New York has recently reached agreement with the credit reporting agencies to change the way they handle medical debt. The agreement will result in the credit reporting agencies implementing the following changes:

- Medical debt can only be put on a credit report 180 days after the bill from the doctor. This will give the insurance company time to pay, and people time to understand the cost. Historically, collection agencies could put a collection items on credit reports at his/her discretion, and they would.
- If a medical bill is ultimately paid by an insurance company, the credit-reporting agency has to remove the item from the credit report. Too often, slow insurance companies ended up wreaking havoc on people’s credit reports.
- When a consumer disputes something on his/her report, the agencies will have a trained employee review all documents submitted by individuals when they submit a dispute.

This is good news for credit union members. However, it should be noted that the medical debt changes in the agreement with credit reporting agencies are part of phase 3 of the settlement, which means the deadline for the medical debt changes to occur is most likely to be over 3 years away.

Having a basic understanding of medical costs

It is important to have a basic understanding of how medical costs and medical insurance work.

Insurance companies do not pay 100% of the member’s medical bills. The member who has insurance will still be responsible for a portion of his/her medical costs. This portion of the cost is called deductibles, copays, and coinsurance.

- DEDUCTIBLE: A deductible is a flat amount that the member has to pay for medical care before insurance will pay. Unfortunately, deductibles have been increasing significantly over recent years as insurance companies and employers are looking to cut costs. In the past a common deductible might have been $250-$500. Deductibles now range from $1,000-$5,000.
- CO-PAY: A co-pay is a flat amount generally associated with certain types of care. The amount of the co-pay is outlined in the member’s benefits plan and if the member participates in an employer benefits plan, the employer usually decides the amount of the co-pay. So, a member may have a $30 co-pay for every visit to the family physician and a $60 co-pay for every visit with a specialist like a cardiologist or gynecologist.
- CO-INSURANCE: Co-insurance is similar to co-pay, except it is a percentage, not a flat amount. So, a member with a 15% co-insurance payment would pay 15% of the bill, while the insurance company would pay 85% of the bill.
- IN-NETWORK AND OUT-OF-NETWORK: It is possible the member has two sets of deductibles, co-pays and co-insurances in her/his health plan. Insurance companies normally offer several different plans to employers and each plan normally has a set of health care providers such as doctors, hospitals etc. These providers are referred to as in-network. If the member has an insurance plan that includes an out-of-network benefit, all other providers are referred to as out-of-network providers. If the member does not have an out-of-network benefit in the health plan, then his/her insurance company will not pay for him/her to see those providers.

So what can credit unions do for their members? Start by developing a basic understanding of medical costs and medical insurance.
Strategies for helping members
Credit unions interact with members in a number of ways and each interaction is an opportunity to assist a member cope with an existing medical debt or educate the member to know what to do in the future if confronted with a medical debt. Some members may be more likely to face medical debt. It could be a baby boomer member taking care of elderly parents or it could be the family of a veteran. Staff can be trained to know what to look for.

Using existing partnerships or developing new partnerships might also be a good way for credit unions to help members with medical debt. For example, a community organization or government agency may be in a better position to identify members who need help. The partnering organization would alert members to how his/her credit union can help them.

Many credit unions partner with hospitals through his/her work with Children’s Miracle Network. However, there are other good reasons to partner with local hospitals. If key hospital staff are aware that your credit union is assisting members with medical debt and also have a good understanding of how you plan to do that, it will make it much easier to help members. Building positive relationships with staff in the hospital billing area as soon as possible is very worthwhile strategy. It will make it easier when helping members with a billing issue and you will find that a hospital is likely to refer members to you for information and counseling.

Credit unions that have member education programs should also look for ways to identify members who need help and to also help members understand what to do if faced with a problem in the future. Providing educational opportunities specifically around medical debt could achieve this. It could also be achieved by adding a small piece to all training/workshops alerting members how the credit union can help them with medical debt issues.

Screening members for medical debt
By understanding the consequences of medical debt, you are in a much better position to systematically screen members for it. Whether it is helping a member with budgeting, assisting a member to buy his/her first home or simply helping a member access financial products and services, it is important to know if they have medical debt. Asking the right questions will effectively uncover medical debt issues. Having the techniques to talk to members about medical debt is important and knowing the types of follow up information needed to help members with medical debt is also essential.
ASKING THE RIGHT QUESTIONS WILL EFFECTIVELY UNCOVER MEDICAL DEBT ISSUES.

Asking Questions

When specifically asking about medical debt, credit union staff are often surprised to learn that many of his/her clients say they have medical debt. So knowing the right questions to ask is very important.

You should consider asking the following questions in an attempt to uncover medical debt:

- Do you currently owe money for doctor, hospital, dental, or any other medical bills?

It may be necessary to follow up with:

- Is the money owed directly to the medical provider, a collection agency, or to a credit card company or bank?

Simply by asking this question you will begin to uncover information about a member’s financial health.

Other questions you may find effective when gathering more detail on medical debt and its consequences include:

- Have you been contacted by your healthcare providers or a collection agency about unpaid medical or dental bills?
- Do you owe any money for a loan or on a credit card that you used to pay medical bills?
- Do you have medical collection accounts on your credit report?
- Are you having difficulty paying for basic necessities (like food, heat or housing) due to health expenses?
- Have you delayed or avoided getting needed health care due to cost?

These questions can be incorporated into the discussion whenever it makes sense. The right time could be:

- When you first meet the member;
- As part of an initial needs assessment;
- When discussing a spending plan;
- When collecting information about outstanding debts; and
- When reviewing the credit report.

Sometimes you will uncover medical debt issues when looking through the documentation that the member brings with him/her to the counseling session. For example, you may see hospital or doctor bills mixed in with other household bills when creating a budget or might notice medical debt when reviewing the member’s credit report.

When initiating a conversation about medical debt, it is important to remember to let the member know that medical debt is a common problem. You should tell the member that one in four adults have it, so they are not alone. The member should also be told that medical debt is recognized as a national problem. It results from illness or injury and they do not need to feel in embarrassed by the situation. It might also be a good time to restate that they can be sure that you will protect the confidentiality of any information they share with you in your discussions with them.
Getting specific information

Once you are aware that the member has medical debt, it is necessary to ask follow-up questions to get the information needed to help the member. Follow-up questions can uncover more details and help you decide how to proceed. When following up you’ll need three types of basic information:

• Demographic and contact information;
• Information on the debt; and
• Information about medical insurance coverage.

You will have most likely already collected demographic and contact information. So it is important to gather specific information on medical debt such as amount owed, the provider or creditor to whom the bills are owed and whether the medical debt is on a credit report.

Some members will have more than one medical bill. Regardless of whether the member has one or more bills, you will need to gather a detailed list of bills, including the entity collecting the bill such as a healthcare provider, a collection agency or financial institution. It may also be necessary to ask the member if she/he has pulled her/his credit report and whether any of the medical accounts are on it.

It is also important to ask the member if she/he was insured or uninsured at the time of the medical incident for which she/he owes money. If she/he was insured, there may be consumer protections to help the member get his/her claims paid. If she/he was uninsured there may be public programs for which the member is eligible but not currently enrolled in.

Now that you are armed with the right questions to ask a member, what do you do now? There are several strategies.

Strategies for addressing Medical Debt

There are four key strategies for addressing medical debt:

• Pursuing private insurance claims;
• Applying to public programs;
• Accessing charity care and financial assistance programs; and
• Negotiating payment restructuring.

It is vital to have a detailed understanding of these four basic strategies for addressing medical debt. You need to know the action steps that must be taken to assist members to reduce or limit his/her debt.

Exploring private insurance

The first strategy to explore is whether the member had private insurance when the debt was incurred. Start by looking into why the private insurance has not paid. There are a variety of reasons why members may owe medical debt despite having insurance coverage. For example, the provider may not have current insurance coverage information, or the member may have used an out-of-network provider, or the procedure itself may not have been covered. The member may also owe debt from a deductible or an amount above and beyond that covered by insurance.

So, you may find that insurance should cover some or the entire bill. One important thing to consider at this point is whether a member’s medical bills are the result of a work or auto accident. If the member’s bills are related to an auto accident, his/her medical care is most likely covered by an auto insurance company. If the member was injured in a work-related accident, a state Worker’s Compensation Program would most likely cover his/her medical bills. Employers pay money into a state Worker’s Compensation fund so that workers are covered if they get injured at work. This is important to note, because employer-based health insurance will not want to pay if treatment is covered by another program.

Private Insurance Action Plan

Sometimes bills are easily resolved. For instance, a provider may not have a patient’s correct insurance information. The most common reason that insurance companies deny claims is an incorrect policy number, an incorrect enrollee number or an incorrect patient’s date of birth. You should help the member check to see if this has occurred.

It is common for employers and individuals to change insurance companies and if the provider does not send the invoice to the correct insurer, claims will not be paid. This problem is usually resolved by having the member contact the provider with new insurance information and asking the provider to resubmit the claim.
Medical billing errors are also common. Insurers make mistakes in how they categorize and code expenses or apply cost-sharing. Because some hospitals don’t comply with Medicare’s billing requirements, they can end up improperly billing the program—sometimes quite significantly. Medicare Compliance Reviews of US hospitals conducted by the Office of the Inspector General in 2013 found that none of the audited hospitals was fully compliant with Medicare medical billing requirements and all of the hospitals demonstrated billing errors. In each case, the billing errors led to overpayments, the study said.

Another reason for claims to be denied is because the service is not a benefit in the member’s plan. It is possible that the service was never part of the member’s plan or it is also possible that the members’ employer changed the plan as part of a cost reduction exercise. Most employees don’t check his/her benefit plan until it is too late. So, if the member has received a claim denied notice from the insurance company, which states that the service was not a benefit in his/her plan, you should help the member check the benefit plan to make sure the insurance company is correct.

If you believe that the claim may have been denied in error, you should help the member exercise her/his private insurance appeal rights. The first thing that needs to be done is file an appeal internally with the insurance company. If the issue remains unresolved, help the member file an external appeal, most often with a state agency or department. Many bills that are covered by insurance go unpaid because people fail to exercise his/her right to appeal.

Many out-of-pocket costs are legitimate, like deductibles and co-payments, but medical bills are confusing. If you and the member do not know why a bill wasn’t paid, you should have the member contact the insurance company and ask for an explanation. If you and the member are still not satisfied, consider filing an appeal.

If a member lost her/his job, the member may be covered by COBRA – The Consolidated Omnibus Budget Reconciliation Act of 1985. This Act requires health plans to continue to offer insurance coverage to employees whose job has been terminated or they have been “laid off.” However, it is the responsibility of the employee to pay the premium. So if you are helping a member who may have incurred a medical bill after being laid off, you should check with the member to see if he/she is covered and could have made a claim.

**Coaching members**

We are all busy people and should not try to do all the work for the member. Instead, work with the member, in almost all cases, urge the member to do the work for him/herself. It is also very important to coach the member by explaining what needs to be done and how to do it.

You can not only help a member take the initiative by calling a provider for more information, but you can also prepare a member for calls that they might get from a biller or collector. It is important that the member is prepared to talk to a biller when he or she calls. You should also explain the difference between billers and collection agencies. A “biller” is an employee of the provider such as a person who works for the physician or hospital, where a “collector” is from a collection agency and is not an employee of the provider.

You should explain to the member that she/he really doesn’t want a biller to send his/her bill to a collector. Dealing with a biller will give the member options. Billers have the authority to set up payment plans, arrange deferments, and possibly get bills for some services waived. A member doesn’t have these options when dealing with a collector.

Other useful advice you can give to a member who is
going to be talking to a biller includes:

• Be cooperative and business like. Don’t be argumentative, aggressive or sarcastic;
• Don’t share personal problems with the biller;
• Don’t argue about the price of procedures;
• Don’t argue about minor details that have no significance; and
• Don’t use minor service quality issues for not wanting to pay a bill.

You should explain to the member that billers are looking to find out if a patient is unable to pay and or unwilling to pay. So it is important for the member to stress that they want to pay the bills but they are not able to at the moment. Billers who think a patient is unwilling to pay are likely to send the account to collections. Explain to members who are dealing with not-for-profit hospitals that these hospitals have to provide charity medical care in the form of free care and write-offs or the IRS could penalize them. Evidence of an inability to pay becomes important.

Explain to the member that she/he should not ignore contact from billers. The member should take calls from a biller or return a call promptly. Ignoring calls just makes the problem worse.

Billers usually keep very good records of his/her cases. Explain to the member that she/he should aim to have positive notes on her/his records. For example, the notes should say things like... “called back promptly,” and “good demeanor.”

Billers are more likely to make favorable decisions if they see the member making an effort. Explain to the member that being proactive and even offering to or making small payments will enhance the possibility of favorable treatment. It is also important to tell the member to make sure to follow through and do what he/she tells the biller he/she is going to do. For example, if a biller agrees to reduce the debt and the member enters a payment plan, the member should ensure he/she makes the payments on time or if he/she can’t, he/she calls the biller in advance and explain what is happening.

Be sure to tell the member to keep good notes of what he/she does, who he/she talks to and what he/she is told. It is very important that the member records the date, time and the name of the person to whom he/she spoke. When making follow up calls, this is vital because rarely do you get to talk to the same person. You should coach the member to be able to say things like – “On October 10, I spoke to Bill Smith, who said ABC.”

Explain to the member that he/she should start by making a phone call. For example, if the member is questioning a bill from a doctor’s office he/she should ask to speak to the person who handles the billing. It may take more than one call and it might mean talking to multiple people until he/she talks to the right person. However, it needs to be stressed to the member that he/she needs to be both patient and persistent. The payoff for the member may be significant.

You should suggest to the member that after the initial call, if it is appropriate he/she should put his/her request in writing and mail it. Suggest that he/she then fax it as well.

It should also be noted that the Department of Treasury and the IRS issued new regulations in December 2014 that will take effect in 2016.

Under these regulations nonprofit hospitals will be required to get approval from the governing board before the hospital or any third-party collection agency operating on their behalf uses extraordinary collection actions to collect on bills. Actions covered by these regulations include:
• reporting collections to credit bureaus,
• selling debt to another party,
• taking action that requires legal or a judicial process such as putting a lien on property, seizing a bank account, causing an individual’s arrest or wage garnishments.

Under the new regulations hospitals must typically wait 120 days following the date of the first billing statement before taking these types of actions and patients must be given a 30-day notice of the actions a hospital intends to take. The notice must also include a plain language summary of the financial assistance offered.

Hospitals will also be required to accept applications for assistance up to 240 days following the date of the first billing statements. Both the hospital and its collection agencies must accept the application, and if the patient is found eligible, extraordinary collection actions must cease and a refund issued of amounts paid in excess of what the individual would be required to pay under the policy.

These new regulations do not go into effect until 2016. However, hospitals are currently required to rely on a reasonably good faith interpretation of the statute, which calls for transparency on policies and collection practices, and requires hospitals to make reasonable efforts to screen people for assistance.

Understanding a medical bill
Unfortunately medical bills from a health provider are not easy documents for most people to understand. Many members will be very confused with what they see when they receive his/her bills. By knowing how the medical billing process works you can help members understand just exactly how much they are being asked to pay.

For every medical service the member has, he/she should receive a bill from the provider and an Explanation of Benefits (EOB) from his/her insurance company. An EOB is a notice from the insurance company that will tell the member what the insurance company paid and what, if anything, the member must pay to the provider. If the member doesn’t have insurance, he/she will only receive the bill. It is important to ask the member to bring both the bill and the EOB with them.

Some bills may only list a total amount owed, even if the member has received multiple services. If this is the case, get the member to request an itemized bill that lists all services and the cost of each individual service. This makes it much easier to identify errors.

For more detailed information in how to read and understand medical bills please refer to the information contained in the appendix.

Summary
• Determine why members owe medical debt despite coverage.
• Contact the healthcare provider to obtain an itemized bill.
• Resubmit updated insurance coverage information to providers.
• Redress denied claims and insurer errors through exercising private insurance appeal rights.

Applying to Public Programs
If the member did not have private insurance coverage when the medical debt was incurred, the next strategy to explore is whether he/she might have been eligible for public insurance. This includes Medicaid and Children’s Health Insurance Programs.
You may be able to help the member enroll in a public program and maybe even receive retroactive benefits to pay the past-due medical bills.

The types of available public health insurance programs and eligibility criteria vary widely from state to state, so it is hard to provide general rules. However, the same general action plan steps will apply no matter which state you are in.

The key point to know is that both uninsured and privately insured clients may be eligible for public programs and that public programs sometimes pay for past medical bills.
Public Programs Action Plan

First, it is important to find out if the member has received or applied for public health insurance programs before, during or after the time that medical bills were incurred. If she/he is, or has been covered under public programs, urge her/him to contact the program about his/her medical bills. Even if the member was not enrolled at the time she/he received the medical service, encourage her/him to contact the program to ask about retroactive coverage.

If the member has not applied for benefits, you should do a quick check to see if the member may be eligible. For example, if you have access to a prescreening tool, use it or review with the member, the general information on program income guidelines. If it appears the member may be eligible, you should refer her/him to an organization doing screening and enrollment work and encourage her/him to submit an application.

Even if you are helping the member to pursue other avenues (such as appealing a private insurance denial), a member should never wait to apply for public programs. There is always a time limit on retroactive payment by public programs, so it is crucial to have the member apply as soon as possible.

Summary
- Find out whether the member has ever received or applied for public coverage under Medicaid, etc.
- If so, encourage him/her to submit his/her medical bills, even if he/she was not enrolled at the time they were treated.
- If not, do a quick check to see if the member may be eligible – e.g. does he/she meet income guidelines for coverage?
- Encourage the member to complete and submit applications for public health insurance.

Accessing Charity Care and Financial Assistance Programs

The third strategy to explore is charity care and financial assistance. Members who are not able to fully cover medical bills with either private or public insurance may be eligible for charity care or other financial assistance programs.

Medical providers, especially non-profit hospitals, frequently have private programs to help his/her patients to cover past medical expenses. Medical providers can offer assistance to his/her patients who are struggling with the costs of care. These programs are institution specific. Therefore eligibility criteria for charity care can vary greatly across different providers.

You should urge the member to contact his/her providers to ask whether they offer charity care or financial discounts.
MANY PEOPLE DO NOT KNOW THAT BOTH UNINSURED AND UNDERINSURED PATIENTS MAY QUALIFY.

Although many health care providers offer this type of assistance, members may be unaware of its availability. Many people do not know that both uninsured and underinsured patients may qualify.

It should also be noted that the Department of Treasury and the IRS issued new regulations in December 2014 that will take effect in 2016. Under these regulations nonprofit hospitals will be required to:

- Establish financial assistance policies that clearly describe eligibility and the level of assistance provided e.g. whether free or discounted care is available.
- Have policies that include the information and documentation required to make an eligibility determination, and no one can be denied eligibility based on documentation not clearly referenced in the policy.
- Make its financial assistance policy, application and a plain language summary available on its websites.
- Post information on assistance conspicuously in the emergency room and admitting sites.
- Take proactive steps to inform groups in their service area of this assistance, so as to reach those most likely to benefit from such assistance.
- Limit the amount charged to patients who qualify for assistance to amounts generally billed patients with insurance. (This is aimed at putting an end to the practice of charging the uninsured the highest of rates.)

As mentioned earlier in the Toolkit, these new regulations do not go into effect until 2016. However, hospitals are currently required to rely on a reasonably good faith interpretation of the statute, which calls for transparency on policies and collection practices, and requires hospitals to make reasonable efforts to screen people for assistance.

**Financial Assistance Action Plan**

The first step you should take is to review the provider’s website or help the member to contact each provider and find out if they have a charity care financial assistance or medical hardship program. If they do, have the member ask about any eligibility rules and how to apply. Then work with the member to complete any paperwork and gather all documentation required to submit a completed application. For example, the provider will want proof of income and employment, along with other documentation.

You may need to help the member follow up with the provider after the application has been submitted and eligibility determined. Some charity care programs only cover a portion of the bills due and the member may need assistance with strategies to repay the remaining amount.

**Summary**

- Contact providers to learn about charity care, financial assistance, or medical hardship programs.
- Collect information on eligibility and the documentation required to complete the application processes.
- Help client assemble documentation and complete paperwork.
- Follow up as needed.
Negotiating Payment Restructuring

After working with a member to explore these three strategies it is possible that:

- None of these strategies has worked at all;
- The member has no private insurance, and does not qualify for public benefits;
- Charity care is unavailable or does not cover the member’s bills in full;
- The member is not able to access any financial assistance programs; or
- One of more of these strategies has helped to reduce the member’s debt but the member still faces difficulty in paying it off.

If this is the case, you should now work with the member to explore the fourth strategy – payment restructuring.

Payment restructuring is where you help a member negotiate a repayment plan that is reasonable and affordable. You can help the member reduce his/her debt over time, while eliminating much of the stress that accompanies medical debt.

Negotiating payment restructuring is a strategy that is greatly enhanced when the member is committed to working with you. By using this toolkit, you have the guidance you need to work with members as they approach the healthcare providers to develop reasonable and affordable plans. You will most likely have to work from both ends—advocating with providers to reduce payments and/or extend the payment timeframe while also working with the member to identify ways to set aside some amount each month for a realistic repayment plan.

However, the end result will be that the member, over time, will be able to reduce and eliminate his/her debt, and take greater control over his/her financial situation.

Payment Restructuring Action Plan

The first step you take is to review the member’s budget and current payment plan and identify what payment amounts would be more realistic. While most members would obviously like the lowest possible payments, they also should be looking to pay off the debt in a reasonable time frame. You should help the member to come up with an idea of what the member hopes to achieve from the restructuring process.

Then, you will encourage the member to contact the provider and initiate a conversation about the bill. The member can call or write to his/her medical providers to ask for assistance in creating an affordable payment plan. Many providers, especially non-profit providers, provide interest-free payment terms.

Coach and encourage the member to do the following in discussions with the provider:

- Be considerate, flexible and open. The member should not be rigid. Sometimes the provider may actually come up with a better option than the member might have envisioned.
- Ask about any other payment arrangements the provider can offer.
- Keep a target monthly payment amount in mind, and let the provider know that this is what the member believes is affordable.
- Be appreciative of any discounts offered for services.

Make sure the member is aware that he/she will still need to pay off bills that have been reduced or extended over a longer time period.
It is also important to remember that even if the member is not eligible for charity care, he/she may still be able to negotiate a reduction in the bill, especially if they face medical hardship.

Encourage the member to make sure every provider he/she is dealing with is aware of any significant bills from other providers or that the client’s financial situation has changed (for example, if he/she has been recently laid off or given reduced hours at work). Doctors, hospitals and other medical providers regularly negotiate discounts for the same service, based on medical hardship, whether the patient has insurance, the type of insurance they have, or other factors. So there is typically room to negotiate medical bills.

After the member negotiates with a provider, he/she will come back to you with a tentative agreement with the provider for a restructured payment plan. If this occurs, you and the member should revisit the member’s budget and run the numbers again. Make sure that the member is able to afford the new payments. It is possible that at this point you will need to work with the member to identify where the money in his/her budget will come from to make those payments. After confirming that the member is comfortable with the arrangement, have the member ask the provider to put the terms of the agreement in writing.

The last step is to help the member set up a plan for when and how they will make the payments each month. Visualizing carrying out the plan will help the member make it a reality.

While on the subject of negotiating with medical providers, you should encourage both uninsured and insured members to contact their medical providers to ask for bill discounts and payment plans. Members can initiate this process while appealing an insurance decision or waiting for a decision on an application for public benefits.

Not only are many Americans burdened by medical debt, but they are also burdened by having to navigate a complicated health system and an even more complicated health insurance system. Hundreds of thousands of credit union members are struggling to cope with medical debt. Because it is such a complex issue, they are struggling to work out just how much they owe and how they can pay it. By using this toolkit, Credit Unions can play a role in helping their members navigate all aspects of medical debt. Credit Unions are already involved in philanthropic efforts in the medical care field through our partnership with Children's Miracle Network and other initiatives. Credit Unions can play an even greater role by equipping our members with the financial information and skills to manage their medical debt.

DOCTORS, HOSPITALS AND OTHER MEDICAL PROVIDERS REGULARLY NEGOTIATE DISCOUNTS FOR THE SAME SERVICE

Conclusion:

Not only are many Americans burdened by medical debt, but they are also burdened by having to navigate a complicated health system and an even more complicated health insurance system. Hundreds of thousands of credit union members are struggling to cope with medical debt. Because it is such a complex issue, they are struggling to work out just how much they owe and how they can pay it. By using this toolkit, Credit Unions can play a role in helping their members navigate all aspects of medical debt. Credit Unions are already involved in philanthropic efforts in the medical care field through our partnership with Children’s Miracle Network and other initiatives. Credit Unions can play an even greater role by equipping our members with the financial information and skills to manage their medical debt.
Determine whether the member has medical debt:

- Ask the member if he or she owes money to hospitals, doctors, or other providers for medical care they have received;
- Check if the member is waiting for a payment from a health insurer for any medical claims or bills; and
- Inquire about credit card debt or payday loans and whether any of it resulted from medical treatment

Investigate whether any medical bills have been turned over to collection:

- Ask if the member has been contacted by a collection agency for any medical bills;
- Inquire about any medical debt collections that are on his/her credit reports;
- Investigate whether the member was properly notified or informed of any bills that are now in collection or on his/her credit report;
- See if the member knows whether they were obligated to pay the medical bill or if they believe that his/her insurer was supposed to pay; and
- Ask if any of the medical collection accounts on his/her credit report have been fully paid or settled.

Look into the member’s insurance status:

- Check on whether the member currently has health insurance coverage;
- Ask whether the member had insurance at the time of the medical incident for which they have bills;
- Find out if the medical debt is a result of a work or auto accident, and
- Check to see whether the member lost his/her job and is covered by COBRA.

Find out what steps the member has taken to resolve the medical bills:

- If the member had insurance coverage at the time of the medical visit, ask if the member has checked to see whether the insurance company had the patient’s correct insurance information;
- Help the member check his/her medical bills for errors;
- Find out whether the member has asked the insurer to review the claim or has the member filed a formal appeal;
- If an internal appeal has been declined, ask if the member has lodged an external appeal with a state agency or department;
- If the member could not afford or had no insurance at the time of the medical visit, ask if they have applied for public insurance coverage under Medicaid, for example;
- Ask whether the healthcare provider, especially if it was a non-profit hospital, informed them of any financial assistance that they might provide;
- Whether insured or not at the time of the medical incident, find out if the member has approached the provider to establish a long-term repayment plan; and
- Find out whether the member is currently paying off his/her medical bills and if they have a formal arrangement for doing so.

Impact:

- Find out if the member is having difficulty paying for basic necessities (like food, heat or housing) due to health expenses, and
- Ask if the member has delayed or avoided getting needed health care due to cost.

Communication:

- Urge the member never to ignore his/her bills, whether owed to a healthcare provider or a collection agency;
- For bills owed to healthcare providers, encourage the member to contact the provider to negotiate a reduction in the bill, establish a reasonable repayment plan, and to refrain for sending the bill out to collection, and
- For bills that have been sent to collection, clarify whether the member believes they are obligated to pay the bill or seek to establish a reasonable repayment plan.
1. Client Demographic and Contact Information
1) Name: ________________________________________________________________________________
2) Address: ________________________________________________________________________________
   City: ____________________________________________ State: _________ Zip: ______________
3) Telephone: (home): _______________ (cell): _______________ (work): _______________
4) Email: ________________________________________________________________________________
5) Preferred method and time to contact: ____________________________________________________
6) Date of birth: __________________ Gender: ___________________
7) Marital status: _________________ Household size: ____________
8) Profession/employer: ___________________________________________________________________
9) Family income: $ _______________ (circle one: per month or per year)

2. Provider and Debt Information
3) Describe any steps you have taken to deal with these medical bills: ___________________________
   _______________________________________________________________________________________
   _______________________________________________________________________________________

3. Insurance Information
1) Did you have health insurance at the time any of your bills were incurred? _____________________
   If privately insured:
1) Type and name of insurance: ________________________________________________________________________
2) Key characteristics of your insurance plan (deductible, co-payments, caps, etc.):
   _______________________________________________________________________________________
   _______________________________________________________________________________________
3) Can you explain why you have medical debt despite insurance coverage?
   _______________________________________________________________________________________
   _______________________________________________________________________________________
   If publicly insured through Medicaid, Medicare or another program:
1) Name of program: _________________________________________________________________________
2) Key characteristics of the program (deductible, co-payments, insurance caps, etc.):
   _______________________________________________________________________________________
   _______________________________________________________________________________________
   If uninsured:
1) Have you recently applied to any health insurance programs? __________
2) If yes, which programs? __________________________ When? ___________________
3) What is the status or result? _____________________________________________________________
   _______________________________________________________________________________________
   _______________________________________________________________________________________
   _____________________________________________________________
APPENDIX

1 Commonwealth Fund “Biennial Health Insurance Survey” 2012
http://www.commonwealthfund.org/publications/surveys/2013/biennial-health-insurance-survey

2 American Medical Association “National Health Insurer Report Card” 2013

Stephen Parente, University of Minnesota quoted
http://www.wsj.com/articles/SB10001424052748703312904576146371931841968

4 Quicken Health Financial Healthcare Check-Up 2010 – A study of the attitudes and behaviors of

5 Kaiser Family Foundation and the Health Research & Educational Trust Annual Survey of private and nonfederal public employers with three or more workers 2014 –


7 NerdWallet Health Study “Medical Debt Crisis Worsening Despite Policy Advances” by Christina LaMontagne October 8, 2014
http://www.nerdwallet.com/blog/health/2014/10/08/medical-bills-debt-crisis/


9 Medical Bankruptcy in the United States, 2007: Results of a National Study
David U. Himmelstein, MD, Deborah Thorne, PhD, Elizabeth Warren, JD, Steffie Woolhandler, MD, MPH
Department of Medicine, Cambridge Hospital/Harvard Medical School, Cambridge, Mass; Department of Sociology, Ohio University, Athens; and cHarvard Law School, Cambridge, Mass.

10 Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures
Christopher T. Robertson - University of Arizona - James E. Rogers College of Law; Harvard University - Edmond J. Safra Center for Ethics; Harvard University - Petrie-Flom Center for Health Law Policy, Biotechnology, and Bioethics
More REAL Solutions Tool Kits

Most American workers (88%) drive to work. Not owning a car is a barrier to economic mobility and decreases a person’s chance of improving job opportunities. Those with credit challenges are often forced to use predatory buy here/pay here auto lots, where they are more apt to be sold a poor quality car at a questionable price and interest rate, regardless of the buyer’s ability to repay. This toolkit explains how to lend to low credit score members in a way that does not place the credit union at risk.

An estimated 15 to 20% of credit union members are using or have used a payday loan product sometime within the past five years. Members turn to alternative providers because they provide fast and easy loan approval with few questions asked or because they do not want their credit union to know they are having financial difficulties. This toolkit shows how credit unions can offer an affordable payday loan alternative that is sustainable for the credit union.

More than 30 million Americans do not have traditional bank accounts and use check cashers as alternative financial outlets to perform basic financial services. Credit unions can be part of the solution to high cost check cashers by offering reasonable fee-based check cashing services to members and potential members that represent a good value for the consumer. This toolkit shows how it can be done.

Most banks and many credit unions use Chexsystems or TeleCheck as a decision maker for opening a checking account for an individual. However, a negative ChexSystems record can make it difficult for an individual to open a checking account. Credit unions can use their existing checking product or develop a second product, but with some restrictions built into the product for those with past checking blemishes. This toolkit shows how this can be done.

Toolkits can be downloaded by going to the Foundation’s Website – https://www.ncuf.coop/resources/toolkits/toolkits.cmsx