Access to Health Care & Coverage

ABC for Health, Inc. Recommendations for Dane County Hospitals Responding to the Gaps in the 2025 Community Health Needs Assessment

December 2024

Hope for the Holidays

The holiday season is a time for family, reflection, and a poignant reminder to help those in need. For our friends and neighbors facing an illness and lacking medical insurance or other benefits, this can be a season of despair, debt, and disappointment. With some help from our community and our hospitals, driven by a sense of commitment, we can do so much more to help our neighbors secure the health care services they need and deserve.

The quietly prepared and released "2025-2027 Dane County Community Health Needs Assessment"[1] (CHNA) failed to provide broad input to improve policies that promote the access to health care and coverage needs for those in need in our community. The reports lacks any recommendations to improve financial assistance policies, practices, and processes to equitably serve populations negatively affected by health disparities. Unfortunately, the Assessment lacks broad community input and reflects a hospital-driven marketing piece that ignores and sidesteps Affordable Care Act requirements. ABC was largely shunned despite our multiple efforts over the past 2 years to provide client-based input to the CHNA. Our own report herein offers sensible recommendations that highlight access to health care and coverage barriers and the medical debt crisis faced by low-income Dane County patients. We review the results and outcomes of the promise Dane County hospitals made to the IRS, taxpayers, and the communities they should serve.

"Don't leave a stone unturned. It's always something, to know you've done the most you could. But, don't leave off hoping, or it's of no use doing anything. Hope, hope, to the last!" -Charles Dickens

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ABC for Health, Inc. Recommendations for Dane County Hospitals

Contents:

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About ABC for Health:

ABC for Health is a Wisconsin based nonprofit public interest law firm dedicated to health equity & social justice.

ABC for Health's mission is to provide information, legal services, advocacy tools, & expert support needed to obtain, maintain, & finance health care coverage services.

Executive Summary

December 2024

Dane County hospitals must do more to justify extensive tax breaks and better serve patients impacted by health disparities. In 2023, Dane County hospitals spent an average of only 0.7% of their gross patient revenues on charity care.[2] The national average is 2.3%.[3] Medical debt, collections actions, and stress continue to burden patients and families in Dane County.

> *"No one is useless in this world who lightens the burdens of another."*
> *-Charles Dickens*

Dane County hospitals can and must do better to reduce the burden of medical debt. Getting sick or taking care of a loved one should not create financial hardship. Unfortunately, several Dane County and Wisconsin hospitals espouse a philosophy of "patient responsibility," insisting that low-income, sick, or other vulnerable patients take on the burden of understanding the complexities of health care coverage, financial assistance policies, and bureaucratic hospital practices - or suffer the consequences. The burden incorrectly falls on the patient to prove that they do not owe a debt. A Senior Advisor with the Wisconsin Hospital Association recently repeated "…[financial] assistance can only happen if a *patient* [emphasis added] is proactive."[4] He complains of patients getting a service "then they sort of ghost the hospital." He says a hospital can't make assumptions so bills get sent to collections.[5]

The only ghosts we should discuss are the three spirits that just might visit some hospital administrators that lack awareness and empathy toward the needs of ill patients and family members navigating a tortured system of health coverage.

There is a better way to serve the needs of these patients as identified by ABC for Health in this report. Hospitals have both a legal and moral obligation to help the less fortunate in our communities. This season should inspire a change for the better as our recommendations illuminate. Hospitals are better equipped to understand the nuance of coverage, eligibility and enrollment, application steps and protocols. Certainly, hospitals can be expected to understand and accurately apply their own financial assistance rules and policies. Even more, hospitals are in a better position than sick patients to work proactively to help prevent medical debt in the first place.

> *"Just remember this, Mr. Potter, that this rabble you're talking about... they do most of the working and paying and living and dying in this community."*
> *-George Bailey, It's a Wonderful Life*

Yet, certain area hospitals fail to sufficiently help patients identify access to health care coverage programs and instead persist in sending patients to collections, and worse, engage in credit reporting of medical debt.

Access to Health Care & Coverage

Introduction

A Community Health Needs Assessment should include an opportunity to provide valuable input into the health services and needs of many vulnerable patients and community stakeholders. The Affordable Care Act requires nonprofit hospitals to complete a Community Health Needs Assessment (CHNA) every three years that identifies a range of these community health and service needs.[6] The CHNA process should inform each hospital's policies and practices with the goal of maximizing their positive impact on their patient populations, particularly those who face health disparities due to income, disability, race, gender identity, or other marginalized identities.

ABC for Health, Inc. (ABC)[7] is a nonprofit, public interest law firm that promotes equitable access to health care and coverage for Wisconsin families and individuals affected by health disparities. ABC helps clients and patients obtain and maintain health coverage, challenge incorrect medical bills, appeal insurance denials, and secure needed care. Our work promotes health equity and helps Dane County families navigate health insurance and hospital bills. ABC's unique experience provides a unique insight into the red tape and bureaucracy families face on the path to health coverage and care. Failures to help families secure proper coverage and care can result in medical debt that often unjustly traps families, sometimes generationally, in poverty.

Part of ABC's approach includes researching medical debt policies, rules, and community impact. We pair our findings with the experience, observations, and perspective of our direct client services and community collaborations. ABC has served over 72,500 Wisconsinites since its founding in 1994.

In this report, ABC for Health offers sensible recommendations for process improvement, timed to coincide with the 3-year cycle of Community Health Needs Assessment reporting and implementation strategies required of hospitals. We examine the results and outcomes of the promise Dane County hospitals made to the IRS, taxpayers, and communities they serve.

ABC focused its input and recommendations on the CHNA process to highlight **access to health care and coverage barriers and related medical debt** for patients who live in and around Dane County. ABC has issued many reports on medical debt over the past decade. We maintain a thoughtful CHNA process must include data on medical debt issues and strategies for improving access to health care and coverage. The causes of medical debt are myriad and complex, but ABC has found that insufficient or inaccessible hospital financial assistance policies create stress and confusion among patients, especially among vulnerable populations, and avoidable medical debt.

Our appendices include other significant access to health care and coverage issues identified through our direct client services, like the Birth Tax, improved coverage for children with disabilities and special healthcare needs, ensuring access to care and coverage for gender-affirming care, and increasing accessibility for low literacy or immigrant patients.

"You know, George, I feel that in a small way we are doing something important. Satisfying a fundamental urge. It's deep in the race for a man to want his own roof and walls and fireplace, and we're helping him get those things in our shabby little office." -Pa Bailey, It's a Wonderful Life

Recommendations for Dane County

Summary of Recommendations

Medical debt is a public health crisis in Dane County, Wisconsin, and across the country. Patients across the United States owe at least $220 billion in medical debt.[8] The share of adults with medical debt varies by state—in Wisconsin, 8.7% of adults hold some form of medical debt.[9]

Medical Debt

Dane County area families and individuals face avoidable medical debt due to knowledge barriers and inaccessible hospital financial assistance policies. ABC maintains we can prevent substantial amounts of this avoidable medical debt with **proactive hospitals** through informed patient financial assistance programs. Better practices coupled with knowledgeable and informed staff ensure more patients have access to the care and financial security they need.

Common Sense Recommendations for Financial Assistance Policies

1. Improve, Coordinate, & Measure Progress in Financial Assistance Staff Training
2. Remove Barriers and Red Tape to Financial Assistance
3. Promote Equity in the Financial Assistance Process
4. Adopt a Uniform Financial Assistance Application
5. Create Presumptive Eligibility for Financial Assistance
6. Minimize Involvement of Revenue Cycle Management Companies
7. Eliminate incentives that promote bill collection over FA

Medical Debt Collection

Currently, Extraordinary Collections Actions (ECAs) defined by IRS regulations include medical debts lawsuits, credit reporting, and denied care. The threat of ECAs looms over patients and creates stress that leads to missed or avoided health care. Before the COVID pandemic, Wisconsin's nonprofit hospital systems routinely filed lawsuits against patients to collect medical debt. In these lawsuits, our research found over 99% were filed against patients who lacked legal representation, and over 95% resulted in default judgments, raising concerns about the validity of the alleged debts. Hospitals were represented 100% of the time.[10]

Common Sense Recommendations for Medical Debt Collections

1. Stop mass filing medical debt lawsuits.
2. Stop the inequitable practice of credit reporting of medical debts.
3. Stop denying care or treatment to those with outstanding medical bills.

Promote Access Through Uniform & Community Wide Financial Assistance Policies

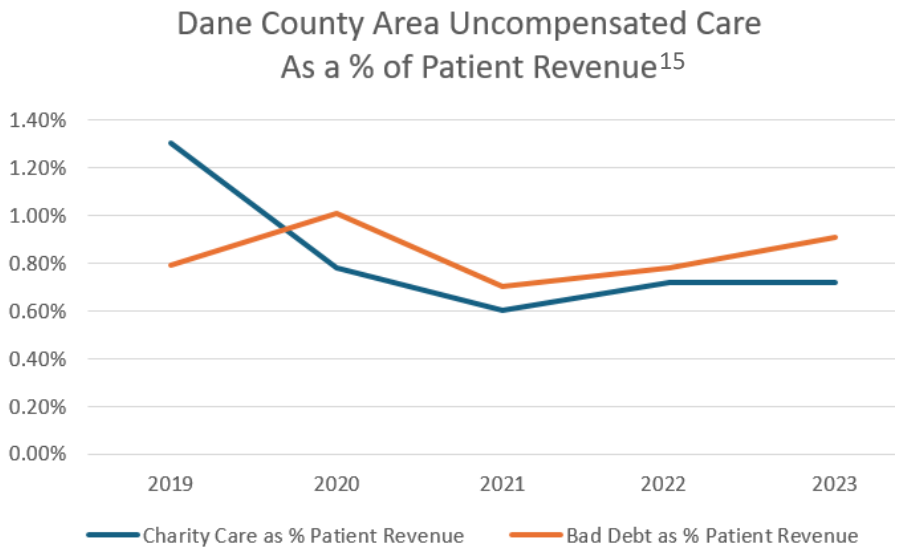
Hospitals must improve community wide access to FA services through uniform and consistent FA policies. These providers include UW Health, UnityPoint Health—Meriter Hospital, SSM Health St. Mary's Hospital, and Stoughton Health.

Proactive Hospital Financial Assistance

ABC's work with clients demonstrates that we can prevent certain medical debt with proactive patient financial assistance programs. The Affordable Care Act (ACA) requires nonprofit hospitals[11] to develop and publish financial assistance (FA) policies that allow certain low-income patients to apply for and receive discounted or free medical care. The ACA's provisions on hospital FA are found in section 501(r) of the Internal Revenue Code, establishing compliance requirements for nonprofit hospitals, including that hospitals must:

- Develop financial assistance policies and widely publicize those policies
- Publish accessible, plain language summaries of FA policies
- Translate the policies into every language used by over 5% of the community
- Give patients a reasonable opportunity to apply for assistance, including allowing at least 240 days to apply, counting from the first post-discharge billing statement
- Restrict extraordinary collections actions (e.g. lawsuits and credit reporting) against patients seeking FA eligibility
- Refund any patient payments if they are later found to be eligible for FA

Hospitals have both a legal and moral obligation to serve the most vulnerable members in a community. In 2023, Dane County hospitals spent an average of only **0.7%** of their gross patient revenue on charity care. While on par with the 2023 state average, Dane County is below Milwaukee County Hospitals and well below the national average.[12]



In fact, Dane County fails to come close to this national mark. According to a recent Wall Street Journal report, nonprofit hospitals across the US are spending only 2.3%[13] of their revenue on financial assistance. If Dane County hospitals spent 2.3% of their revenue on financial assistance instead of 0.7%, they could cover the **$105.7** million in uncovered medical expenses not covered by FA and characterized by the hospitals as bad debt.[14]

Nonprofit hospitals must develop effective FA policy implementation strategies to ensure access by populations affected by health disparities. When implemented correctly, FA prompts accessible healthcare for such patients and helps hospitals meet community benefit and need requirements. Clarity in hospital FA policies is paramount for a smooth, transparent, and understandable process. ABC's review, however, identified that some hospitals created inaccessible FA for patients, while touting their nonprofit status. Our research also shows that certain hospitals aggressively pursue and collect bills from the communities they serve.

Recommendations for Dane County

Inconsistent Financial Assistance Policies Block Access

FA policies vary widely at Dane County hospitals, causing community confusion, service gaps, and a lack of access to health care and coverage. This is despite UW Health and UnityPoint Health—Meriter Hospital (Meriter) sharing a FA application and determination process. Appropriate, straightforward hospital FA policies will help patients secure needed benefits. This causes community confusion, service gaps, and a lack of access to health care and coverage. For example, UW Health and Meriter provide no FA for patients with income above 600% FPL, while Stoughton Health provides no FA for patients with income above 180% FPL. This means a patient could qualify for a full discount at UW Health, but no discount at Stoughton Health.

Additionally, ABC's experience has revealed that FA eligibility differs in policy and in practice. For example, SSM Health's FA application says applicants only need to provide verification of income from the last two months and their most recently filed tax return or a non-filing letter from the IRS. But in practice, SSM Health's FA application also requires asset verification. This delays and unnecessarily complicates the FA process. Below is a data table showing wide differences in the FA policies at the major hospital systems in Dane County:

Hospital	FPL Required for Free Care	FPL Required For Sliding Scale Discount	Asset Limit	Deadline to Submit FA Application	Verifications Required	FA Allowed for Patients with Insurance	Presumptive Eligibility for patients with Medicaid?
UW Health	300%	600%	N/A	240 days*	2 months	Yes	Yes
UnityPoint Health – Meriter	300%	600%	N/A	240 days	2 months	Yes	Yes
SSM Health St. Mary's Hospital	200%	400%	N/A**	240 days	2 months	Yes	No
Stoughton Health	150%	180%	N/A	240 days	3 months/pay periods	Yes	Yes

**In practice, we have found this deadline to be flexible*

***Countable assets are added to yearly income*

Aside from eligibility criteria, hospital FA application processes include major roadblocks. For example, ABC clients encounter problems with hospitals demanding excessive verification of income and assets, or only accepting certain forms of verification. This paperwork sometimes simply does not exist, like requiring paystubs from someone who is self employed or working in the cash economy.[16]

Other times, it's difficult to obtain for populations facing poverty and illnesses, creating a barrier for many patients that unfairly limits their access to the financial assistance they deserve. Further, verifications are often requested only in English, with unreasonable deadlines; some providers send patients to collections while FA applications are still being "processed;" and others fail to inform patients of the FA application or provider policies at all.

Financial Assistance Barriers

Hospital FA policies are long, complex documents that most patients find confusing, especially while dealing with an illness or injury. Barriers to accessing hospital FA services are exacerbated by disability, illness, literacy, immigration status, lack of a computer or internet connection, or poverty. ABC's experience with clients shows that non-literate or non-English-speaking patients experience greater difficulty with applications for hospital FA, as there is scant evidence of FA policies in languages other than in English. Most hospitals fail to use plain language or keep application materials in other languages up to date. In addition, some verification documents, such as tax forms, are not available for certain patients.

Dollar For, a national nonprofit that helps patients access charity care, detailed shortcomings in hospital FA in a new report, namely burdensome requirements on patients and notable racial disparities: Only 29% of patients with unaffordable bills are able to learn about, apply for, and receive financial assistance; 52% of surveyed patients report receiving no information about financial assistance; and black patients are 62% less likely to be approved for financial assistance.[17]

To reduce disparities and promote health equity, federal regulators require nonprofit hospitals to develop community-level services that include a responsibility to address and overcome these obstacles.[18] ABC recommends Dane County hospitals ensure the availability of plain language and multilingual forms, letters, and notices for patients. This will help nonprofit hospitals meet their responsibility to develop and provide community-level services. Hospitals must shift the burden of accessing charity care from the patient, to the provider. Dane County hospitals can improve transparency of financial assistance policies and prioritize financial assistance over collections.

Julia's Story

"Julia" (*name changed to protect privacy*) is a single mother of 2 young children. After an accident left her youngest son in the UW Health's emergency room, Julia started getting bills. She was in the process of applying for Medicaid, having just moved back to the US after a few years abroad, so she applied for Financial Assistance to cover her son's bills. Julia contacted ABC for Health after her UW Health Financial Assistance application was stuck in limbo. ABC for Health's advocate called UW's financial assistance office and learned that extra documentation of income was the hold up. Julia struggled to provide verification documents. The requested materials were proving challenging to acquire because of her recent move and additional stressors in the household. ABC asked Julia be found presumptively eligible, as UW Health's financial assistance policy clearly states that absent sufficient information to support Financial Assistance eligibility, UW Health may use external sources, such as SNAP benefits (FoodShare) to qualify a patient for presumptive eligibility. Julia's entire family received FoodShare, and WIC. The Financial Assistance office said that after consulting with a team lead in Illinois, they were not familiar with that policy, and insisted again on receiving paystubs as proof of income. It took several more weeks of persistent advocacy from ABC for Health before UW Health finally agreed to honor their policy and award Julia Financial Assistance.

Common Sense Path Forward: FA Recommendations

FA Recommendation #1: Improve, Coordinate, & Measure Progress in Financial Assistance Staff Training

Effective financial assistance policy is about more than just connecting patients with a single service of free or discounted care. ABC encourages hospitals to be more proactive and adopt "smart" charity care by first helping patients optimize a system of helping patients identify and secure ongoing health coverage, before deploying a FA strategy. To do this successfully, regular knowledge assessment, training, and professional development of patient FA staff must be a priority. Training progress must be measured and evaluated. This training must include an orientation to the rules and eligibility criteria for myriad health coverage programs and the skills needed to work with diverse patients and patient needs. This approach makes fiscal sense because it secures ongoing coverage for a patient, an ongoing payment source for the provider. It eliminates stress and roadblocks to care.

Better provider-staff training will promote patient access to various Medicaid programs and features. Most hospitals provide some level of Medicaid screening for patients, but this effort typically fails due to a lack of FA staff knowledge and training about critical eligibility features of Medicaid. Many low-income families with existing bills may be eligible for Medicaid, but a hospital's screening failed to account for variables such as unique income situations or Medicaid sub-programs.

Additionally, training must include FA staff baseline knowledge assessments and continuing education on health coverage options and FA. This must be supported by employee training sessions and outside learning opportunities, for example HealthWatch Wisconsin's informational materials.[19]

FA Recommendation #2: Remove Barriers and Red Tape to FA

As part of nonprofit hospitals' community benefit obligation, we expect our nonprofit hospitals to remove the barriers to hospital FA and provide improved access to needed community services. In a charity care report, *Dollar For* estimated that nationally, hospitals charge patients $14 billion in medical bills for services that should be forgiven through charity care.[20] We ask Dane County area hospitals to revise their FA policies and procedures so that they can better serve their communities in compliance with ACA and IRS requirements.

Providers can simplify their FA applications by removing unnecessary verification requirements, and like Wisconsin Medicaid, adopt a "best available information" standard of documentation. This is particularly true for immigrant populations that lack access to much of the "required" paperwork.

Providers must limit restrictive deadlines and geographic barriers to FA. They must stop sending patients to collections before making a FA decision. They must help patients secure documentation. Finally, providers need to develop accessible, meaningful, and transparent appeals processes for patients who disagree with a FA decision, many of whom currently have no opportunity to raise valid objections with decision makers.

Common Sense Path Forward: FA Recommendations

FA Recommendation #3: Promote Equity in the FA Process

We expect, and the law requires,[21] that non-English speakers have access to the same level of customer service as English speakers. Hospitals, working together with communities, hold the key to improving access to health care and coverage for disparity populations. An education, outreach, and service initiative can close the equity gap that disproportionately impacts non-English speakers from accessing, understanding, and utilizing their coverage and FA options. Providers can easily present clear FA eligibility criteria and all other notices and communications in all languages in which the policy must be published.

FA Recommendation #4: Adopt a Uniform FA Application

To promote equity, communities across the country have collaborated to create accessible FA policies. To resolve confusion with hospital FA policies, ABC recommends a uniform FA application for Dane County hospitals. A uniform FA application provides more predictability and understanding to the FA process. Colorado[22] and Maryland[23] already require uniform hospital FA forms. Maryland created this requirement in part to protect uninsured and underinsured patients,[24] and because it found that "reduced cost care policies and payment plans can yield higher recoveries than instituting judgments and liens."[25] In fact, at the recent Interim Meeting of the American Medical Association, physician members voted to support greater oversight of nonprofit hospitals and standardization of charity care policies so financial assistance reaches patients in need, including standardizing the financial assistance process across all nonprofit hospitals.[26]

FA Recommendation #5: Create Presumptive Eligibility for FA

Developing policies that include presumptive eligibility for FA will promote equity and access to services for patients. One nonprofit hospital system in South Dakota recently implemented a presumptive eligibility process for charity care.[27] The hospital system developed and implemented internal charity care screening procedures and found that it was targeting people for charity care that did not have the means to pay.[28] This is a good start, but nonprofit hospitals can do more to meet their community benefit obligation. Nonprofit hospitals should create expansive presumptive eligibility for FA. In addition, providers should automatically extend FA approval from a hospital to all affiliated clinic locations and ensure that non-hospital providers commonly working with hospital patients (emergency physician groups, anesthesiologists, ambulance, etc.) honor the hospital FA.

Spotlight on North Carolina[29]

On July 26, the Centers for Medicare and Medicaid Services approved North Carolina's plan to eliminate approx. $4 billion in existing medical debt for people and families across the state. The plan uses the state's Medicaid program to incentivize hospitals to relieve a decade's worth of old debts, while preventing new debt from accumulating. All state hospitals elected to participate in the program in exchange for a higher Medicaid reimbursement rate. Hospitals must: automatically enroll people into FA by implementing a presumptive eligibility process, not sell medical debt to collectors for patients under 300% FPL; and not report a patient's debt covered by these policies to a credit reporting agency. The changes, by and large, **shift the responsibility** of enrolling patients in charity care programs to hospitals.

Common Sense Path Forward: FA Recommendations

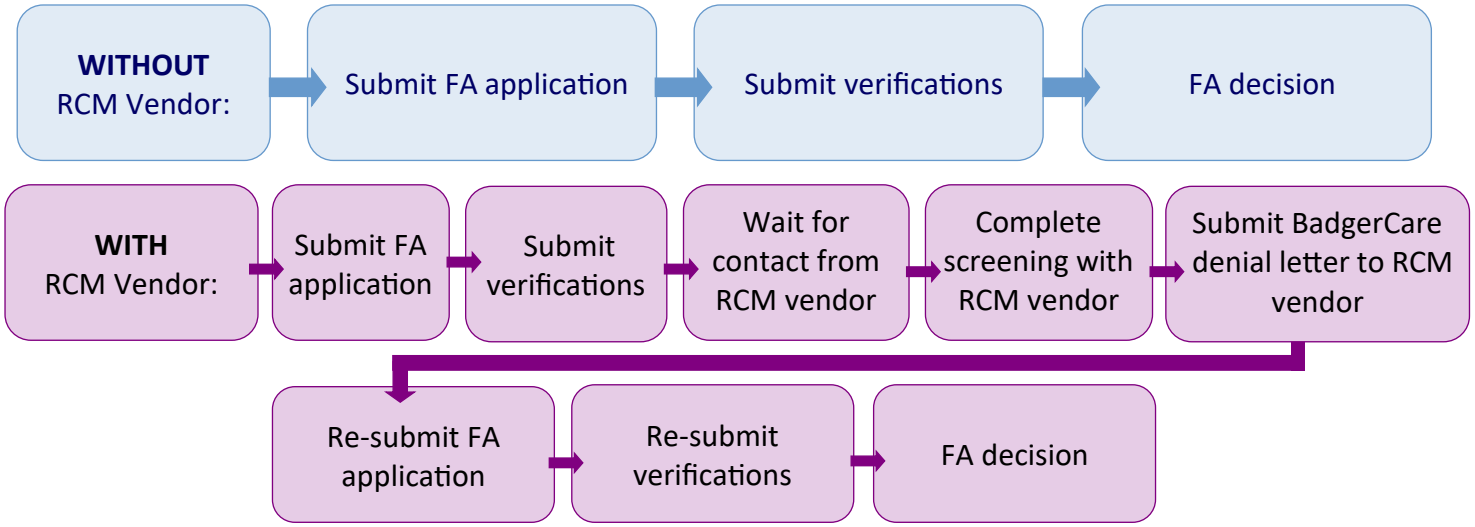
FA Recommendation #6: Minimize Involvement of Revenue Cycle Management Companies

Recent charity care data suggests that hospitals' reliance on outside "Revenue Cycle Management" companies is correlated with a reduction in charity care. This effect is particularly pronounced in the data for Dane County. SSM's charity care **plummeted** when their billing and financial assistance was being managed by Optum, and began to recover in 2023, after they ended that relationship. On the flip side, UW Health has been a consistently high performer in terms of charity care, but their charity care dropped (and bad debt increased) in 2023, coinciding with an increased reliance on their contractor, Elevate.

"There are many things from which I might have derived good, by which I have not profited." -Charles Dickens, A Christmas Carol

These trends agree with ABC's experience working with clients, where Revenue Cycle Management (RCM) companies often prove to be a major barrier to patients due to unnecessary, additional steps in the process, as well as many vendors' unfamiliarity with eligibility requirements for charity care and government benefit programs, poor communication, ill-defined processes, and a clear profit motive that makes patients hesitant to work with them:

Our Process Experience Working with Revenue Cycle Management (RCM) Vendors:



FA Recommendation #7: Eliminate incentives that promote bill collection over FA

Patients that call to inquire about FA, may instead be directed to pay bills or set up payment plans. Some FA staff asked ABC clients to pay towards bills, even with pending financial assistance applications. This aggressive tactic suggests that either an incentive structure or workplace culture that promotes bill collection over helping patients navigate the FA process. This issue is amplified when dealing with Revenue Cycle Management companies (see above). We recommend hospitals adopt policies that prohibit this behavior, and encourage staff to prioritize FA screening over bill collection.

Medical Debt Collections

The collection process for medical debts must be sharply curtailed. The law requires hospitals to make a reasonable effort to determine whether the patient is eligible for FA before taking an Extraordinary Collections Actions (ECA).[30] However, the implicit threat of these actions looms over patients in all their interactions with hospital billing departments and can drive patients to make extreme financial decisions or avoid medical care. Collection actions should be avoided at all costs. In fact, federal law includes protections from certain collections activity. Hospital providers and partners must view ECAs as the worst-case scenarios for medical debt. ECAs include medical debt lawsuits, credit reporting, and denied care.

Medical Debt Lawsuits

"Over 99% of patients in these lawsuits lacked legal representation." -ABC for Health

Based upon ABC's research, over 99% of patients in these lawsuits lacked legal representation, and over 95% of judgments from these lawsuits were default judgments, meaning that courts awarded hospitals judgement based purely on the hospitals' complaints.[31] Meanwhile hospitals and other medical partners are always represented by legal counsel. Before the COVID pandemic, Wisconsin's nonprofit hospital systems routinely filed lawsuits against patients to collect medical debt. These judgments often led to the garnishment of patients' wages or other forms of execution such as liens against patients' property. Research from other groups has found that medical debt lawsuits disproportionately affect low-income Black and Latino communities.

ABC research found that during the COVID pandemic (2020), most of Wisconsin's hospital systems including all Dane County hospitals highlighted in this report stopped filing medical debt lawsuits in response to public pressure. However, only a small number of hospitals amended their billing and collection policies to prohibit filing suits against patients. This means that hospital systems may resume medical debt lawsuits at any time.

Credit Reporting of Medical Debt

Hospitals may report medical debt to a credit reporting agency as part of a process to compel payment. If reported to a credit reporting agency, medical debt can adversely affect a patient's credit score. Credit scores act like a modern-day debtor's prison for many disparity populations, locking them in a doom loop and preventing financial opportunities like credit, housing or even a job.

Recently, credit reporting of medical debt has come under higher scrutiny. In 2022, in response to pressure from the Consumer Financial Protection Bureau (CFPB), the three major credit bureaus adopted voluntary policies to limit the reporting of medical debts. Medical debt cannot appear on credit reports if it is less than a year old, less than $500, or has been fully paid off. While this is a positive change, it leaves the largest and most harmful medical bills on credit reports and doesn't help people from disparity populations.[32]

A Common Sense Path Forward: Collections Recommendations

Collection Recommendation #1: Stop Filing Medical Debt Lawsuits

Medical debt lawsuits pit unrepresented patients against a coordinated medical debt collections industry. While the impact of the COVID pandemic is still being felt by Wisconsin families, ongoing collections actions increase stress and harm the communities served by medical providers. Medical debt lawsuits by medical providers should be a rare exception, not a commonplace tactic against people who cannot afford medical care. Providers should instead focus on common sense strategies that proactively help patients obtain and maintain health care coverage for needed services or prescriptions. Providers should end collection referrals, terminate collections litigation against patients, and amend billing and collection policies to minimize confusion and promote equity for patients.

Hospitals should end unproductive and detrimental practices such as: denying financial assistance to patients unless they produce denial of coverage from Medicaid, performing coverage screening with revenue cycle management companies, and berating or penalizing patients for not complying with screening procedures. Hospitals must take steps to consider and understand the broader access to health care and coverage needs of patients like children and youth with special health care needs, immigrant populations, and other services needed by populations affected by health disparities. By including these topics in hospital FA or medical debt conversations, hospitals, counties, and their partners can more equitably meet community needs.

Collection Recommendation #2: Stop the Inequitable Practice of Credit Reporting of Medical Debt

*"UW Health, SSM Health St. Mary's Hospital, UnityPoint Health - Meriter, and Stoughton Health **all explicitly allow credit reporting of medical debts**."*

Medical debt is less predictive of a consumer's propensity to repay loans than other forms of debt, and consumers often have little control over how much medical debt they incur. Credit reporting of medical debt is unfair and inequitable, trapping vulnerable patients in a cycle of poverty. A low credit score can make it difficult to access housing or transportation, secure lending, or find employment, creating a doom loop that particularly affects people in health disparity populations.

Federal authorities continue to watch the process of financial assistance and community benefits. In June 2024, the Biden-Harris administration affirmed the importance of reducing medical debt with a proposed rule to remove medical bills from most credit reports.[33] The proposal calls on states, local governments, and health care providers to take additional actions to reduce the burden of medical debt for millions of Americans. The proposal leverages public dollars to purchase and eliminate medical debt, and seeks to expand patients' access to charity care and limit coercive debt collections practices by health care providers and third-party debt collectors.

"While the CFPB initiated the rulemaking process to remove all medical debt from credit reports, until the approval of final rules, medical debts continue to trap families in this modern-day debtor's prison."

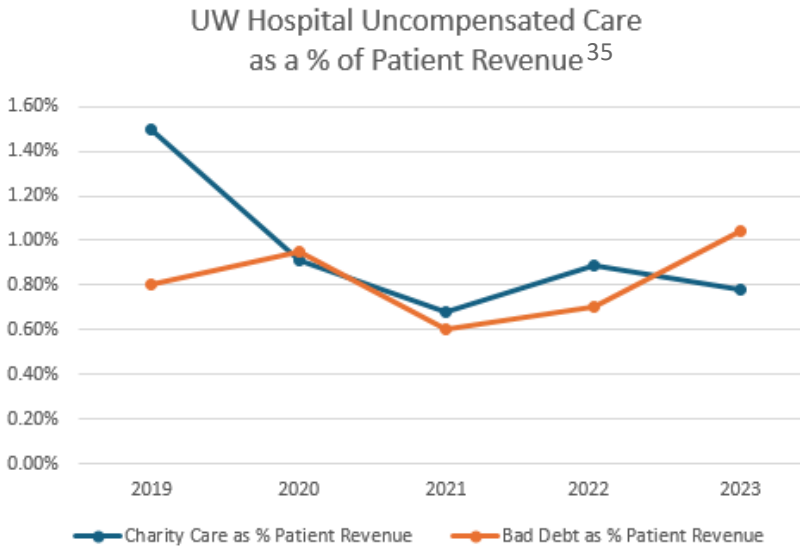
Hospital Specific Recommendations

UW Health

In several past years, UW Health awarded the most charity care and had the least bad debt of any Dane County hospital. However, in 2023, UW Health's charity care dropped significantly while its bad debt skyrocketed. This aligns with ABC's observation last year - our clients with UW Health bills started having a much harder time getting financial assistance than before. The change appears to coincide with a heavier reliance by UW Health on Elevate, the contracted Revenue Cycle Management company. We recommend that UW Health evaluate Elevate's role in the FA process and the impact upon patients' access to financial assistance.

Notwithstanding Elevate, UW Health can greatly improve its FA policy[34] through improved, measurable training and continuing education for FA department staff. For example, although UW Health gives presumptive eligibility to patients with Medicaid coverage or other public benefits, most UW Health FA workers fail to apply that part of the policy and insist on asking for verifications. In fact, ABC staff requests for presumptive assistance are not typically honored until the request is escalated to *one particular worker* who understands the policy.

In addition, UW Health should revise their FA policy to include certain traveling/visiting international patients that receive non-emergent care from UW Health. Currently, UW Health's FA policy states that "internationally traveling/visiting patients who seek non-emergent treatment from UW Health are not eligible for Financial Assistance." However, patients with area residency of for at least a year are eligible for FA for non-emergent care at UW Health. This policy creates a significant equity gap in FA accessibility for those affected patients. To make matters worse, UW Health denied some ABC clients on this basis even though they resided in the eligibility area. In fact, UW Health refused to reconsider patients that were ever determined to be a non-resident, even if that determination occurred years ago.



Charity care at UW Health decreased by 12% from 2022 to 2023, while bad debt increased by 48%.

On a positive note, UW Health, at least temporarily, eliminated medical debt collection lawsuits against its patients. But this collections and billing policy is not formalized in writing. We recommend UW Health formalize its commitment to not sue patients for medical debt and not report medical debt to credit reporting agencies.

As previously mentioned, UW Health shares a financial assistance policy with Meriter. While we occasionally see issues (e.g. delays in informing Meriter about patient eligibility), the shared policy creates efficiency for patients. We recommend UW Health and all other hospitals expand a shared policy to support patients across the entire area.

Recommendations for Dane County

Hospital Specific Recommendations

UW Health & Access Community Health Center

Access Community Health Center plays a vital, federally-supported role in serving low-income patients and patients adversely affected by health disparities in our region. Coordination and regular planning between Access and UW Health - and other area patient financial assistance programs requires communication and re-alignment of policies to equitably serve the needs of our community. Low-income patients are often moved between the UW Health and Access systems. However, these systems have very different financial assistance criteria, meaning that patients have to go through two separate applications to get the discounts they deserve at both locations. Other closely linked hospital and clinic pairs, such as SSM/Dean, have a streamlined financial assistance process between hospital and clinic. In addition, though the exact criteria of Access' current sliding scale discount policy are not publicly available,[36] it appears that all Access patients, no matter how low their income, must pay some fee for care.[37] For one ABC client, these flat fees accumulated to around $600 in medical debt. By contrast, patients under 300% FPL shouldn't owe anything under UW Health's financial assistance policy.

Pregnant immigrants with BadgerCare Prenatal coverage often receive prenatal care at UW Health, but are moved to the Access system for postpartum care (when the Prenatal coverage ends). However, if these patients stayed within one system, their providers could take advantage of a Medicaid billing rule that would allow Prenatal coverage for all pre- and post-partum treatment under one billing code. By moving these patients between systems, UW and Access are not only increasing costs for patients, they are losing out on potential Medicaid reimbursements. We urge UW Health and Access to improve portability and transparency of their financial assistance policies, and to evaluate the potential patient costs associated with patient transfers between systems.

Dane County Safety Net Free & Charitable Services

Free and charitable clinics provide a safety net for patients excluded from needed health care and coverage due to issues related to race, poverty, immigration status, or fear. In Dane County, Madison Street Medicine, Specialty Care Free Clinic, Neighborhood Free Health Clinic, Perry Family Free Clinic, and MEDiC Student-Run Free Clinic, along with the St. Vincent de Paul Charitable Pharmacy[38] to name a few, fill a gap in community charitable care services. Dane County hospitals can create a better, more proactive process to ensure improved services and support to these charitable clinics and the patients they serve: Eliminate roadblocks and bureaucratic barriers to care, coverage, and financial assistance; Proactively enroll patients in health coverage; Close staff knowledge gaps around Medicaid and immigrant health coverages; Reduce the strain of shifting vulnerable patients to a safety net clinic.

Consider a pilot project of ABC for Health: The "SafetyWeb Network for Free and Charitable Clinics," is a novel partnership with select clinics across Wisconsin.[39] The project promotes access to health coverage and helps assure legal rights for uninsured patients. ABC staff help clinic patients cut through reams of red tape and system indifference and have changed the trajectory of many lives. To date, we've served over 1200 patients and families who presented with over $1.5 million in medical debt. Staff interventions and advocacy eliminated almost $1 million of those debts, while also connecting many patients to an ongoing sources of coverage to prevent future, avoidable debts. One of our partnering clinics, Good Neighbor Free Clinic, is just across the border in Sauk County. ABC staff helped almost 200 patients and family members holding over $234,475 in medical debt eliminate almost $158,000 of those debts.

Hospital Specific Recommendations

SSM Health St. Mary's Hospital

SSM Health's FA policy[40] includes significant equity gaps that result in FA denials for patients. First, SSM Health's FA policy requires strict verification documentation. ABC's client work identified that the SSM policy requires a tax return (or a non-filing letter) with a FA application. Generally, patients can only get a non-filing letter from the IRS if they have a Social Security Number or Individual Taxpayer Identification Number. Consequently, patients that lack this documentation must file a specific "attestation form" that is not publicly available on the SSM website. This process is confusing and chilling, especially for immigrant patients who may not be aware of their options.

For another documentation example, an ABC client appeared eligible for FA but faced a short deadline to submit her application, and securing an inked signature was the only step holding up her submission. Despite written policies that permit verbal signatures, SSM refused to allow her to verbally sign the documents over the phone. After advocacy from ABC, SSM finally relented and allowed her to complete a verbal signature. Patients shouldn't need professional advocacy to enforce SSM policy language.

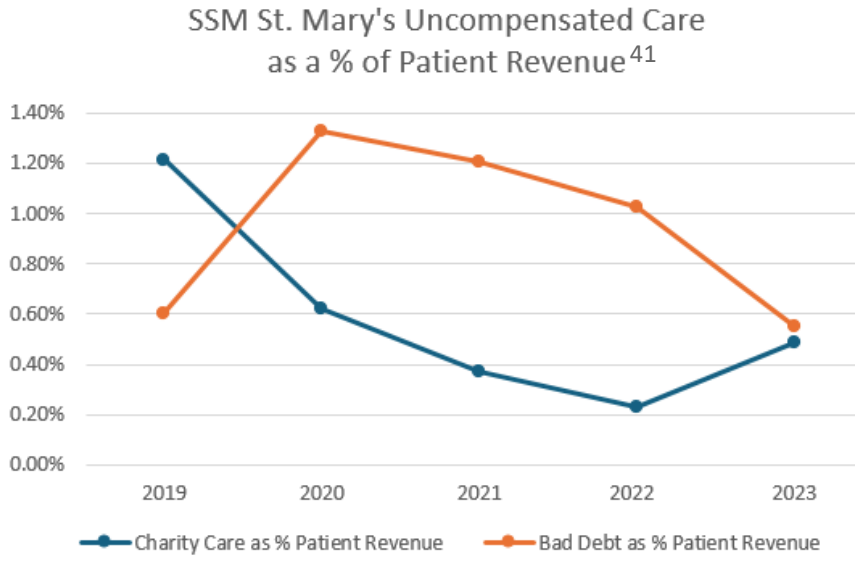
We expect SSM and other area providers to adopt a "best available information" policy. This allows patients to verify FA application information with the flexible standard used by Wisconsin Medicaid and envisions situations where a patient could not reasonably or promptly obtain a verification document.

Second, patients who are approved for FA often face difficulty in having the FA applied to their accounts, or in using the FA approval for third-party bills. For example, an ABC client was approved for SSM FA in early May 2024, but kept seeing a balance on her MyChart for months afterward. After several escalation steps from ABC, her accounts were finally updated at the end of September 2024, almost 5 months later!

Finally, SSM Health's FA policy does not include presumptive eligibility for patients with Medicaid.

SSM Health is the only Dane County hospital included in this report that does not include presumptive FA eligibility for patients receiving Medicaid.

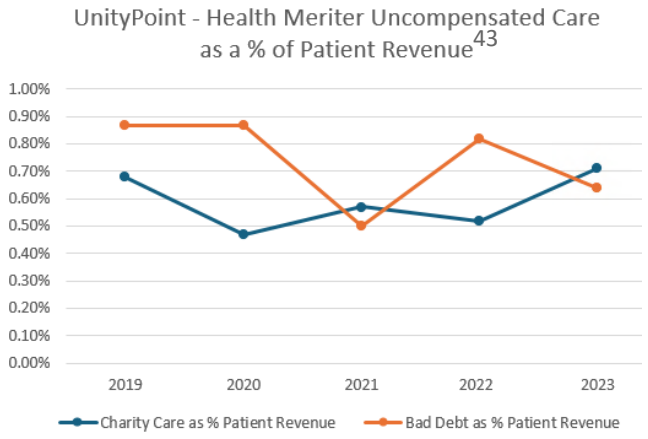
We recommend SSM Health formally adopt presumptive eligibility for patients already assessed eligible for Medicaid or other qualifying public benefits, like WIC or FoodShare.



Recommendations for Dane County

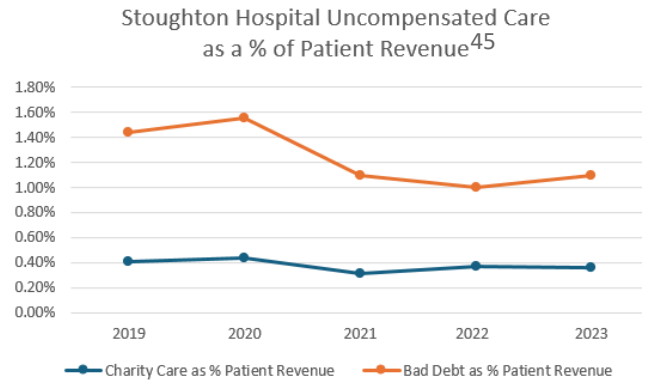
Hospital Specific Recommendations

UnityPoint Health—Meriter Hospital



UnityPoint Health—Meriter Hospital has the same FA application and policy as UW Health.[42] All recommendations for UW Health also apply to UnityPoint Health—Meriter Hospital. We also specifically recommend that UW Health and Meriter improve communication between the two entities with respect to financial assistance determinations, as we have seen that it can take weeks or months for UW Health to inform Meriter that a patient has been determined eligible for assistance. Note: ABC for Health has a contractual relationship with Meriter in which Meriter refers some patients seeking long term care services to ABC.

Stoughton Health



As of January 1, 2021, Stoughton Health stopped filing new collections actions. While this conforms with our recommendations, this policy has not been formalized by any hospital policy. We recommend Stoughton Health formalize this practice to protect patients from potential future legal actions. Stoughton Health's FA policy[44] has a considerably lower FPL than most other hospitals in the county. Only patients under 150% FPL are eligible for 100% write offs, compared to hospitals such as UW Health and UnityPoint Health—Meriter that provide 100% write offs for people who have 300% FPL. Additionally, Stoughton Health's sliding scale discount only includes patients up to 180% FPL. These policies severely limit those who can get FA from the hospital, leaving many with very large hospital bills that are difficult to pay. Stoughton Health should expand their FPL cutoff and sliding scale discounts so that more people can access FA, aligning their policies to other hospitals in Dane County.

Charlie's Story

"Charlie" (*name changed to protect privacy*) had visited multiple Dane County hospitals after an emergency. His bills were from each major hospital in the area, as well as pathologist & emergency services groups, leaving Charlie just over $106,000 in medical debt. ABC for Health's advocate helped Charlie apply for Financial Assistance at UW Health & UnityPoint Health-Meriter and SSM St. Mary's, with paystubs and bank statements as verification items. UW Health & UnityPoint Health-Meriter quickly approved Charlie for 100% Financial Assistance, leaving him with a $0 balance. SSM St. Mary's, however, sent Charlie's bills to collections, even though he was still working through their Financial Assistance process as they were insisting on additional verification items. SSM St. Mary's then denied his application because they did not receive a copy of Charlie's tax return (he was not a tax filer), and would not accept his wife's 1040 or his W-2 as a substitute.

Conclusion

Hospitals have a legal and moral obligation to provide charity care to the region's most vulnerable residents. With a thoughtful and proactive approach, hospital financial assistance provides a powerful shield against medical debt for low-income community members. Burdensome documentation requests, strict deadlines, and unfair and inconsistent policies at many Dane County hospitals, however, create obstacles and red tape that leave many patients defenseless against medical debt collection. They fail to mitigate the stress and burdens of patient medical debt. ABC expects hospitals to provide financial assistance services that are helpful, inclusive, and equitable. Better staff learning opportunities and skill building is critical to implementing financial assistance policies. ABC also expects hospitals to stop reporting medical debt to credit bureaus, de-linking medical bills from credit reports that create a modern day electronic debtor's prison. Hospitals must make medical debt lawsuits a rare occurrence, not a commonplace one. Moreover, to promote improved access to coverage, community hospitals can collaborate to uplift issues like Wisconsin Wayfinder, HealthCheck and "Other Services," behavioral health services and gender-affirming care. We expect hospitals to promote and engage in practices that measurably improve access to health coverage and equity for patients while also reducing their own uncompensated care.

Health coverage program red tape continues to create challenges for families, and this leads to medical debt, ruined credit, and mounting stress. The causes of medical debt are myriad and complex. Through ABC's direct client work for uninsured patients, we found that insufficient or inaccessible hospital financial assistance policies are a primary cause of medical debt. These systemic shortcomings create confusion among patients, especially among immigrant populations. Aside from vastly different eligibility criteria from provider to provider, hospital financial assistance application processes contain major roadblocks.

For example, ABC clients encounter problems with hospitals demanding excessive verification of income and assets, or only accepting certain forms of verification. This paperwork, often difficult to obtain and understand for populations facing poverty and illnesses, creates a barrier for many patients that unfairly limits their access to the financial assistance they deserve. Further, verifications are often requested only in English, with unreasonable deadlines. And some providers send patients to collections while applications are still being "processed." Others fail to inform patients of the financial assistance policies and applications.

Recommendations for hospital systems include: better provider staff training; removing red tape and barriers for all patients, especially immigrant families; improving equity; and streamlining the process, with a uniform, plain language financial assistance application across all providers in a region, as well as a presumptive eligibility standard for the most vulnerable patients.

"No space of regret can make amends for one life's opportunity misused.''
-Marley's Ghost to Scrooge, Charles Dickens, A Christmas Carol

APPENDIX A: Children and Youth with Special Health Care Needs

Strengthen and Uplift Wisconsin Wayfinder

Children and Youth with Special Health Care Needs (CYSHCN) face unique and often more frequent challenges in securing access to the right health care coverage and care. For many years, Aging and Disability Resource Centers (ADRCs) with an annual budget of $42 million have promoted and provided advocacy, outreach, and education systems designed for seniors over age 60 and adults with disabilities. They excluded services for children. This system is evolving in more positive ways. Wisconsin Wayfinder[46] is a collaborative support network for CYSHCN. It functions similarly to the ADRCs across the state with legal back-up, learning, and advocacy resources. Far too many families across Wisconsin navigate bureaucracy and complex information to secure access to health care coverage and care for their children. Previously, children with disabilities and CYSHCN were not provided the advocacy assistance with links to legal help and education in a comprehensive way. Wisconsin Wayfinder and its Children's Resource Centers (CRCs) build upon lessons learned in serving adults with disabilities and seniors through the ADRC network, and now is emerging to help families secure and maintain access to health coverage and care and promote health equity for all. As Wisconsin Wayfinder continues to evolve to better serve CYSHCN, Wisconsin counties and hospitals must strengthen their relationship with regional CRCs to enhance patient/client centered services. ABC suggests strategies to do this:

1. **Prioritize health equity.** Reducing knowledge barriers, improving health literacy, and acknowledging cultural relevance can help achieve health equity. Strengthening partnerships will improve access to support and address these issues in practice.
2. **Build collaborative partnerships.** Recognize that each partner plays a different and vital role in the system of care, coverage, communication, and resource sharing. Partners should collaborate effectively to ensure that families find the right next steps and connect to the proper help.
3. **Build accessible systems for resource sharing and communications between partners.** Partners can build resource sharing systems through regular communication that emphasizes best practices.
4. **Distribute and spread across networks that support children's system of care.** Wisconsin counties and hospitals can share the responsibility with CRCs in disseminating information to related networks and groups that regularly work with children, parents, caretakers, and families.
5. **Support a Medical Home.** Providers can better understand the role they play in establishing a medical home for CYSHCN and their families, supported and strengthened by CRCs.

By creating new bridges with more groups across Wisconsin, CRCs and Wisconsin counties and hospitals can promote further innovation and ensure that CYSHCN and families receive support and care quickly and efficiently. Currently, the CRC serving Dane County is at American Family Children's Hospital at UW Health, putting them in a prime position to benefit CYSHCN and their families by enhancing and supporting their relationship with regional CRCs.

APPENDIX A: Children and Youth with Special Health Care Needs

HealthCheck and HealthCheck Other Services

CYSHCN often have specialized needs for medication, equipment, and services. Fortunately, the law provides some help when it comes to medically necessary services for children. Federal law requires Wisconsin to provide early and periodic screening, diagnosis, and treatment (EPSDT) for Medicaid-eligible persons under 21 years of age. In Wisconsin, this program is called HealthCheck. It includes services such as comprehensive screening, case management, and treatment (HealthCheck Other Services).

Unfortunately, our research and client work demonstrates that Wisconsin Medicaid and contracted Managed Care Plans fail to fully deliver key HealthCheck-related services due to many access-to-care and coverage barriers that slow or prevent families from obtaining these services. One way Wisconsin counties and hospitals can overcome these access-to-care and coverage barriers for CYSHCN in Medicaid is to adopt a “Health Benefits Check-up" for every Medicaid-eligible person. Health Benefits Check-ups are regularly scheduled services by a trained family advocate or health benefits counselor that helps guide families through the complex health insurance and benefits programs to promote and ensure access to continuous health care coverage that meets a person’s needs. A successful Health Benefits Check-up proactively assesses and identifies health care coverage options by analyzing variables including income, family size, and health status. This process helps ameliorate health disparities and promotes measurably improved access to health coverage benefits and services so that no family falls through the cracks. Wisconsin hospitals and counties can implement Health Benefits Check-ups in partnership with Wisconsin Wayfinder. Wisconsin hospitals and counties can also implement Health Benefits Check-ups through existing hospital infrastructure, such as virtual patient services or emerging health care IT tools.

Medicaid Coverage for Residential Treatment for Wisconsin Children and Youth

Wisconsin Medicaid fails to provide residential treatment for Wisconsin children and youth, which means that basic Medicaid enrollee needs of children are not met. Wisconsin counties and hospitals should advocate for the State of Wisconsin to create and contract with in-state Psychiatric Residential Treatment facilities (PRTFs). This would increase access to medically necessary residential treatment for children enrolled in Medicaid.

Thousands of Medicaid-eligible and enrolled children across the state with behavioral, mental, and emotional conditions receive Medicaid Home and Community-Based Services (HCBS). In Wisconsin, the Children’s Long-Term Support (CLTS) Waiver Program provides many of these services. CLTS is designed to fund community support and services for children who need support to remain in their home or community.

Medicaid Coverage for Residential Treatment for Wisconsin Children and Youth *(continued)*

When a child's behavior puts themselves and/or others at risk, their care team may determine that residential treatment for longer than an emergency inpatient stay is necessary, whether that is for medication management, intensive behavioral therapy, or other similar treatments that require 24/7 monitoring and management.

Wisconsin lacks Medicaid-certified Psychiatric Residential Treatment facilities. This means that thousands of low-income children and foster youth in Wisconsin lack any access to this medically necessary service. Residential treatment is a last resort in treatment for behavioral, mental, and emotional conditions, which means symptoms are critical, yet the child cannot receive the appropriate treatment. In very rare circumstances, Wisconsin Medicaid covers this service at an out of state facility, but only after the parent goes through the time-consuming process of finding an appropriate facility and negotiating on their own. For most children in need of this medically necessary service, this isn't an option.

Currently, Wisconsin fails to follow principles of equity and federal legal requirements related to Residential Treatment services. Federal law requires that "(a) the state agency must (emphasis added) […] (2) provide information about […] (ii) the services under the EPSDT program and where and how to obtain those services" (emphasis added).[46]7This means that WI DHS has a duty to not only contract with PRTFs or similar services, but to identify available providers for CLTS coordinators, Medicaid ombudsmen, Medicaid HMOs, and Medicaid-enrolled providers to facilitate the proper referrals and assistance required and needed by families.

Medicaid-covered Residential Treatment Services are a major community need. Wisconsin counties and hospitals must collaborate to resolve this significant equity and service lapse by advocating for the Wisconsin Department of Human Services to contract with in-state PRTFs. ABC maintains that the Wisconsin DHS already has the authority through CFR § 441.56(a)(2)(ii) and DHS 107.22(4)[48] (HealthCheck Other Services) to establish contractual relationships with in-state PRTFs.

The failure to provide Medicaid-contracted PRTFs or equivalent services results in a constructive denial of prior authorization and services since there are no available means for Wisconsin families to seek a prior authorization. The United States 7th Circuit Court of Appeals found that states have an affirmative obligation to ensure that the services are provided when an EPSDT screening reveals that they are medically necessary for a child. This finding places a legal obligation on the State of Wisconsin. Wisconsin counties and hospitals should advocate for the state to follow through on this legal obligation.

APPENDIX B: Support Pregnant and Post Partum Persons after The Birth Tax

Dane County Has (Almost) Eliminated the Birth Tax

Birth Cost Recovery (BCR), also known as the Birth Tax, is a practice allowed but not required under title IV-D of the federal Social Security Act that allows states to pursue the recovery of Medicaid supported birthing costs from non-custodial fathers. It is a county-driven medical debt collections process that affects pregnant persons across Wisconsin, especially women of color. The Birth Tax is NOT child support, but rather an inequitable medical collections process coordinated by state agencies and run by counties to recover birth expenses for unmarried people on Wisconsin Medicaid. In fact, none of the money collected directly supports the affected children or families. In fact, recent research by Dr. Tiffany Green at UW Madison's Institute for Research on Poverty suggests that eliminating the Birth Tax could increase child support compliance.[49]

Recognizing the policy as inequitable, racially biased, and harmful to families, Dane County executive Joe Parisi announced in October 2019 that Dane County would eliminate the Birth Tax starting in 2020. However, an open records request revealed another story: the county only stopped entering new collections actions in 2020, but continued to aggressively collect pre-2020 Birth Tax judgments.[50] In fact, the county collected almost twice as much in Birth Tax in 2020 ($2.18 million) as it did in 2019 ($1.3 million) by intercepting COVID aid and enhanced unemployment benefits during the pandemic.[51] The Child Support office retains at least 15% of the amount collected.

Finally, in fall 2023, Dane County by way of its budget process took corrective steps to end the collection of pre-2020 Birth Cost Recovery judgments.[52] The County Budget was adopted by the board and signed by the county executive. But there is more work to do. First, the County needs to be held accountable to do this quickly, following Milwaukee's example which completely eliminated all Birth Tax judgments as of August 1, 2024, instead of slow-walking this policy implementation and prolonging the harm to unmarried families on Medicaid in the county.

Second, the March of Dimes grades Dane County as a B- for its poor health outcomes for expectant mothers and babies, with a pre-term birth rate at 9.1%.[53] While better than the state rate of 9.9%, Dane County lags behind counties like Outagamie and Waukesha. While many factors including racism and poverty affect birth outcomes, we see the correlation between this data and the policies like the Birth Tax that disproportionally affects black, indigenous, and Latinx families.[54]

Both Hospitals and shareholders can take steps to ensure the process continues in a positive direction, and Dane County can lead by example for the rest of the state:

- Adopt the equity priorities exemplified by the county board in adopting this policy change.
- Take additional steps to protect access to health care and coverage for underserved, pregnant and post-partum minority women in Dane County.

APPENDIX C: Fulfill the Promise of a Transgender Sanctuary

Increase Access to Gender-Affirming Care

"Gender-affirming care" is a general term used to refer to a wide array of medical treatments aimed at aligning a patient's outward appearance with their gender identity. Although it is usually associated with the transgender community, patients of all gender identities might seek gender-affirming care. Gender-affirming care is medically necessary and often life-saving treatment. Despite the proven effectiveness of gender-affirming care, however, there are systemic barriers that prevent people from accessing this type of care, up to and including outright bans on this medical treatment in some parts of the country. Many insurance plans also either explicitly or implicitly restrict coverage of gender-affirming care. These factors and more have combined to create a crisis of health access for people who need this treatment.

Ensuring access to gender-affirming care across the state of Wisconsin is a priority. In 2019, a federal court struck down a longstanding ban on Wisconsin Medicaid coverage of gender-affirming care, and ForwardHealth policy guidelines allow for coverage of a wide variety of gender-affirming treatments. As of late 2023, Dane County is a sanctuary county, guaranteeing that transgender and non-binary people will be shielded from any future laws that aim to strip their human rights.[55] The UW Health system is a major provider of many types of gender-affirming care for patients from Wisconsin and other Midwestern states.

However, there is more that can be done to ensure patients' access to this care. While ForwardHealth's written policies on gender-affirming care are quite generous, many patients, including ABC clients, have experienced frustrating and senseless denials for their treatment. Private insurance has its own problems: Three of the insurers offering coverage for Wisconsin residents on the 2023 ACA Marketplace explicitly excluded coverage for some or all gender-affirming treatments.[56] Employer-sponsored plans might lock someone into a network that does not offer gender-affirming treatment, such as the SSM Health system, which stopped providing certain lifesaving gender-affirming treatments in 2023, citing their affiliation with the Catholic church.[57]

It is imperative that lawmakers, insurers, providers, and advocates all do our part to promote access to gender-affirming care. If Dane County is to realize its promise of being a sanctuary for trans people, gender-affirming care must be available to everyone, not just patients lucky enough to be able to go to UW Health. Other hospital systems can step up and start providing gender-affirming care. UW Health can expand access to their gender-affirming care for uninsured patients or patients from other networks.

Estimate of Tax Benefit of Non-Profit Hospitals

The Journal of the American Medical Association published a new study that found non-profit hospitals received $37.4 billion in federal and local tax benefits in 2021.[58] The goal of the report: transparency—to shine a light on the tax benefit data that previously was kept in a "black box." The study recommends state and local governments require nonprofit hospitals to disclose the value of their property and sales tax benefits to provide the local taxpayers insight into the tax subsidies they are offering these hospitals.

Methodology

This report contains aggregate data for charity care, bad debt, and total uncompensated care for all hospitals in the targeted region, given as a percentage of those hospitals' total gross patient revenue. We calculated these numbers as follows. First, we identified our target hospitals (named here as they appear in Wisconsin Hospital Association (WHA) data reports): UW Health, UnityPoint Health-Meriter, SSM St. Mary's Hospital, & Stoughton Hospital.

Gross patient revenues are as reported in 2019-2023 in the WHA's Guide to Wisconsin Hospitals in each year. Charity care and bad debt are as reported in the WHA's Uncompensated Care Report. For each region and year, we added the charity care, bad debt, and gross patient revenue figures for all hospitals in the region to obtain aggregate numbers. We divided the total charity care by the total gross patient revenue to obtain the percentage of gross patient revenue spent on charity care across all hospitals in the region. Similarly, we divided the total bad debt by the total gross patient revenue to obtain the percentage of gross patient revenue attributed to bad debt. We added these percentages together to obtain the region-wide percentage of uncompensated care in each year. Again, we use the percentages of Gross Patient Revenue, not the raw numbers, which we think is more relevant to our discussion – otherwise, a large increase in gross patient revenue could mask a relative decrease in charity care.

We use charity care and bad debt amounts by charges instead of at cost. The charges are more relevant to the impact on patients. For example, a $100,000 charity care award represents a $100,000 decrease in medical debt, and $100,000 in bad debt represents a $100,000 medical debt that someone owes.

The following tables reflect the bad debt, charity care/financial assistance, and total hospital revenues per hospital, per year.

2023

Hospital	2023 Charity Care	2023 Bad Debt	2023 Total Revenue	2023 % Charity Care	2023 % Bad Debt
UW Health	$61,434,389.00	$82,187,110.00	$7,869,452,020.00	0.78%	1.04%
UnityPoint Health - Meriter	$13,314,672.00	$12,149,235.00	$1,885,297,244.00	0.71%	0.64%
St. Mary's	$8,423,446.00	$9,481,341.00	$1,733,425,982.00	0.49%	0.55%
Stoughton Hospital	$617,273.00	$1,885,000.00	$171,911,981.00	0.36%	1.10%

Charity care and bad debt numbers for each hospital come from the Wisconsin Hospital Association's Uncompensated Care Report (UCR) for 2023, available at: https://www.whainfocenter.com/Data-Products/Publications/Uncompensated-Health-Care-Report-Wisconsin/Uncompensated_2023.

Percentages were calculated based on these numbers, to two decimal places (the UCR only rounds to one).

Gross Patient Revenue numbers for each hospital come from data attached to the Wisconsin Hospital Association's annual Guide to Wisconsin Hospitals for 2023, available at: https://www.whainfocenter.com/Data-Products/Publications/Guide-to-Wisconsin-Hospitals/Guide-to-Wisconsin-Hospitals-Fiscal-Year-2023/General-Medical-Surgical-Hospitals

Methodology

The following tables reflect the bad debt, charity care/financial assistance, and total hospital revenues per hospital, per year.

2022

Hospital	2022 Charity Care	2022 Bad Debt	2022 Total Revenue	2022 % Charity Care	2022 % Bad Debt
UW Health	$62,333,682.00	$49,281,409.00	$7,021,628,260.00	0.89%	0.70%
UnityPoint Health - Meriter	$8,747,286.00	$13,747,296.00	$1,670,006,954.00	0.52%	0.82%
St. Mary's	$3,827,580.00	$16,788,599.00	$1,631,385,889.00	0.23%	1.03%
Stoughton Hospital	$552,839.00	$1,503,000.00	$150,046,338.00	0.37%	1.00%

Charity care and bad debt numbers for each hospital come from the Wisconsin Hospital Association's Uncompensated Care Report (UCR) for 2022, available at: https://www.whainfocenter.com/Data-Products/Publications/Uncompensated-Health-Care-Report-Wisconsin/Uncompensated_2022. Percentages were calculated based on these numbers, to two decimal places (the UCR only rounds to one).

Gross Patient Revenue numbers for each hospital come from data attached to the Wisconsin Hospital Association's annual Guide to Wisconsin Hospitals for 2022, available at: https://www.whainfocenter.com/Data-Products/Publications/Guide-to-Wisconsin-Hospitals/Guide-to-Wisconsin-Hospitals-Fiscal-Year-2022/General-Medical-Surgical-Hospitals

2021

Hospital	2021 Charity Care	2021 Bad Debt	2021 Total Revenue	2021 % Charity Care	2021 % Bad Debt
UW Health	$42,525,162.00	$38,015,268.00	$6,288,347,142.00	0.68%	0.60%
UnityPoint Health - Meriter	$8,769,514.00	$7,750,605.00	$1,541,031,558.00	0.57%	0.50%
St. Mary's	$5,873,692.00	$19,268,114.00	$1,587,709,496.00	0.37%	1.21%
Stoughton Hospital	$375,902.00	$1,356,000.00	$123,246,427.00	0.31%	1.10%

Charity care and bad debt numbers for each hospital come from the Wisconsin Hospital Association's Uncompensated Care Report (UCR) for 2021, available at: https://www.whainfocenter.com/Data-Products/Publications/Uncompensated-Health-Care-Report-Wisconsin/Uncompensated_2021 . Percentages were calculated based on these numbers, to two decimal places (the UCR only rounds to one).

Gross Patient Revenue numbers for each hospital come from data attached to the Wisconsin Hospital Association's annual Guide to Wisconsin Hospitals for 2021, available at: https://www.whainfocenter.com/Data-Products/Publications/Guide-to-Wisconsin-Hospitals/Guide-to-Wisconsin-Hospitals-Fiscal-Year-2021/General-Medical-Surgical-Hospitals

Methodology

The following tables reflect the bad debt, charity care/financial assistance, and total hospital revenues per hospital, per year.

2020

Hospital	2020 Charity Care	2020 Bad Debt	2020 Total Revenue	2020 % Charity Care	2020 % Bad Debt
UW Health	$48,078,094.00	$50,507,825.00	$5,302,170,966.00	0.91%	0.95%
UnityPoint Health - Meriter	$6,224,611.00	$11,585,210.00	$1,333,502,625.00	0.47%	0.87%
St. Mary's	$8,438,454.00	$17,929,671.00	$1,350,644,917.00	0.62%	1.33%
Stoughton Hospital	$461,811.00	$1,630,000.00	$104,713,156.00	0.44%	1.56%

Charity care and bad debt numbers for each hospital come from the Wisconsin Hospital Association's Uncompensated Care Report (UCR) for 2020, available at: https://www.whainfocenter.com/Data-Products/Publications/Uncompensated-Health-Care-Report-Wisconsin/Uncompensated_2020. Percentages were calculated based on these numbers, to two decimal places (the UCR only rounds to one).

Gross Patient Revenue numbers for each hospital come from data attached to the Wisconsin Hospital Association's annual Guide to Wisconsin Hospitals for 2020, available at: https://www.whainfocenter.com/Data-Products/Publications/Guide-to-Wisconsin-Hospitals/Guide-to-Wisconsin-Hospitals-Fiscal-Year-2020/General-Medical-Surgical-Hospitals

2019

Hospital	2019 Charity Care	2019 Bad Debt	2019 Total Revenue	2019 % Charity Care	2019 % Bad Debt
UW Health	$76,838,474.00	$40,860,757.00	$5,119,566,638.00	1.50%	0.80%
UnityPoint Health - Meriter	$9,027,245.00	$11,667,837.00	$1,334,102,558.00	0.68%	0.87%
St. Mary's	$16,976,693.00	$8,425,927.00	$1,394,738,345.00	1.22%	0.60%
Stoughton Hospital	$464,487.00	$1,640,000.00	$113,823,673.00	0.41%	1.44%

Charity care and bad debt numbers for each hospital come from the Wisconsin Hospital Association's Uncompensated Care Report (UCR) for 2019, available at: https://www.wistatedocuments.org/digital/collection/p267601coll4/id/26034/rec/4. Percentages were calculated based on these numbers, to two decimal places (the UCR only rounds to one).

Gross Patient Revenue numbers for each hospital come from data attached to the Wisconsin Hospital Association's annual Guide to Wisconsin Hospitals for 2019, available at: https://www.whainfocenter.com/Data-Products/Publications/Guide-to-Wisconsin-Hospitals/Guide-to-Wisconsin-Hospitals-Fiscal-Year-2019/General-Medical-Surgical-Hospitals

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[2] See "Methodology," at p. 23

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