



Central Virginia Health
Planning Agency, Inc.

Breaking Down Financial Barriers to Healthcare:

Synopsis of Issues and a Call to Action

Developed by:

**The Central Virginia Health Planning Agency's
Financial Access to Care Committee**

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EXECUTIVE SUMMARY

The triad of good health care planning rests on three cornerstones – cost, quality, and access. Building upon these health planning cornerstones, the Central Virginia Health Planning Agency’s (CVHPA) Financial Access to Care Committee met in 2004 and determined there was a pressing need for a synopsis of the issues that impact access to care and to provide some practical recommendations to improve the healthcare “system”, and ultimately the health status, within communities. Begun in early 2005, this synopsis summarizes available information related to financial access to medical care in the United States and Virginia and details recommendations for a plan of action to improve financial access to medical care.

The American healthcare system is fragmented and leaves millions unable to afford healthcare services. Compared with other industrialized nations, the United States spends significantly more money on healthcare but the country’s health status indicators are worse than most other comparable industrialized nations. In 2001, 1.9 – 2.2 million Americans experienced bankruptcy due to burdensome medical expenses, and 75.5% of these individuals had insurance. In our employment-based system of health insurance, illness compounds financial problems by generating high medical bills and simultaneously causing loss of income and potential loss of insurance coverage because the ill can’t continue working.

While Medicare covers most elderly and disabled persons, Medicaid provides medical benefits to some low income people. There is a common misperception that Medicaid covers all low income people, whereas, in Virginia, Medicaid is generally restricted to the very poor elderly and disabled (as a supplement to Medicare), children in households up to 200% of the Federal Poverty Level (inclusive of FAMIS, Virginia’s State Children’s Health Insurance Program), and pregnant women in households up to 150% of the Federal Poverty Level. All of these programs are generally limited to persons who are United States citizens.

The number of uninsured people in America grew by approximately 15% to almost 46 million people from 1999 to 2004 and is expected to represent 27.8% of the projected non-elderly working population by 2013. Nearly half of the uninsured are non-elderly adults who are suffering from a chronic condition. Relative to the insured population, uninsured individuals receive less preventive care, are diagnosed at more advanced stages of disease, are less likely to be receiving therapeutic care, are less likely to be admitted to the hospital after an ER visit, and are more likely to die when they are admitted to a hospital. Employment-based health insurance

continues to erode due to the high cost of health care, which is further compounded by the growing numbers of uninsured who often are unable to pay for their care when they require expensive emergency and inpatient care. Moreover, uninsured people often forego primary and preventative care which can result in higher costs when they do become insured by a private or public insurer.

By assuring financial access to care and investing in effective prevention programs for all Americans, the costs of chronic disease, mental illness, and dental disease may be decreased and overall health improved. There are evidence-based cost-effective preventive strategies that should be used to produce the maximum benefit to the population.

In addition to a lack of appropriate preventative and primary care for many Americans and lifestyle choices, the high cost of health care is partly attributable to private providers' costs and profits. For example, the net income of Virginia's acute care hospitals (including children's and general hospitals) was found to be approximately \$647 million in 2003, or about \$88 per Virginia resident. Anthem Corporation had a profit of \$960 million in 2004, the lowest of the four largest insurers that serve Virginia, while physicians and health care executives routinely earn more than \$250,000 annually.

Several issues that exacerbate financial access to health care include the following and are detailed in this report: 1) misunderstandings created by the billing and collection practices currently used by healthcare facilities, 2) the ambiguity and confusion of federal and state regulations regarding reporting and compliance for tax exempt status, and 3) the inconsistencies of health care providers' financial policies which uninsured consumers must navigate to get affordable care. In addition, it is often difficult or impossible for patients, or purchasers, to get accurate estimates of healthcare costs for specific procedures or types of care, making the healthcare industry unique from almost all other services purchased by consumers.

This report includes specific recommendations to improve financial access to care for all populations, increase preventive health services, and improve the cost-effectiveness of the care being delivered. They are:

- Utilize cost effective prevention strategies and needs assessments in decision making, and implement these strategies as standard practice in planning and policy development.
- Adoption of financial policies for low income and/or uninsured patients by all health care providers.

- Develop educational publications with the cooperation of community partners, which will aim to inform consumers of the healthcare system and assist patients in finding the most appropriate and affordable care available.
- As a longer term recommendation, adoption of healthcare coverage for the entire population at the state or federal level which includes the concept of “medical homes,” ensuring that all people will have access to primary medical care and preventive services.

Through careful planning and use of resources, increased public awareness, and cooperation, a foundation for collaborative community action can be established. With increasing public awareness of the problems of the uninsured and underinsured and dissatisfaction with rising health care costs, interest in a health system that benefits all segments of society is growing.

INTRODUCTION

The triad of good health care planning rests on three cornerstones – cost, quality, and access. These cornerstones are interdependent, with positive community health outcomes being dependent on the support provided by all three. Financial access, or the ability to pay for health services either personally or through a third party, such as an insurance company or the government, includes elements of all three and is the focus of this report.

Building upon these health planning cornerstones, the Central Virginia Health Planning Agency (CVHPA) and its Capital Health Advisory Council (CAHAC) formed an ad hoc Charity Care Committee in 1997 in response to concerns regarding the lack of enforcement of Certificate of Public Need (COPN) charity care commitments, lack of alternatives to comply if obligations were not met, quantifying the actual value of such obligations, and other ways of increasing the provision of health care to the region's uninsured and/or low-income populations. The Committee provided recommendations to Virginia's Commissioner of Health regarding its findings and recommendations. As a result of personnel changes at the State level and the need to standardize charity care conditioning language and reporting of compliance, the CVHPA Charity Care Committee reconvened in 1999 to develop a standardized language and method for recommendations relative to charity care conditions in its region. This effort became the foundation of the methodology that was adopted by Virginia in conditioning applicants statewide. As a result of these efforts, plus increased enforcement in conjunction or in collaboration with area providers, the Central Virginia region has experienced greater access to health care to "non-governmental" hospitals and to some other providers in the Richmond area.

Nevertheless, there continues to be many gaps in services to the neediest residents of the Central region and State, and many providers continue to be confused about what is required by various state and federal regulations. Moreover, many people are unaware of how to access our fragmented health care industry - not only the uninsured, but all of those who struggle to obtain appropriate and cost-effective care - and what might be done to improve it. The ad hoc Financial Access to Care Committee of CVHPA met in 2004 and determined there was a pressing need for a synopsis of the issues that impact access to care and to provide some practical recommendations to improve the healthcare "system", and ultimately the health status, within communities. Begun in early 2005, this synopsis summarizes available information related to

financial access to medical care in the United States and Virginia and details recommendations for a plan of action to improve financial access to medical care.

STATE OF ACCESS TO CARE

The American healthcare system does not serve Americans well and it is in need of significant change. The system is fragmented and leaves millions unable to afford healthcare services. As illustrated in Table 1, compared with other industrialized nations, the United States spends significantly more money on healthcare but the country’s health status indicators are worse than most other comparable industrialized nations. The United States spends approximately twice as much per capita on health expenditures, but life expectancy rates and infant mortality rates are worse than Great Britain, Canada, and Germany. The actual average cost of a hospital day in the United States in 2002 was \$2,434, while in Canada it was only \$870⁵².

Table 1

**Comparison of Health Expenditures and Outcomes
for the United States and Other Countries**

Country	Per Capita Health Expenditures*	% of GDP on Healthcare*	Life Expectancy At Birth** (males)	Life Expectancy At Birth** (females)	Deaths /1,000 Live Births**
U.S.	\$5,267	14.6%	74.4	79.8	6.8
Great Britain	\$2,160	7.7%	75.7	80.4	5.5
Germany	\$2,817	10.9%	75.6	80.7	4.3
Canada	\$2,193	9.6%	77.1	82.2	5.2

*Data used from year 2002

www.oecd.org/health

**Data used from year 2001

Health expenditures were measured as the final consumption of healthcare goods and services plus capital investment in healthcare infrastructure. This covers spending on all personal medical services, pharmaceuticals, and other medical goods, as well as public health, prevention programs, and administration. It does not include health related expenditures such as training, research, and environmental health⁴².

Explanations for the high U.S. healthcare expenditures include malpractice litigation and defensive medicine. Countries with lower expenditures often have long waiting lists for services that are easily accessible by insured individuals in the U.S. However, the costs associated with malpractice suits in the U.S. accounted for only 0.46% of total health spending in 2001, and the services that require long waits in other countries are responsible for only 3% of U.S. health

spending⁵². A study published in *Health Affairs* reported the two most important reasons for higher health spending in the U.S. are higher medical care prices and higher incomes of healthcare professionals and executives⁵².

With more than 45 million uninsured citizens²², millions of medically related bankruptcies per year, and a “vast and confusing array of federal laws, rules, and regulations⁸,” it is not only vital that a system of affordable medical care is created, but it is also imperative that consumers have the knowledge and ability to access this system.

MEDICAL DEBT AND BANKRUPTCY

In 2001, 1.9 – 2.2 million Americans experienced bankruptcy due to burdensome medical expenses, and 75.5% of these individuals had insurance. Many of the insured individuals pointed to high co-payments and deductibles as the problem¹. As a consequence of these financial difficulties, these individuals reported problems in obtaining further medical care¹² and/or decreased medical visits after bankruptcy due to fear of being denied care and actual denial of care in a few cases. Additionally, 27.1% of insured families and almost half of uninsured with medical bill problems report not getting needed prescription drugs¹². Prior to bankruptcy, 60.7% of debtors go without a needed medical/dental visit. (see Table 2). An astounding one in four uninsured non-elderly women over the age of 18 report going without or delaying care due to costs⁵⁰. Nearly one in five privately insured women experienced the same problems⁵⁰. Twenty percent of women did not fill a prescription in the past year because of costs⁵⁰.

Many of these medical bankruptcies and financial access to care problems are related to holes in the American health safety net. These gaps in medical insurance coverage, such as transitioning from one job to another; leave insured individuals with co-payments and deductibles that are too high to pay; and/or as a loss of insurance due to the inability to work during serious illness. In an employment-based system of health insurance, illness compounds financial problems by generating high medical bills and simultaneously causing loss of income. It is ironic that just when a person most needs healthcare coverage (due to a costly extended illness), he/she is most likely to lose their coverage because they can't continue working.

Table 2

Privations in Households with Major Medical Cause of Bankruptcy (Problems Due to Finances in the 24 Months Before Filing for Bankruptcy)	
Went without food	21.8% ^c
Water or electricity shut off	29.8 ^c
Lost phone service	43.6 ^c
Moved because of financial difficulties	17.8 ^c
Lost insurance	46.7***
Went without a needed doctor/dentist visit	60.7***
Failed to fill a prescription	49.6***
Changed care arrangements for an elderly relative	6.7**

^c Not significant (p>.05)

*** p < .01

** p < .05

David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Wollhandler. "Illness and Injury As Contributors to Bankruptcy." *Health Affairs – Web Exclusive* Feb. 2, 2005. 2005 Project Hope.

MEDICARE/MEDICAID

Medicare

The Social Security Act of 1965 established both Medicare and Medicaid. Medicare is a federally run program that provides health insurance to people age of 65 and older and to some people under the age of 65 with disabilities. The Medicare Program is administered by the Centers for Medicare and Medicaid Services, CMS, and covers approximately 40 million Americans¹³.

Medicare beneficiaries can select to join either the original Medicare plan or a Medicare Advantage plan. The original Medicare plan is a fee-for-service plan that includes Medicare Part A and Medicare Part B. Medicare Part A covers inpatient care in hospital and skilled nursing facilities, while Medicare Part B helps cover doctors' services and outpatient hospital care. Part A Medicare is funded through Social Security and most participants don't have to pay premiums. Part B requires an additional payment to enroll. In 2004, premiums were \$66.60 per month for Medicare Part B¹⁴. In addition to premiums, deductibles and co-payments are required for both Medicare Parts A and B. Before Medicare will pay, deductibles of \$876 for Part A and \$100 for Part B must be assessed by the provider. Once the deductible is met, the beneficiary must be assessed the co-payment prior to Medicare paying its portion.

Medicare Advantage Plans (formerly Medicare + Choice, and occasionally referred to as Medicare Part C) were created by Congress to offer more options to beneficiaries. These plans allow private health insurance or HMO companies to offer Medicare benefits. The plans provide more choices and sometimes more benefits for additional costs¹⁴.

Medicare also provides prescription drug assistance programs, sometimes called Medicare Part D. These assistance programs include the Medicare-Approved Drug Discount Cards. These cards reportedly can save from 11%-18% on brand name drugs and more on generic drugs, but they may cost up to \$30 annually³⁴. However, individuals qualifying under maximum income restrictions can receive a drug discount card for no cost, and they may even receive an extra \$450 per year to help with drug costs³⁴.

Medicaid

While Medicare covers most elderly and disabled persons, Medicaid provides medical benefits to some low income people (see Table 3 for additional differences between Medicare and Medicaid). The Federal government establishes minimum guidelines for Medicaid, but the state governments are individually responsible for establishing specific eligibility requirements. For this reason, there are vast disparities from state to state relative to who qualifies for Medicaid coverage and what treatments are covered under Medicaid. The State of Virginia is relatively restrictive in its eligibility and benefits covered. There is a common misperception that Medicaid covers all low income people, whereas, in Virginia, Medicaid is generally restricted to the very poor elderly and disabled (as a supplement to Medicare), children in households up to 200% of the Federal Poverty Level (inclusive of FAMIS, Virginia's State Children's Health Insurance Program), and pregnant women in households up to 150% of the Federal Poverty Level. All of these programs are generally limited to persons who are United States citizens.

Table 3

Compare and Contrast of Medicare and Medicaid		
	<u>Medicare</u>	<u>Medicaid</u>
<i>Eligibility</i>	65yrs or older,	Minimum Income
	Disabled	
	Same for the entire nation	Varies state-by-state
	Permanent Eligibility	Periodic Eligibility
<i>Regulation</i>	By Federal Government	Joint regulation by State and Federal Government
<i>Portability</i>	Portable	Non-portable
<i>Benefits</i>	National benefit structure	State benefit structure
	Social Insurance	Social Welfare

THE UNINSURED AND UNDERINSURED

The number of uninsured citizens in the United States continues to increase. In 1999, there were 40 million uninsured Americans, but by 2004 that number had increased to 45.8 million²². One in six Americans and eight million children currently lack health insurance. It has been projected by researchers at the University of California, San Diego, that there will be 56 million uninsured Americans by the year 2013. This number accounts for 27.8% of the projected non-elderly working population³¹. In addition to the large uninsured population, an estimated 16 million people were underinsured in 2003, equaling a total of approximately 62 million American citizens that were inadequately insured⁴³.

Of the almost 46 million uninsured individuals in the U.S., nearly half are non-elderly adults who are suffering from a chronic condition³³. Chronic conditions being defined to include hypertension, high cholesterol, heart disease, asthma, diabetes, arthritis-related conditions, anxiety/depression, severe headache/migraine, cancer, chronic bronchitis, liver condition, stroke, and emphysema³³. Regular medical and preventive care³³, including dental and behavioral healthcare, are important aspects of comprehensive health care and the reduction of complications from the underlying chronic conditions. Unfortunately, uninsured and underinsured individuals do not experience the same access to care as many insured individuals. Relative to the insured population, uninsured individuals receive less preventive care, are diagnosed at more advanced stages of disease, are less likely to be receiving therapeutic care, are less likely to be admitted to the hospital after an ER visit, and are more likely to die when they

are admitted to a hospital⁴⁸. Table 4 illustrates some of the unmet needs of insured and uninsured individuals with chronic conditions.

Table 4

Percent of Adults with Chronic Conditions Reporting Unmet Need for Healthcare in the Past 12 Months					
	Medical Care	Prescription Drugs	Mental Health Care	Dental Care	Vision Care
<i>Uninsured</i>	34%*	34%*	11%*	40%*	25%*
<i>Insured</i>	6%	7%	2%	11%	6%

*Difference between insured and uninsured is significant p<0.05

“Uninsured Americans with Chronic Health Conditions: Key Findings from the National Health Interview Survey.” Cover the Uninsured Week, May 1-8, 2005.

Employer based health insurance is the primary source of health coverage²³, unfortunately, the number of people with employer based health insurance fell from 175.3 million to 174 million between 2002 and 2003²⁴. Given current costs, not all businesses are financially able or desire to offer health insurance. Even when health insurance is offered, it may not be financially feasible for every employee to take advantage of the benefits. As a result, there are 15.1 million employees who do not have health insurance²³. Plans that are offered to employees are following a trend of higher deductibles, increased patient cost sharing, and restricted scope of benefits. This trend is increasing the number of underinsured individuals.

Undocumented immigrants, generally not counted in the uninsured population of the United States, who seek health care present a huge financial burden on many hospitals, which are required to provide emergency care regardless of citizenship or ability to pay. California hospitals have been estimated to spend \$500 million a year on treatments for illegal immigrants³⁵. In 2005, the Bush administration announced that the Federal Government is making one billion dollars available through 2008 to pay hospitals and physicians to care for illegal immigrants³⁵.

According to the U.S. Census Bureau, the largest group of uninsured individuals is the 18-24 year old population²⁴ (see Table 5). This phenomenon could be due to several reasons, including but not limited to, young adults no longer covered by their parents’ insurance but having not yet secured jobs that offer benefits, or simply not being able to afford or not desiring to purchase individual health insurance.

Table 5

Age Distribution of the American Uninsured Population in 2003	
Age	% of the uninsured
18 yrs and under	11.4
18 – 24 yrs	30.2
25 – 34 yrs	26.4
35 – 44 yrs	18.1
45 – 64 yrs	13.9
65 yrs and above	0.8

US Census Bureau

No matter what the causes of this uninsured population, the impacts could effect the entire population. These basically healthy individuals in the 18-24 and the 25-34 year old age group, who often need relatively few health services and are not purchasing insurance, could be contributing to the increasing costs of insurance for the rest of the population. The insurance market relies upon healthy insurance purchasers to subsidize older and/or sicker individuals who have high health expenses. By not purchasing insurance, and, therefore, not contributing to the subsidization of the sick, the costs for those individuals who are purchasing insurance may be higher because there are less healthy individuals in the pool to subsidize the sick. Higher insurance prices may then lead to more underinsured individuals. This unfortunate cycle continues to repeat and expand. In addition, these uninsured and underinsured young individuals may forgo adequate preventive care and/or family planning, which could cause more health needs in the future. These future health needs translate into more money being spent later than what preventive services would cost now.

CHRONIC DISEASE AND PREVENTION

According to the Centers for Disease Control more than 90 million Americans live with chronic illnesses, and those chronic illnesses account for 70% of all deaths in the United States. Medical care costs associated with chronic disease in the United States is staggering at more than \$1.05 trillion³⁷. Behavioral health disorders, including psychiatric and substance abuse problems, also impact emergency room visits, medication compliance, and increased healthcare utilization⁵⁵. In addition, dental health is an important but often neglected part of health that may affect a person’s nutritional status and/or cause systemic infections, among other adverse outcomes. By assuring financial access to care and investing in effective prevention programs

for all Americans, the costs of chronic disease, mental illness, and dental disease may be decreased and overall health improved. Therefore, it is important that the most cost-effective preventive strategies are used to produce the maximum benefit to the population. The following lists some of the reported costs and benefits of disease prevention. This data has been retrieved largely from the Centers for Disease Control and Prevention and the National Center for Chronic Disease Prevention and Health Promotion.

Costs Associated with Disease and/or Care

- Hospitalizations for pregnancy-related complications occurring before delivery account for more than \$1 billion annually.
- The direct and indirect costs of diabetes are nearly \$132 billion a year.
- Each year, arthritis results in estimated medical care costs of more than \$22 billion, and estimated total costs (medical care and lost productivity) of almost \$82 billion.
- The estimated direct and indirect costs associated with smoking exceed \$75 billion annually.
- In 2001, approximately \$300 billion was spent on all cardiovascular diseases. Over \$129 billion in lost productivity was due to cardiovascular disease.
- It is estimated, based on analyses done by the Central Virginia Health Planning Agency (CVHPA), that in 2003 Virginia consumers spent (actual reimbursement, not charges) approximately \$1.4 billion for inpatient cardiovascular disease alone, while consumers in the Central Virginia region spent an estimated \$329.7 million during the same period, far more than our region's relative representation (approximately 17%) of the State's population.
- The direct medical costs associated with physical inactivity were nearly \$76.6 billion in 2000.
- Nearly \$68 billion is spent on dental services each year.
- Based on assessments done by the CVHPA, in 2001, inpatient charges for behavioral health inpatient admissions totaled more than \$18 million dollars in Virginia's Crater District (Planning District 19) and more than \$75 million in the greater Richmond area (Planning District 15). These charges translate to \$109 per resident of the Crater District and \$92 per resident of the greater Richmond area. About one-third of these were persons with 3 or more annual admissions for behavioral health, a level which would usually be considered preventable with appropriate community based services⁵⁶.

Benefits of Prevention

- For every \$1 spent on water fluoridation, \$38 is saved in dental restorative treatment costs.
- For a cost ranging from \$1,108 to \$4,542 for smoking cessation programs, one quality-adjusted year of life is saved. Smoking cessation interventions have been called the gold standard of cost-effective interventions.
- For each \$1 spent on the Safer Choice Program (a school-based HIV, other STD, and pregnancy prevention program), about \$2.65 is saved on medical and social costs.
- For every \$1 spent on preconception care programs for women with diabetes, \$1.86 can be saved by preventing birth defects among their offspring.
- According to one Northern California study, for every \$1 spent on the Arthritis Self-Help Program, \$3.42 was saved in physician visits and hospital costs.
- A mammogram every 2 years for women aged 50–69 costs only about \$9,000 per year of life saved. This cost compares favorably with other widely used clinical preventive services.
- For the cost of 100 Papanicolaou tests, commonly known as pap smears, for low-income elderly women, about \$5,907 and 3.7 years of life are saved.
- After controlling for physical limitation and major socioeconomic factors, more than 12% of annual medical costs of inactive persons with arthritis are associated with physical inactivity. Physical activity interventions may be a cost-effective strategy for reducing the burden of arthritis.
- Engaging in regular physical activity is associated with taking less medication and having fewer hospitalizations and physician visits.

The *Guide to Community Preventive Services*, released by the Centers for Disease Control and Prevention, and *The Guide to Clinical Preventive Services*, released by U.S. Preventive Services Task Force, contain reviews of the effectiveness of many prevention programs. After scrutinizing programs based on ability to improve health behaviors, reduce the burden of disease, and address environmental challenges, the programs are rated. The guides include multiple health programs including substance abuse, water fluoridation, and diabetes case management. The use of cost-effective prevention strategies, such as these, may ultimately increase financial access to care by allowing resources to be shifted away from expensive methods of care used to

correct damage that is already done and towards proven prevention strategies which could benefit larger sections of the population, lowering future healthcare costs.

ACCOUNTABILITY

With rising costs of healthcare, increased medical bankruptcies, and millions of uninsured, Americans are asking the question, “Who is accountable?” Although some sources have suggested that a single factor is responsible, most experts acknowledge that multiple factors contribute to escalating health care costs. Some identified areas of concern include over-utilization of costly diagnostic technology and other health services, rising hospital charges and costs, health insurance costs and coverage, health executive compensation, reimbursement of physicians and hospitals from Medicaid and Medicare costs, hospital and physician charges, confusion about charity care definitions, obligations and compliance of not-for-profit and for-profit hospitals, billing and collection procedures, health care provider compensation, and the role of governmental oversight.

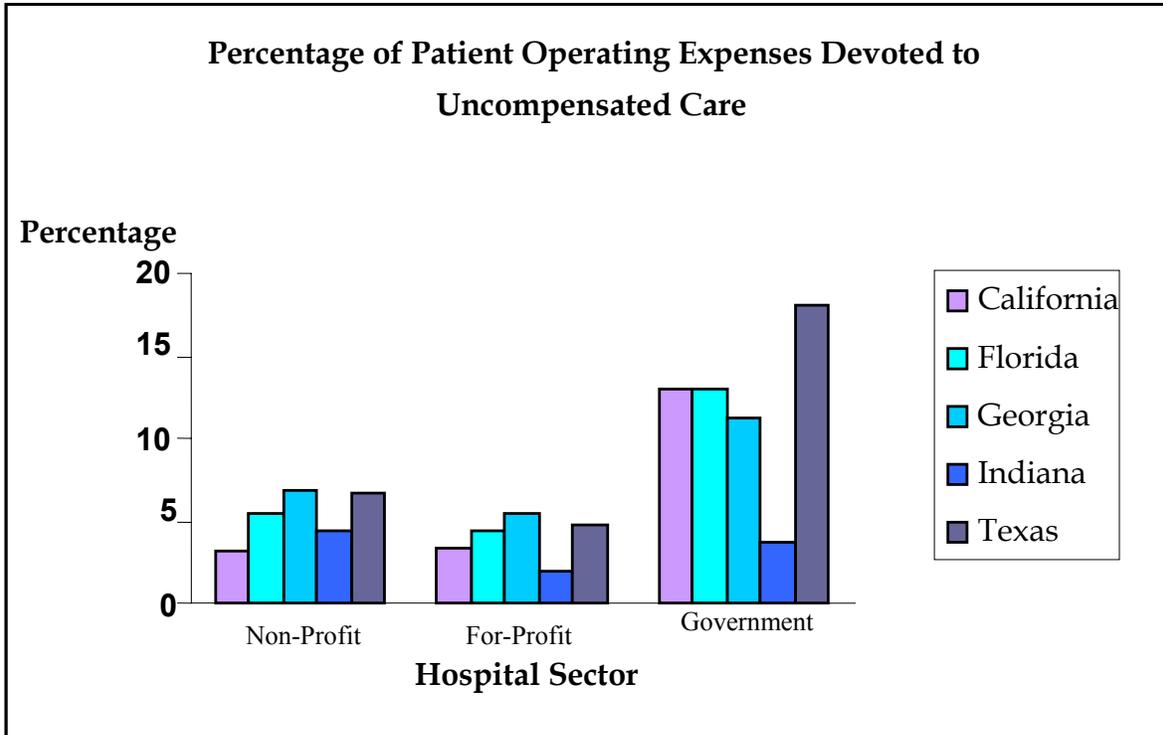
In the United States, more than 50 law suits were filed against nonprofit hospitals and health systems over the summer of 2004¹⁶. Hospitals have been accused of failing to meet requirements for their tax exempt status by giving uninsured patients charges that are above costs and using aggressive strategies to collect on bills¹⁷. Generally speaking, the main contention of the suits is that nonprofit hospitals are not providing efficient community benefit, which is a condition they must meet in order to not be taxed on their profits¹⁸.

One of Virginia’s largest nonprofit hospital chains is being sued for charging uninsured patients significantly more than the insured. The AHA, however, states that these claims are “without merit¹⁸.” In addition, some veterans of the healthcare business say that “nonprofits can’t deliver healthcare to the community by losing money¹⁸.”

Many courts are siding with the hospitals. Cases have been dismissed in Mississippi, Missouri, and Florida, just to name a few^{19, 20, 21}. Judges are deciding that hospital billing practices are based on sound legal principles¹⁹ and that it is not illegal to charge different rates to patients based on their insurance status²⁰. Some plaintiffs have withdrawn cases voluntarily, and arguments currently presented have failed to provide any evidence that hospitals have broken laws. However, most of the dismissed cases have been dismissed without prejudice, meaning that they may be addressed in the state courts again.

Meanwhile, the House Ways and Means Committee asked the Government Accountability Office (GAO) to investigate hospitals' uncompensated medical care. The GAO has looked at the differences in charity care provided by profit and non-profit hospitals in five states (California, Georgia, Texas, Florida, and Indiana) chosen for their geographic diversity and substantial representation of the three hospital ownership groups (for-profit, non-profit, and government). They were not concerned with charges or other pricing matters, but rather investigated dollar amounts of uncompensated care provided²⁹. As shown in the following graph, when looking at the percentage of patient operating expenses devoted to uncompensated care, the GAO found that differences between the for-profit and not-for-profit sectors were very small compared to differences between these sectors and the government hospital sector⁴⁷. *It should be noted that this study's findings did not consider differences in charges or total expenses that may exist between hospital sectors.*

Additionally, it was found that the burden of uncompensated care in all three sectors was concentrated in relatively few hospitals and that there were large differences in the amounts of uncompensated care provided by hospitals in offering the most uncompensated care compared with the hospitals offering the least uncompensated care in each sector⁴⁷. *This report raises serious issues relative to the role of all providers, since all receive public dollars in one form or the other, but, specifically, whether there should be a higher community benefit expected from those providers that receive a greater level of public subsidization.*



Based on the the CVHPA’s analysis of Virginia Health Information (VHI) financial data and census estimates, the net income of Virginia acute care hospitals (including children’s and general hospitals) was found to be approximately \$647 million in 2003, or about \$88 per Virginia resident. Health Planning Region IV, Central Virginia, accounted for more than \$195 million of that net income, or about \$155 per resident in Central Virginia. These state and regional numbers exclude non-operating income associated with the purchase of Southside Regional Medical Center in the Central region. *The profit margin of Virginia’s hospitals was 6.6% in 2003, while Central Virginia’s margin was 8.8%. It should be noted that there was wide variability in profits in the Central Virginia area, with profit margins ranging from -21.4% to 15.5% and profits concentrating mainly in hospitals in suburban areas while hospitals in the urban and rural settings were more likely to break even or lose money. A 3-5% profit margin generally is considered necessary by most businesses to sustain capital infrastructure and ensure organizational viability.*

Of course, hospitals are not the only entities that should be held accountable for rising healthcare costs. Insurance premiums continue to rise to unaffordable levels for some of the most vulnerable segments of society. When the 2004 earnings were viewed for a few of the

largest insurance companies that serve Virginia it was shown that these companies made large profits, as illustrated below:

Table 6

Insurance Companies 2004 Financial Performance			
	<u>Net Earnings</u>	<u>Profit Margin</u>	<u>Operating Margin</u>
	<i>(in millions)</i>		
UnitedHealth Group	2,587	7.1%	11.4%
Anthem/Wellpoint	960	4.7%	8.6%
CIGNA	1,483	11.6%	15.0%
Aetna	2,245	11.5%	11.1%

*Net Earning figures from the companies' respective 2004 annual reports; margins from <http://finance.yahoo.com>.

As mentioned earlier in this report, high professional and executive incomes could also contribute to the disproportionately high costs of healthcare in the United States⁵². Table 7 shows the range of physician salaries based on area of practice. These ranges were reported by Modern Healthcare, compiled from 15 different national surveys, and appear to represent the range of averages from those studies. Of course, individual physicians can earn above or below these ranges based upon experience, geographical location, practice setting, and other variables.

Table 7 (in dollars)

National Physician Compensation Ranges for 2005							
Anesthesiology	Cardiology	Emergency	Family Practice	Gen. Surgery	Hospitalist	Internal Med.	Urology
232,500 – 353,000	287,907 – 403,403	188,111 - 257,015	127,330 – 182,000	236,676 – 320,200	152,374 – 365,000	157,700 – 185,000	260,990 – 428,350
Neurology	OB-GYN	Oncology	Pathology	Pediatrics	Psychiatry	Radiology	
171,298 – 238,511	198,863 – 290,000	223,200 – 372,470	192,500 – 350,286	142,210 – 184,900	150,000 – 225,305	209,365 – 420,505	

ModernHealthcare.com, Physician Compensation – 2005 Survey. www.modernhealthcare.com

Table 8 shows healthcare system executive cash compensations based upon survey data. On top of these cash compensations, executives regularly receive significant compensation in the form of benefits, stocks, etc. Like physicians, individual compensation can vary based on a number of variables.

Table 8 (in thousands)

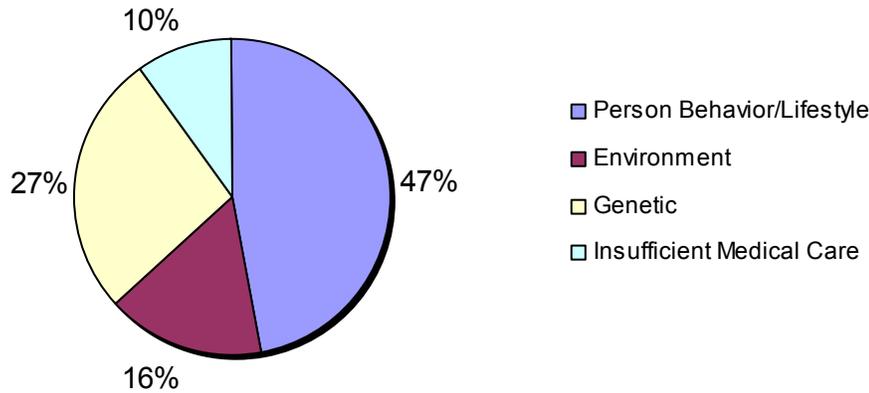
National Healthcare Executive Average Total Cash Compensations – 2005	
President/CEO	732.4
Chief Operating Officer	491.5
Chief Medical Officer	376.6
Chief Network /System Development Officer	317.5
Chief Financial Officer	372.6
Chief Information Officer	256.0
Chief Privacy Officer	113.2

Data collected from ModernHealthcare.com. Executive Compensation Survey

Executive salaries in the largest insurance companies’ in the nation range from \$3 million to \$10 million cash compensation and \$4 million to \$94 million in total dollar compensation in fiscal year 2003⁵³.

Accountability extends beyond government, hospitals, physicians, and insurance companies. Indeed, individuals are responsible for many of the factors that influence premature death, and likely their health, including lifestyle, dietary, and environmental factors. A 1990 seminal report from the U.S. Department of Health and Human Services analyzed factors contributing to premature mortality. The results reported that personal behavior/lifestyle factors contributed approximately 47 percent; environmental factors contributed 16 percent; genetic factors contributed 27 percent; and insufficient medical care accounted for only 10 percent. *Of note, however, this study specifically dealt with mortality and not quality of life issues, such as disability and suffering that also are impacted by inadequate medical care as well as lifestyle.*

Factors Contributing to Pre-Mature Mortality



Department of Health and Human Services, 1990

Confounding Issues

Several issues exacerbate financial access to health care. These issues include but are not limited to the following: 1) misunderstandings created by the billing and collection practices currently used by healthcare facilities, 2) the ambiguity and confusion of federal and state regulations regarding reporting and compliance for tax exempt status, and 3) the inconsistencies of health care providers' financial policies which uninsured consumers must navigate to get affordable care. In addition, it is often difficult or impossible for patients, or purchasers, to get accurate estimates of healthcare costs for specific procedures or types of care, making the healthcare industry unique from almost all other services purchased by consumers. *The following focuses on hospital policies and practices but also applies to most other health care providers, such as outpatient centers and physician groups, as well.*

BILLING AND COLLECTION PRACTICES

The Office of Inspector General's Position

In the recent past, some healthcare institutions were served lawsuits claiming that they were not billing uninsured patients at the same discount offered insured patients. Many hospitals had concluded that laws enforced by the Office of Inspector General (OIG) prohibited them from offering discounted prices to uninsured individuals²⁵. It has even been suggested that “the OIG requires hospitals to engage in vigorous collection efforts against uninsured patients²⁵.” The OIG disagrees, stating that no OIG regulation requires a hospital to engage in any particular collection practice²⁵. Hospitals are not required to charge everyone the same price, nor are they

required to give Medicare and/or Medicaid the best price²⁵. The OIG has issued a proposed rule that will establish standards for a safe harbor under the Federal anti-kickback statute. This rule would protect hospitals which are offering discounts, if those discounts contribute to treatment of underserved populations.

The American Hospital Association's Position

The American Hospital Association (AHA) has developed recommendations for hospitals to help ensure that their billing practices comply with federal guidelines and regulations and take into account the financial situation of individual patients. These recommendations focus around three main points: 1) helping patients with payment for hospital care, 2) helping qualified patients obtain federal or state insurance coverage, and 3) ensuring fair billing and collection practices⁸. These goals are outlined in more detail in Figure 1 of the Appendix. Eighty-one Virginia Hospital and Healthcare Association (VHHA) member hospitals, twelve from Central Virginia, have signed a confirmation of commitment to the AHA regarding these recommendations¹⁷.

In addition to these recommendations, the AHA along with The Healthcare Financial Management Association (HFMA) created a program to work with hospital system leaders and create a report to help hospital revise their billing policies. This program, the Patient Friendly Billing Project, has now published an extensive report advising hospitals on how to make their billing and collection policies both effective and easy to navigate for patients²⁶.

The Virginia Hospital and Healthcare Association's Position

In addition to these guidelines, the VHHA went one step further for Virginia hospitals and developed their own voluntary guidelines which are even more detailed than those described by the AHA. The guidelines give direction to hospitals addressing policy on eligibility for financial assistance, defining collection practices, and monitoring implementation of these policies¹⁷, see Figure 2 in the appendix.

REPORTING AND COMPLIANCE

Internal Revenue Service (IRS) Regulations on Tax Exempt Organizations

Internal Revenue Code (IRC) Section 501(c) (3) sets forth requirements for organizations that hold a tax exempt status. According to Section 501(c) (3), tax exempt organizations must not allow any of their earnings to inure to any private shareholder or individual, the class of beneficiaries must have significant need and be large enough to benefit the community as a

whole, and the organization must not attempt to influence legislation as a substantial part of its activities or participate in campaign activity for or against political candidates².

While inurement is prohibited by IRC Section 501(c) (3), private benefit is not; so long as it is not “more than incidental.”⁴ Inurement involves benefit from income or assets of the organization going to an insider. Private benefit, on the other hand, can involve benefits going to anyone. However, if the organization provides excess benefit to a person with “substantial influence⁴” over the organization, the person as well as any managers that agreed to the transaction may have to pay an excise tax.

An organization will not be regarded tax exempt if “more than an insubstantial part of its activities is not in furtherance of an exempt purpose².” Exempt purposes are: charitable, religious, educational, scientific, literary, testing for public safety, fostering national or international intramural sports activities, and prevention of cruelty to children or animals. A charitable organization must be organized as a corporation, community chest, fund, or foundation, and it must ensure that assets are permanently dedicated to an exempt purpose^{2,4}. Upon dissolution, the assets must be distributed for exclusively charitable purposes.

Further, IRS Rev. Rule. 69-545 sets forth more requirements specifically for hospitals with tax exemption. In addition to meeting the requirements of IRC 501(c) (3), IRS Rev. Rule 69-545 requires five additional conditions to be met. First, the hospital must be governed by a board of trustees consisting of prominent citizens in the community. Second, medical staff privileges must be available to all qualified physicians in the community. Third, the hospital must operate a full time emergency room and cannot deny anyone emergency treatment, regardless of ability to pay. Exceptions are made if it is determined by a governmental health planning agency that an emergency room is not required or if the hospital is a specialty hospital that does not require emergency care. Fourth, the hospital can limit non-emergency treatment to those able to pay, either themselves or through third-party payers. Finally, all surplus funds must be used to improve the quality of patient care, expand its facilities, and advance its medical training, education, and research programs⁴.

In addition to hospitals, the requirements of IRC 501(c)(3) and Rev. Rul. 69-545 apply to non-hospital providers, such as rehabilitation institutions, outpatient clinics, community mental health centers, dental clinics, drug treatment centers or community chiropractic clinics⁴. The

requirement for open staff privileges does not necessarily apply to clinics, specialty hospitals, or similar healthcare providers⁴.

Generally Accepted Accounting Procedures (GAAP) for Bad Debt and Charity Care

According to the Healthcare Financial Management Association (HFMA), “bad debts result from the unwillingness of a patient to pay, whereas charity service is provided to a patient with demonstrated inability to pay³⁰.” HFMA also states that it is important for an organization to make a distinction between bad debt and charity care for several reasons. These reasons include:

- Charity service is a valuable resource which must be managed wisely.
- Charity service is an important indicator of an organization’s charitable purposes.
- Provider eligibility for certain financial assistance is dependent on identification of charity service.
- Bad debt expense is a measure of the effectiveness of the organization’s credit and collection process.

While it is best to determine charity care eligibility as close to the time of service as possible, there is no rigid limit restricting the time that the decision must be made. Collection efforts may reveal information that was previously unknown, which could change the eligibility for charity care of an individual. However, once an amount for bad debt or charity care is written off, the decision should not be changed³⁰. It should be noted that many hospitals include bad debt and write-offs associated with Medicaid, Medicare, and other governmental insurers as uncompensated care even though they may still be making money on these “uncompensated patients.” This practice may skew “charity care” amounts in favor of the hospital and should not be occurring.

The American Institute of Certified Public Accountants Audit and Accounting Guide requires that bad debts be classified as an expense and that charity services be eliminated from both revenue and receivables³⁰. However, it is often not known at the time of service whether a service will meet charity care criteria or not. Therefore, the Institute requires or recommends the following procedure to report charity care³⁰:

1. Record services at the full established charges amount in revenue and receivables as services are rendered.
2. Adjust revenue and receivables to the amount a payer has an obligation to pay.
3. Estimate the amount of remaining receivables that will eventually be written off as charity service. This amount is recorded as a provision for charity service (a

revenue contra account) and an allowance for charity service (a receivable contra account).

4. Write off receivables as they are determined to meet charity service criteria against the allowance for charity service. Documentation concerning charity service should be retained.
5. Regularly evaluate the adequacy of the allowance for charity service with adjustments to increase or decrease the allowance offset by adjustments in the provision for charity service.

Consequently, the charity care information is not visible on the financial statements; therefore, it is necessary to make notes to the financial statements to describe the charity services provided. It is also a requirement of The American Institute of Certified Public Accountants Audit and Accounting Guide that the organization disclose its charity care policy³⁰.

Bad debts are recorded in a similar fashion as charity care and can add to the cost of health care. However, generally accepted accounting principles have no requirements for reporting bad debt on financial statements. Usually, bad debts as well as other collection expenses are included in a general and administrative expense category³⁰. The following procedure should be followed for recording bad debts³⁰:

1. Record services at the full established charges amount in revenue and receivables as services are rendered.
2. The receivables amount is adjusted according to the amount that a payer has an obligation to pay, with an offsetting amount recorded in a revenue contra account.
3. The amount of bad debts is estimated, and a provision for bad debts (an expense account) and an allowance for bad debts (a receivable contra account) are recorded
4. As receivables are determined to be uncollectible, they are written off against the allowance for bad debts. Documentation concerning the collection effort and result should be retained.
5. The adequacy of the allowance for bad debts is evaluated regularly with adjustments to increase or decrease the allowance offset by adjustments in the provision for bad debts.

Virginia Certificate of Public Need

A Certificate of Public Need (COPN) is a document issued by Virginia's Commissioner of Health to legally authorize a regulated medical care facility or project²⁷. A list of facilities that require COPNs and the types of projects that require COPNs are in the appendix, Figure 3 and Figure 4, respectively. In Virginia, in addition to Department of Health Staff, the

appropriate regional planning agency makes recommendations to the Commissioner regarding the public need for each regulated proposed project.

The State Health Commissioner often places conditions on a COPN, which must be agreed to in order for the facility to receive the COPN. Three specific conditions the State Health Commissioner can place on a COPN are:

1. The applicant will provide an acceptable level of care at a reduced rate to indigents (indigent meaning any person whose gross annual family income is equal or less than 200% of the Federal Non-Farm Poverty Level [FPL] as published for the then current year in the Code of Federal Regulations)⁵
2. The applicant will provide care to persons with special needs⁵
3. The applicant will facilitate the development and operation of primary medical care services in designated medically underserved areas of the applicant's service area⁵

There are reporting requirements for organizations that have conditions on their COPNs⁵. Annual reports must be filed based on the COPN holder's fiscal or calendar year for as long as the condition remains in effect. These reports should be received by the Department of Certificate of Public Need and the Regional Health Planning Agency (RHPA) within 90 days of the end of the reporting period. Reports should also be certified by an accountant or by an authorized officer. Figure 5 of the appendix includes the COPN compliance form. Despite these detailed guidelines, a time period is not specified by which an organization must come into compliance if it is determined that there is a deficit in their charity care⁵. Penalties for not meeting the conditions through alternatives outlined in the guidelines include a \$100 a day fine per violation and/or the revoking of hospital/nursing home licenses, if licenses are conditioned upon the COPN.

Indigent Care Trust Funds

The Virginia Indigent Health Care Trust Fund was created in 1989 as a partnership between the government and private acute care hospitals²⁸. The purpose of the fund is to equalize the burden of caring for the indigent population by providing reimbursements to hospitals that provided charity care in excess of the median of charity care costs delivered to those living at or below 100% of the Federal Poverty Level. The funds are supplied by the State General Fund and contributions from other hospitals that provided less than the median of charity care costs²⁸. While the amount of reimbursements varies each year, in 2003 the Fund

supplied \$7,782,532 to Virginia hospitals, of which \$5,215,199 was from the State General Fund⁵⁴.

The Department of Medical Assistance collects data by requiring that each hospital files a statement of charity care and other data that may be required no later than 120 days following the end of each of its fiscal years⁶. The standard for charity care is established annually by finding the median of the percentages of charity care provided by all hospitals, with the exception of the two state authority hospitals (Virginia Commonwealth University Health System and University of Virginia Health System). The percentage of charity care for each hospital is figured by dividing the charity care charges by the gross patient revenue⁷.

CHARITY CARE

The AHA reports that hospitals incurred costs of nearly \$25 billion of uncompensated care in 2003⁴¹. It is important to note that what gets reported as uncompensated care can vary widely including everything from up-front charity care allowances, to bad debt write-offs, to contractual allowances (particularly for Medicaid and other governmental programs). Therefore, consumers need to understand what is actually being reported and whether it represents true care to those unable to afford it or the result of inflated charges that no private insurance company or insured person would ever be obligated to pay. Partially as a result of this lack of transparency, hospitals are still being closely scrutinized and brought to court over claims of inadequate amounts of charity care being provided. In addition, millions of Americans are experiencing bankruptcy due to high medical bills. Charity care policies vary widely among health care providers, making it unclear to consumers what options are available to them at any given hospital, physician's office, or outpatient care center.

Little has been done at a nationwide level to improve the consistency of charity care policies; however, small steps are being taken across the country to improve the situation. For example, four hospital systems in Minnesota have entered into a voluntary agreement that they will not charge uninsured patients, whose annual household is less than \$125,000, more than the rate negotiated by the health insurer from which the hospital earned the most revenue in the previous year. They also agreed to follow certain debt collection standards⁴⁴.

RECOMMENDATIONS

The Central Virginia Health Planning Agency has several recommendations to improve financial access to care for all populations, increase preventive health services, and improve the cost-effectiveness of the care being delivered. They are:

- Utilize cost effective prevention strategies and needs assessments in decision making, and implement these strategies as standard practice in planning and policy development.
- Adopt financial policies for low income and/or uninsured patients both to benefit the provider organizations, through building trust and support throughout their communities, and the low-income and uninsured populations, who are increasingly finding appropriate health care out of reach.
- Develop educational publications with the cooperation of community partners, which will aim to inform consumers of the healthcare system and assist patients in finding the most appropriate and affordable care available.
- As a longer term recommendation, adoption of healthcare coverage for the entire population at the state or federal level which includes the concept of “medical homes,” ensuring that all people will have access to primary medical care and preventive services.

The following provides additional details relative to these recommendations:

UTILIZE COST EFFECTIVE PREVENTION STRATEGIES AND NEEDS ASSESSMENTS

It is essential that resources are allocated to the sectors of our society where the greatest health benefit can be realized. To achieve this, needs of society must be evaluated on a regional basis. The CVHPA, therefore, recommends an initiative to systematically collect, analyze, and publicly report data relative to the evolving health needs of Virginians and the impact of public policy changes. An example might include tracking the impact of changing Medicaid reimbursements for obstetrics and pediatric dental care. This should be a priority in moving forward with these recommendations.

Once a thorough needs assessment has been conducted, decision makers should evaluate the costs of prevention programs and the benefits they will provide to the targeted population. Minimum standards for analyzing cost-effectiveness of a program are set forth by the Basic Assessment Scheme for Intervention Costs and Consequences methodology (BASICC) and are recommended for use by the Centers for Disease Control and Prevention³⁸. The findings of the needs assessment and the costs and benefits of prevention programs can then be combined to find the best options for particular populations.

BASICC assesses only intervention costs and savings from direct costs, and thus may not be completely accurate³⁸. A comprehensive analysis would include productivity costs and intangible costs (those costs, such as pain and suffering, which cannot easily be valued monetarily)³⁸. Comprehensive cost analysis standards can be found in “A Practical Guide to Prevention Effectiveness: Decision and Economic Analysis³⁹.”

It is highly recommended that all prevention programs currently in use, or at least all new programs, begin collecting the data necessary to perform the BASICC methodology, if not the more comprehensive cost-effective analysis. The six elements necessary for completing BASICC are:

1. Units in which the services are provided and time frame of the program
2. Health outcomes averted by the program and estimated time between its implementation and when the health outcome is averted
3. Rates and social burden of the averted health outcome
4. The preventable fraction for the health outcome, with the program used in a realistic manner
5. Intervention costs, per unit of intervention, including costs of side-effects
6. Direct medical treatment costs of the health outcome prevented

Exemplary state prevention programs have been identified by state chronic disease directors, state prevention program coordinators, and CDC staff. The CDC states that these programs are based on strong research, demonstrate innovative approaches, or yield positive, measurable outcomes. A few of these programs are outlined in the Appendix, Figures 5-7. A complete list of the identified programs can be found at <http://www.cdc.gov/nccdphp/exemplary/index.htm>.

ADOPT FINANCIAL POLICES FOR LOW-INCOME AND/OR UNINSURED PATIENTS

The CVHPA has adopted a policy to recommend to the State Health Commissioner denial of any project that is being applied for if the organization requesting the Certificate of Public Need (COPN) has not met prior charity care commitments. The Agency recommends that Virginia’s other four health planning agencies also adopt this policy, if they haven’t already, and the Division of COPN staff and the Commissioner support the regional planning agencies’ recommendation for denial if compliance is not forthcoming. The CVHPA has found that most providers respect this position and come into compliance with prior charity care obligations

rather than risk the denial of a current application and/or the bad public relations associated with not meeting such an obligation. It has also resulted in many providers actively addressing issues of access to care rather than passively waiting for those from lower income households with acute needs to come to their doors. Moreover, enforcement of charity care obligations has resulted in additional resources being made available to safety net providers delivering primary health care, thereby, potentially impacting the use of more expensive and less effective emergency and inpatient services.

It is in the best interest of the patient, as well as the organization, for healthcare providers to have detailed policies in place for identifying and assisting patients in financial need. It is also of utmost importance for patients to be educated concerning the availability of charity care and the questions they need to ask upon arrival at a healthcare organization. The appendix, figure 9, displays a model notice, prepared by the Virginia Hospital and Healthcare Association, to all patients that can be visibly displayed throughout a facility, posted on a website, and handed out to patients at registration (except where prohibited by law). *Note that the CVHPA is concerned about wording on the notice and its interpretation by patients and staff that because of “federal requirements, hospitals must bill all patients for the amount they owe and attempt to collect those debts in the same fashion for all patients.”* The CVHPA is unsure of the federal requirements that are being referred to and many patients may not realize that the “amount they owe” can vary widely based on insurance coverage and/or their eligibility for free or reduced price care. Nevertheless, all efforts, such as this model notice, to inform patients and/or their families about financial access should be applauded and revised, as needed, to improve consumer awareness and remove barriers to care.

CONSUMER EDUCATION/PUBLICATIONS

As stated previously, there is little transparency relative to health care in the United States, whether it’s the cost or quality of care, impacting the ability of the consumer to judge effectiveness, appropriateness, or value. Well educated persons with considerable resources can’t get adequate answers to many of their questions (and they often have an insurance company or human resources employee to assist them). How are less educated, uninsured, and/or lower income persons supposed to advocate for their or their family members’ health? Assistance may come in the form of consumer-friendly information resources ranging from brochures to internet sites to media coverage of important and practical issues.

For example, the Kentucky Hospital Association (KHA) launched a web site (<https://www.kyha.com/Pricing/main.asp>) for consumers that lists median acute care hospital charges for the top 25 diagnosis related groups, or illness categories, in the state. The site also lists the median lengths of stay, median patient age and number of discharges for the top 25 DRGs, which represent about half of hospital discharges in the state. Consumers can search for the information by hospital, condition and severity level. KHA plans to update the site annually. "When a patient has an opportunity to plan for a hospital stay, this site is a starting point to research potential out-of-pocket costs so that the patient and family can plan accordingly," said KHA President Michael Rust. The hospital and other health care provider associations in Virginia and other states should investigate developing a similar site, perhaps with the addition of a summary of each organization's charity care policy.

Working collaboratively with our community partners, the CVHPA intends to produce a brochure in the coming year that will provide information to uninsured and/or low-income consumers regarding what questions to ask health care providers about their health care bill (including dental, behavioral and associated services) and what documentation they should be prepared to provide. This publication will be linguistically and culturally appropriate to reflect the diversity of the Virginia population. The Agency also will continue the work of its Financial Access to Care Committee by bringing local media attention to the issues outlined throughout this paper and to expand its membership to include more of our community partners. Finally, the CVHPA will work with State and Federal legislators to increase their knowledge of and interest in addressing the health-related access difficulties that many Virginians and Americans face every day. These difficulties impact both individual and societal well-being and have enormous short and long range costs to our communities, state, and nation.

ADOPTION OF HEALTHCARE COVERAGE FOR THE ENTIRE POPULATION

In order for all citizens of Virginia to receive adequate preventive, primary, and follow-up care, there must be some form of universal health insurance to cover indigent patients. As a long term goal, the Agency recommends that the state of Virginia implement a universal health insurance system which would establish a "medical home" for every citizen and encourage local communities, including its health providers, to be an active participant in the development, implementation, and monitoring of the system. Not only does this system have the potential for

increasing the health of all Virginians, but it may also lower administrative and overhead costs by using universal standards to maximize efficiency.

Specialty referral systems already exist within Virginia, but are typically not widespread. The Richmond Academy of Medicine is developing a program of non-contractual agreements with local physicians. Physicians who agree to participate will commit to serving a specified number of indigent patients within a 12 month period. This initiative will also include enhanced tracking of services provided to the indigent and education for physician practice managers.

At least two other states have developed, or are implementing, a program with medical homes including North Carolina's Moore County and California's El Dorado County^{45, 46}. Both counties have the goal of increasing financial access to care for indigent patients. Using a community approach that includes hospitals, doctors, county services, and businesses, patients will be ensured a medical home. Issues of improved quality and efficiency are addressed. The program hopes to reduce emergency room crowding, increase the number of employers offering insurance programs and aims to improve the counties' return on investment in healthcare.

CONCLUSION

The Central Virginia Health Planning Agency acknowledges the efforts made by public and private organizations to meet the needs of indigent populations. However, additional efforts and significant community commitment are required to implement these recommendations and improve financial access to care in our communities.

Through careful planning and use of resources, increased public awareness, and cooperation, a foundation for collaborative community action can be established. With increasing public awareness of the problems of the uninsured and underinsured and dissatisfaction with rising health care costs, interest in a health system that benefits all segments of society, not just the poor, ill, and disabled, is growing. Such a system would provide a medical home for each person and include basic preventive and primary care, and efficient use of healthcare expenditures. The goal would be to create a healthier, more productive population. Key elements to this vision are:

- Targeted collection and use of data/information to identify gaps, promote cost effective solutions, and establish priorities.
- Utilization of this information to develop informed and cost-effective public policy.

- Implementation of best practices targeted to specific community needs.
- Participation by all stakeholders in actively providing healthcare to all segments of society.

The CVHPA encourages others to share this vision and hopes that this report will stimulate further discussion of the issues and most importantly, generate possible solutions to our looming national healthcare crisis.

Appendix

Figure 1

AHA Recommendations for Hospital Billing and Collection Practices⁸

- I. Helping Patients with Payment for Hospital Care by:**
 - a. Communicating Effectively*
 - 1) Provide financial counseling and make it widely known
 - 2) Respond promptly to patients' questions
 - 3) Use a billing process that is clear, concise, correct, and patient friendly
 - 4) Make charges available to the public in a meaningful and clear format
 - b. Helping patients qualify for coverage*
 - 1) Make information on hospital-based charity care policies and other known programs of financial assistance available to the public
 - 2) Communicate this information understandably, culturally appropriately, and in the most prevalent language of the region
 - 3) Have understandable written policies to help patients determine if they are eligible for assistance programs
 - 4) Share policies with appropriate community health and community services agencies
 - c. Ensuring hospital policies are applied accurately and consistently*
 - 1) Ensure that written policies are applied consistently
 - 2) Ensure that staff members working closely with patients are educated about hospital billing, financial assistance, and collection policies and practices
- II. Making Care More Affordable for Patients with Limited Means**
 - a. Ensure all charges are reasonably related to cost of the service and to meeting all of the community's health care needs*
 - b. Offer discounts to patients who do not qualify under charity care policy but who meet standards to be eligible for those discounts*
 - Policies should clearly state eligibility criteria, amount of discount, and payment plan options
- III. Ensuring Fair Billing and Collection Practices**
 - a. Patient accounts should be pursued fairly and consistently*
 - b. Define the standards and scope of practices to be used by outside collection agencies acting on the hospital's behalf*
 - c. Written policies about when and under whose authority patient debt is advanced for collection*

Figure 2

Voluntary Guidelines for Financial Assistance Policies of Virginia Hospitals and Health Systems from the Virginia Hospital & Healthcare Association

Preamble

Virginia's hospitals and health systems have a long history of providing financial assistance to patients who need it. Their mission is to provide care for patients 24 hours a day, seven days a week, 365 days a year, regardless of the patient's ability to pay.

In 2002 Virginia hospitals and health systems provided nearly \$500 million in uncompensated care to patients who were uninsured or underinsured. This number, valued at cost, grows every year.

The provision of free or reduced-cost care by hospitals and health systems is one way that individuals gain access to the health care they need, but it cannot be the sole, long-term solution to serving the uninsured. What is needed is a strategy for making privately or publicly funded health care coverage available to all Virginians.

Hospital and health system financial assistance should not be a substitute for employer-sponsored, public or individually purchased insurance.

To the extent that financial assistance provided by hospitals and health systems is the means by which individuals obtain health care services, the Virginia Hospital & Healthcare Association recommends that its members develop their billing and collection policies based on the following principles and guidelines.

For purposes of this document, "financial assistance" refers to instances where the patient is eligible for either free or partial assistance, including discounted billing and/or special payment provisions.

Principles

- All patients should be treated with respect, compassion and dignity.
- Lack of financial resources should never get in the way of a patient receiving essential health services. Hospitals and health systems should convey this message to prospective patients and local community service agencies.
- Hospitals and health systems should have written policies that explain the billing and collection policies that apply to low-income uninsured and underinsured patients. These policies should reflect the mission and values of the organization, and they should be reviewed and updated periodically.
- Billing and collection policies should be reasonable, clear, communicated in a consumer-friendly manner and applied consistently to all patients. They should also encourage appropriate access to care and responsible utilization of services.
- Financial assistance policies do not eliminate personal responsibility. Individuals must be willing to: provide in a timely manner the information needed to determine eligibility for assistance; apply for other types of healthcare coverage for which they may be eligible; and contribute to the cost of their care based on their ability to pay.

Guidelines for Financial Assistance Policies

Financial assistance is intended to assist those low-income, uninsured and underinsured individuals who do not otherwise have the ability to pay the full cost of their care. It should take into account each individual's ability to contribute to the cost of his or her care. Consideration also should be given to providing financial assistance on a case-by-case basis to patients who have exhausted their insurance benefits and/or who exceed financial eligibility criteria but face extraordinary medical costs.

VHHA suggests that a hospital's or health system's policies:

- State plainly the eligibility criteria for receiving full or partial financial assistance.
- Explain whether and how assets will be used in determining eligibility for financial assistance.
- Define the type and scope of essential services eligible for financial assistance.
- Ensure that charges for services reflect both the cost of meeting all community health care needs, including the necessary subsidies to maintain essential public services and the cost of the service itself.
- Consider billing patients who do not qualify for full assistance on some basis other than charges for services.
- Require that any patients seeking financial assistance shall comply with financial assistance application requirements, including the timely production of necessary documentation, and will provide the hospital or health system with any and all financial and other information needed to enroll in a publicly funded insurance program (e.g., Medicaid, Medicare, FAMIS).
- Require financial documentation that is easy to understand and provide (e.g., pay stubs, tax returns, mortgage papers, rent receipts, etc.)
- State clearly if a minimum payment is required to ensure patients recognize the value of medical care and use the healthcare system responsibly.

Guidelines for Collections Policy

Although clear and consistent financial assistance policies will go far toward promoting access to care and minimizing bad debts, hospitals and health systems must have collection policies that reflect the mission and values of their organization. They also should ensure that debt collection activities exercised by outside collections agencies reflect the hospital's or health system's mission, values and directions.

VHHA suggests that hospitals and health systems:

- Work with the patient to establish a reasonable payment plan.
- Take legal action, including the garnishment of wages, only if: there is evidence that the patient or responsible party has income and/or assets in excess of the levels suggested in the financial assistance policy; the patient has failed to provide the information needed to determine eligibility for financial assistance or the patient is no longer meeting his obligations under an agreed-upon payment plan and has not informed the collections office of a change in financial condition.
- Do not force the sale or foreclosure of a patient's primary residence to pay an outstanding medical bill. Liens placed by hospitals and health systems on a patient's primary residence are to be satisfied only in the case of a willing seller.
- Review the patient's record before any outstanding bills are assigned to a collection agency to determine if the action is appropriate.
- Have written policies that specify who may authorize write-offs.
- Have written policies about when and under whose authority a patient account is turned over to a collection agency.

- Stipulate in contracts between the hospital or health system and its collection agency the policies that the agency must observe when pursuing collection on patient accounts.
- Correct the situation promptly and apologize if mistakes occur in the administration of the collection policies.

Implementation

In order to properly implement financial assistance policies, hospitals and health systems should: determine how the policy will be communicated to patients; identify and train the appropriate staff to administer the policies; and periodically review actual billing and collection practices to monitor compliance with the written policies.

Communicate the Availability of Financial Assistance

- Communications to the public regarding financial assistance should be written in consumer-friendly terminology and in a language that the patient can understand, to the extent practicable.
- Information on financial assistance policies should be posted in key public areas with instructions on how to obtain further information or apply. (See the attached suggested sample notice.)
- Brochures outlining the facility's financial assistance policies and how to apply for assistance should be available in their registration and waiting areas.
- Hospital bills should include information about the availability of financial assistance.
- Patients should be educated about their responsibilities, the potential financial obligation they may incur, their obligations for completing eligibility documentation and the hospital's collection policies in a manner that does not discourage their seeking needed emergency care.
- Patients should be referred to a facility employee or to the appropriate agency for information and possible enrollment in Medicare, Medicaid, FAMIS or other assistance programs that maybe available.
- Translation services should be available as needed.

Educate and Train Staff

- All staff who interact with patients on financial assistance matters should receive training that explains the facility's policies, how these policies should be communicated to patients and how to direct patients to other financial assistance staff if appropriate.
- Staff should treat applicants with courtesy, confidentiality and cultural sensitivity.
- Staff should make appropriate efforts to make correct, timely and consistent financial assistance decisions.

Review Actual Billing and Collection Practices

Hospitals are encouraged to monitor the implementation of their billing and collection policies by, for example:

- Sending "test patients" through the application process.
- Visiting patient care department meetings and asking how to access financial assistance.
- Making "blind" telephone calls to hospital departments asking for assistance.
- Soliciting patient feedback on the ease of obtaining financial assistance information and applying for assistance.
- Monitoring the performance of collection agencies.

Accountability/Advocacy

Hospital or health system boards should be provided with the details of the organization's financial assistance policies, including how it is administered, at least once annually.

Hospitals or health systems should share information about their financial assistance policies with the appropriate community service agencies.

Figure 3

**Medical care facilities subject to review under the
COPN regulations include the following:**

- General Hospitals
- Sanitariums
- Nursing homes
- Intermediate care facilities
- Mental hospitals
- Mental retardation facilities
- Psychiatric hospitals and intermediate care facilities established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts
- Rehabilitation hospitals
- Any facilities licensed as a hospital
- Specialized centers or clinics or that portion of a physician’s office developed for the provision of:
 - outpatient or ambulatory surgery
 - cardiac catheterization
 - computed tomographic (CT) scanning
 - gamma knife surgery or stereotactic radiosurgery
 - lithotripsy
 - magnetic resonance imaging (MRI)
 - magnetic source imaging (MSI)
 - nuclear medicine imaging
 - positron emission tomographic (PET) scanning
 - radiation therapy
 - such other specialty services as may be designated by regulation.

Figure 4

**Reviewable projects under the
COPN program include the following:**

- the establishment of a medical care facility
- an increase in the total number of beds or operating rooms in an existing authorized medical care facility
- relocation at the same site of 10 beds or 10 percent of the beds, whichever is less, from one existing physical facility to another in any 2 year period (except that a hospital shall not be required to obtain a COPN for the use of 10 percent of its beds as nursing home beds for a maximum of 30 days for any one patient, i.e. swing beds)
- introduction into any existing medical care facility of:
 - any new nursing home service, such as intermediate care, extended care, or skilled care facility services except when such medical care facility is an existing nursing home
 - any new cardiac catheterization, CT, gamma knife surgery, lithotripsy, MRI, MSI, medical rehabilitation, neonatal special care services, obstetrical services, open heart surgery, PET scanning, organ or tissue transplant service, radiation therapy, nuclear medicine imaging, psychiatric, substance abuse treatment, or such other specialty clinical services as may be designated by regulation, which the facility has new provided or has not provided in the previous 12 months
- the conversion of beds in an existing medical care facility to medical rehabilitation beds or psychiatric beds
- the addition by an existing medical care facility of any medical equipment for cardiac catheterization, CT, gamma knife surgery, lithotripsy, MRI, MSI, open heart surgery, PET scanning, radiation therapy, or other specialized services designated by regulation
- any capital expenditure of \$5 million or more by or on behalf of a medical care facility not defined as reviewable under the categories listed above (*but capital expenditures between \$1 million and \$5 million shall be registered with the Commissioner of Health*).

Figure 5

Virginia Department of Health Division of Certificate of Public Need Report of Compliance Certificate of Public Need Indigent Care and Primary Care Conditions			
Reporting period:	-	-	
	Calendar Year	Fiscal Year	
Name of conditioned facility:	_____		
Conditioned facility address:	_____		
Conditioned service:	Report only ONE service per form, e.g. CT, MRI, cardiac catheterization, surgery, etc...		
COPN number(s):	VA-0	VA-0	VA-0
Gross patient revenue from the conditioned service:	A	\$	_____
Total dollar value required by the condition: <small>(total conditioned service gross patient revenue x conditioned percent)</small>	B	\$	_____
Total dollar value of charity care provided this period:	C	\$	_____
Total number of patients served by conditioned service:	_____		
Total number of patients who received charity care:	_____		
Conditioned <i>service</i> shortfall or (excess):	B-C	\$	_____
Contributions and/or expenditures made to facilitate the development and operation of primary care: <small>Per paragraph I.B.1.b. or paragraph I.B.1.c. of the Compliance with Conditions on Certificates of Public Need Guidance Document</small>	D	\$	_____
<i>Provide, on a separate sheet, a detailed explanation of qualifying contributions and/or expenditures including the dollar value of each, the date each was made, and to what facility or organization it was made.</i>			
Total value of indigent and primary care contribution:	C+D	\$	_____
Total shortfall or (excess) conditioned contribution:	B-(C+D)	\$	_____
Organization/facility to which contributions and/or expenditures were made:	_____		
Have the terms of the condition been met? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Signature:	_____		_____
	<small>Company Officer, Managing Partner or Manager, Auditor or Owner</small>		<small>Date</small>
<small>Report of Compliance</small>	<small>Revised 2/2/04</small>		

Figure 6

Heart Disease and Stroke

Capacity Building

Kentucky

Working With Partners to Address the Secondary Prevention of Death and Illness Among People With Coronary Artery Disease

Public Health Problem

In Kentucky, heart disease and stroke accounted for 37% of all deaths in 2000, with 11,936 (30%) people dying of heart disease and 2,637 (7%) dying of stroke. In addition, about 40% of all hospitalizations in the state were due to cardiovascular disease, resulting in hospital costs exceeding \$863 million, according to the *Kentucky State of the Heart 2000* report.

Program Example

The Kentucky Department of Public Health's Cardiovascular Health Program partnered with the American Heart Association Kentucky Affiliate, the Kentucky Hospital Association, Healthcare Excel, and the American College of Cardiology to improve quality of care and patient care management. The partners used the American Heart Association's *Get With the Guidelines—Coronary Artery Disease* to improve patient outcomes in acute care settings. In April 2003, a statewide training program was launched in Lexington, with 142 people from 57 hospitals across the state participating. The state Cardiovascular Health Program provided funds to cover the training costs and the annual Patient Management Tool fee for hospitals starting the program by June 2003. Twenty-five hospitals in major metropolitan and rural areas in all five regions of Kentucky are conducting this secondary prevention program. Regular technical assistance is provided through telephone conference calls to the participating hospital teams by the American Heart Association, the state Cardiovascular Health Program, and the project's information technology manager.

Implications and Impact

These partners shared the vision of reducing deaths, disability, and recurrent heart attacks among patients with coronary artery disease and successfully collaborated to put in place secondary prevention guidelines in hospitals across Kentucky. By uniting and leveraging their strengths and resources, each organization contributed to the development of a hospital-based quality improvement infrastructure that focuses on protocols to ensure patients are treated and discharged with appropriate medications and risk counseling. The impact of this intervention is being evaluated by assessing compliance with secondary prevention measures. As more acute care hospitals across the state launch quality improvement programs, reductions in illness and death from heart disease and stroke are expected.

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Contact Information

Kentucky Department of Public Health • Division of Adult and Child Health
275 East Main Street, HS 1C-B • Frankfort, Kentucky 40621
Phone: (502) 564-7996, ext. 3823 • Web site: <http://www.chs.ky.gov/publichealth/dph-structure-ach.htm>

Figure 7



Providing Diabetes Self-Management Education and Support Through a Health Care Clinic Serving Homeless People

Public Health Problem

In Louisiana, an estimated 230,691 adults — 7.1% of the state’s adult population — had diagnosed diabetes in 2002. Diabetes was the fifth leading cause of death for Louisiana residents in 2001, and diabetes-related medical care in Louisiana exceeded \$2 billion in 2000. Diabetes is of special concern for homeless people, who often are transient and lack financial resources and social supports. Because homeless people with diagnosed diabetes often lack access to routine health care and diabetes prevention and control programs, they usually end up in hospital emergency rooms in a crisis that could have been prevented. Education is direly needed for homeless people who have diabetes or prediabetes. Recent research shows that for people with prediabetes, who are at high risk for developing the disease, the onset of diabetes can be prevented or significantly delayed through modest changes in diet, weight, and exercise levels.

Program Example

The Louisiana Diabetes Prevention and Control Program partnered with the City of New Orleans Health Department’s Healthcare for the Homeless Clinic to improve the clinic’s ability to provide diabetes education to patients. This facility is the only full-service clinic in the area that serves homeless people, free of charge. Project Assist is a diabetes education program developed at the clinic to help patients manage their diabetes and improve their health status and quality of life. To be eligible to attend the sessions, individuals must be enrolled in a diabetes registry that monitors the health of homeless people. They can attend an individual or group session on glycemic control and complications of diabetes, self-monitoring, weight loss and exercise instruction, review of medications, diet instruction, or self-care questions. The program uses audiovisual aids (i.e., instructional pamphlets, personal care cards with a protective pouch, and a place mat with nutrition tips) and referrals to identified community resources. These interventions seek to improve patient compliance with treatment regimens, empower patients to take charge of their diabetes, and promote lifestyle changes. To determine how effective the sessions have been, patients’ A1c levels are compared before entering the diabetes registry and after they complete the sessions.

Implications and Impact

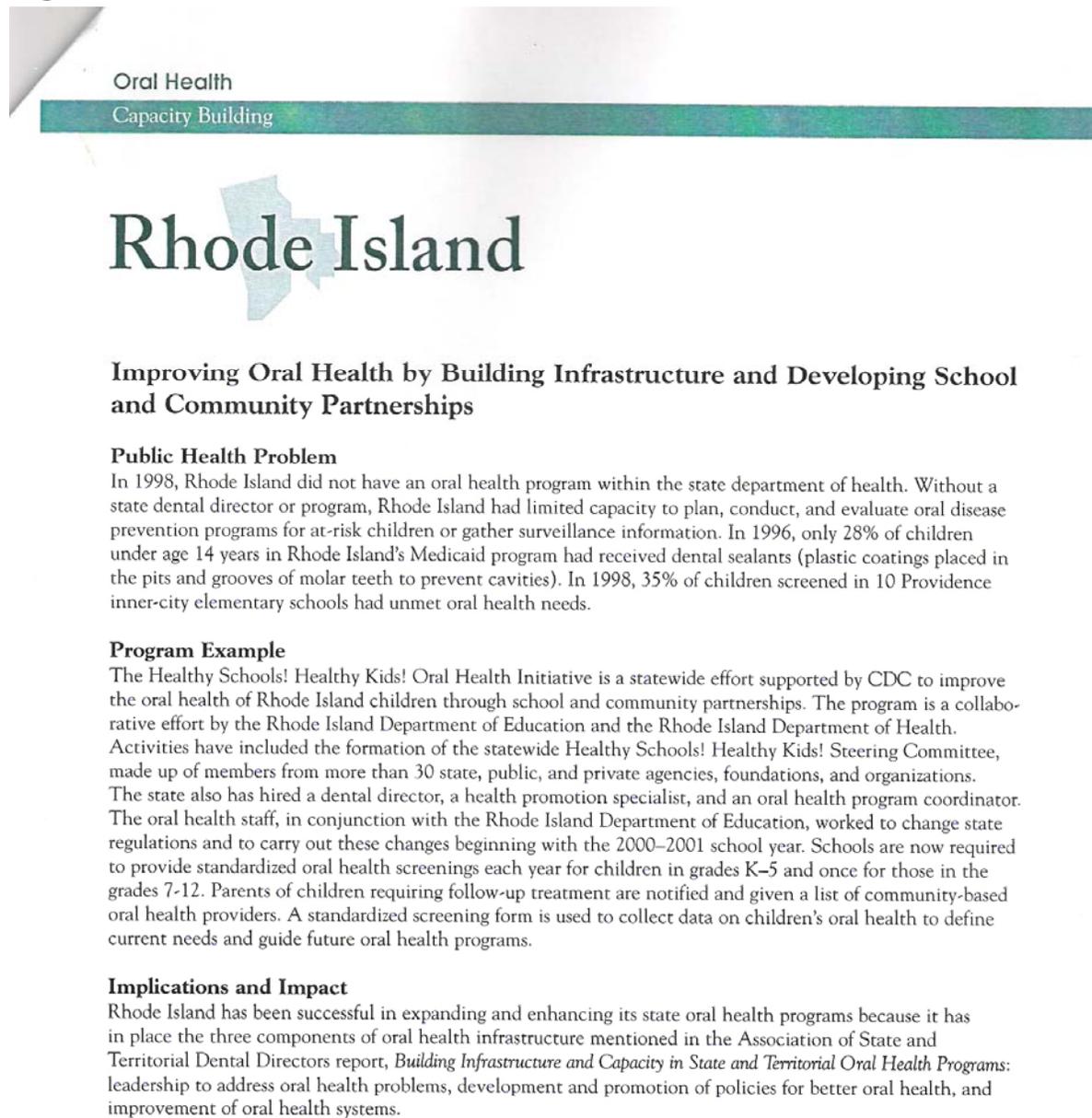
By March 2003, the average A1c level for 153 project participants was 8.8%; this represents a 1% decrease for half of the homeless patients on the diabetes registry. In addition, 32% of these patients had at least one A1c check, and 38.6% had at least two A1c checks in the past year, compared with 15.75% and 25.5% in September 2001. Also in March 2003, more participants had had a foot examination and more had had an oral examination in the past year compared with the number in September 2001. By May 2003, 99% of participants had met diabetes management goals compared with 94.1% in September 2001. Project Assist is a successful example of how a state program can promote healthy behaviors and reduce needless disease and economic burden for homeless people with, or at risk for, diabetes.

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Contact Information

Louisiana Department of Health and Hospitals • Office of Public Health • Diabetes Control Program
 325 Loyola Avenue, Room 213 • New Orleans, Louisiana 70112 • Phone: (504) 568-7210 • Fax: (504) 568-7005
 Web site: <http://www.oph.dhh.state.la.us/chronicdisease/diabetes/index.html>

Figure 8



Contact Information

Rhode Island Department of Health • Office of Primary Care • Oral Health Program
Three Capital Hill • Providence, Rhode Island 02908
Phone: (401) 222-1171 • Web site: www.health.state.ri.us/disease/primarycare/oralhealth/home.htm

Figure 9

Sample Patient Notice of Financial Assistance

[NAME OF HOSPITAL OR HEALTH SYSTEM] is proud of its mission to provide quality care to all who need it.

If you do not have health insurance and worry that you may not be able to pay in full for your care, we may be able to help. [NAME OF HOSPITAL OR HEALTH SYSTEM] provides financial assistance to patients based on their income, assets, and needs. In addition, we may be able to help you get free or low-cost health insurance or work with you to arrange a manageable payment plan.

It is important that you let us know if you will have trouble paying your bill. To meet certain federal requirements, hospitals must bill all patients for the amount they owe and attempt to collect those debts in the same fashion for all patients. This means we may turn unpaid bills over to a collection agency, which could affect your credit status.

For more information, please contact [NAME OF PERSON IN] our financial counseling Office at [PHONE NUMBER]. We will treat your questions with confidentiality and courtesy.

Prepared by the
Virginia Hospital
& Healthcare
Association

An alliance of hospital and health delivery systems

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