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Protecting Minnesota Consumers from the Suffocating Effects of Medical Debt

A Position Paper by Communicating for America

Getting sick should not result in financial ruin and toxic anxiety. But too often, it does. More than 8 percent of Minnesota adults (roughly 400,000) are burdened by stunningly high medical debt, totaling an estimated $1.5 billion.

Healthcare financing punishes consumers because they bear unpredictable costs, navigate a highly complex payment system, and assume financial risks that insurance is intended to reduce but frequently doesn't. The impact falls heavily on low-income as well as middle-class families.

Communicating for America proposes that Minnesota become the model state to create a better path to financing medical care with more fairness, affordability, transparency, choice and accountability.

Our policy platform addresses crucial elements for a reasonable system that will lessen the catastrophic burden of medical debt:

1. Creating new hospital charity care requirements to provide a safety net for patients.
2. Changing healthcare financing ground rules to prevent unfair and predatory practices.
3. Expanding eligibility requirements for MNsure, the state-run marketplace for individuals who pay for their own plans.
4. Modifying health insurance deductibles so that they are based on the incidence of care, and not solely on a calendar year.

We believe these changes will reduce the number of Minnesotans with unsustainable medical bills dramatically. These changes will not increase government spending. We hope they have bi-partisan support.

REFORMING HOSPITAL CHARITY CARE

While Americans are forced into carrying suffocating debt, charity care at most nonprofit hospitals has all but disappeared. Remember, nearly every hospital in Minnesota is nonprofit, and thus exempt from most state and local taxes.

Nonprofit hospitals were founded with the principle that they would be exempt from state and federal taxes in exchange for providing community benefits. The definition of "community benefits" is set by each hospital. Sadly, there are no regulatory formulas for how hospitals meet that definition. According to independent watchdog organizations, hospitals are getting about $3 in tax breaks for each dollar in direct charity care. And each year, it gets worse.

In addition, certain nonprofit hospitals are generating huge amounts of cash surpluses and paying large bonuses to their administrators. But others – mostly rural and inner-city nonprofits – are struggling to keep their doors open. Some nonprofits are getting richer, while the others are getting poorer, with no mechanism for balance.

Guidelines for Charity Care in Non-Profit Hospitals:

1. Minnesota should establish uniform standards, oversight and enforcement of calculating charity care. Thirteen states have mandated charity care for patients with income below 200% of the poverty level. We believe the threshold in Minnesota should be set at 250% of the poverty line. Patients should be processed under the assumption that they are eligible for charity care as the default status -- the opposite of current practices in most hospitals.
2. Each hospital should be required to prominently make public information on how much direct charity care it provides per hospital bed as compared to the tax breaks per bed that it attains. In addition, hospitals should include this information as part of every invoice for services.
3. Minnesota should pilot a risk adjustment pool in which nonprofit hospitals with excess margins, located in areas with a more affluent population, share a portion of their surplus with hospitals that serve a larger percentage of low-income patients. Also, an independent group should examine how differences in hospital size and geographic service area impact the amount of direct charitable care. For example, hospitals in rural communities serve an older population, limiting their ability to provide charitable care.
4. Minnesota should consider limiting charity care to residents of our state. Other states – both red and blue – have this requirement.
5. Within three years, non-profit hospitals should be required to establish lending programs for patients with incomes below 400% of the poverty level if the amount of direct charity care by a hospital is less than 2.5% of total revenue.
6. New lending programs that qualify as a part of a hospital's "community benefit" services should have interest rates not to exceed the one-year treasury benchmark, plus no more than 4%. There should be strict anti-discrimination provisions based on income and health status.

Citizens and lawmakers need to ask tough questions of hospital administrators and boards of directors: *How are the massive dollars in tax breaks being used? Do the "community benefits" meet present-day expectations of service to their community? How can non-profits enact responsible and patient-oriented lending programs?*

CHANGING THE MODEL OF MEDICAL CARE FINANCING

Several factors are driving severe, debilitating consumer medical debt:

- Health insurance deductibles and copayments continue to rise at twice the level of medical inflation.
- Increasingly, patients are required to make upfront payments to receive medical care.
- Fewer people can afford health insurance with reasonable deductibles.

- Consumer healthcare financing is plagued by predatory terms and conditions, punitive deferred interest, and hidden fees.

The amount of healthcare costs being financed by consumers has jumped exponentially in the past five years. Estimates from multiple sources say this type of debt has grown nationally from $7 billion to more than $60 billion in the past ten years.

Despite this growth, there is scant regulation to govern this emerging field of medical debt lending. Unlike other loans, healthcare financing has unique characteristics and unintended consequences which raise many questions: *Would a provider be allowed to pause treatment if a loan is in default? Could customers of a health insurer who provides deductible-financing cancel coverage if the loan is in default? Would the healthiest borrowers get lower interest rates than the sickest? Will participants be steered toward more services provided by the lender at predatory costs? What type of patient collateral would be allowed, or disallowed, as a lien?*

GUIDELINES FOR THIRD PARTY MEDICAL LENDING

1. Patients should receive -- and accept in writing – a full disclosure about the terms and conditions of each financing programs of any kind that is offered by providers, payors or third parties.
2. All written disclosures to patients should state the relationship between the provider and the lender, and any direct or indirect compensation that the provider may receive, along with current and potential interest rates, fees and penalties.
3. Consumers should be allowed a 48 hour “free look” provision to avoid high-pressure loan situations.
4. Interest rates should be limited to usury laws in the state in which patients reside, not the state in which the lender is located.
5. Financing companies should not be allowed to raise interest rates during the term of the loan by more than 500 basis points (5%) above any introductory offer. Too often, a single payment default results in an enormous interest rate penalty for the borrower.
6. Enrollment fees should be capped at no more than $20 per application, and monthly fees capped at no more than $5.
7. Providers should not solicit or require patients to enroll in a financing plan before emergency treatments.
8. If health insurers provide loans (a recent CMS ruling in 2025 allows this), they should be subject to the same fair financing provisions as any other type of lender.
9. Insurance brokers should not be allowed to receive separate and distinct compensation from a health insurance carrier or hospital for promoting sponsored programs.
10. No information or data about a patient that comes into the possession of a provider, insurer or third party should be used to deny medical treatment in any form. Information about a patient who participates in a financing program should remain secure and confidential.

EXPANDING ELIGIBILITY REQUIREMENTS FOR MNsure

Much has changed in how Americans finance their healthcare expenses since 2014 when the Affordable Care Act (ACA) was created, soon followed by the establishment of MNsure. Today, fewer people are enrolled in traditional employer-paid group health insurance. Faith-based plans and other individual market enrollments have become more popular. More small employers are choosing to self-fund their employees' medical cost. And, finally, certain gaps in coverage that existed at the time the ACA was created have not been fixed in most states, including Minnesota.

We propose the following to fill those gaps and institute fair coverage:

A. All individuals who lose coverage, no matter the type of plan, should be automatically eligible for Special Enrollment Periods in MNsure. This would include small employer self-funded plans, certain kinds of short term medical and fixed benefit plans, and faith-based plans. This would open eligibility for an estimated 3,000 individuals.
B. If an uninsured woman becomes pregnant, she would automatically be eligible for Special Enrollment. Federal law does not require this, but 11 state-based exchanges have modified their rules to cover pregnancy. This would open eligibility to 500 to 1,000 Minnesota women per year who would then no longer have to self-finance childbirth.
C. Uninsured individuals seeking treatment for the first time for alcohol and substance abuse at a licensed facility would immediately be eligible for coverage. This would help about 3,000 Minnesotans who need treatment but can't afford it. The cost-benefit ratio of encouraging more treatment for substance abuse is overwhelmingly positive.

REPLACING CALENDAR YEAR DEDUCTIBLES AND CO-PAYS

An unexpected outcome of the Affordable Care Act is that nearly every type of health insurance renews on the calendar year. This has resulted in – for example – cancer treatment or a pregnancy or a knee replacement that starts late in one year and continues into the next year being subject to a new deductible. Replacing calendar year deductibles with what the health insurance industry refers to as 'carry-over deductibles' would shift this unfair deductible away from unsuspecting consumers. Any course of treatment that starts in the first year would not be subject to a new deductible in the next year.

Carry-over deductibles would mostly reduce out-of-pocket costs for those receiving treatment in four distinct categories:

A. Chronic Disease Management. An estimated 250,000 Minnesotans pay a deductible twice because the course of treatment extends into two calendar years.
B. Pregnancy. Approximately 40,000 women pay two deductibles because the pregnancy, birth and post-partum treatments cover two calendar years.
C. Addiction and Mental Health. Although difficult to estimate, we believe a change from calendar year to course of treatment deductibles would reduce out of pocket costs for 10,000-30,000 people each year.

D. Major Orthopedic Surgeries. In Minnesota, there are more than 100,000 major orthopedic surgeries that mostly average at least four months for a full course of treatment. Patients bear redundant deductibles when that treatment crosses over into a new year.

The savings for everyone caught in these circumstances would be in the range of $1,000 to $5,000. If just 50,000 Minnesotans were able to pay an average of $3,000 less in out-of-pocket expenses, it would put $150,000,000 back into consumers pocketbooks, thus stimulating the economy.

SUMMARY

If Minnesota enacts reforms like those recommended above, our state would be on a path to eliminating all onerous medical debt within five years, making it a model for others to follow.

- More healthy people would have insurance.
- Nonprofit hospitals would give back more to those who can't pay the full cost of care.
- Consumers would pay less in deductibles and co-pays.
- Interest rates for onerous medical financing would be lower and administered more effectively.

These gains in a healthier, productive, tax-paying population unburdened by debt would likely stimulate the economy. There is no direct cost to state or local government to implement these changes.

CA is ready to assist any individuals or groups seeking to implement these types of reforms, without regard to any political party or bias.

Note: Data cited in this report are projections made by CA based on publicly available information from the Minnesota Department of Health and Department of Commerce, a Legislative Audit Report in 2024 and other sources. Additional information comes from KFF, the Commonwealth Fund and the Lown Institute.

About CA:

Founded in 1972, CA has roughly 75,000 dues-paying members. It makes insurance benefits available to its members and has a long history of advocating for steps to lower the number of uninsured and reduce medical debt. It has erased $10 million in medical bills for Minnesota residents.

About Jeff Smedsrud:

Jeff is the CEO of CA. He serves on the board of several non-profit organizations that seek to improve access to healthcare and is an executive board member of Undue Medical Debt which has erased $49 billion in medical debt for 31 million Americans. He has testified dozens of times before state and federal legislative committees and is frequently quoted by national and state media. He has started multiple insurance and healthcare companies, and has been one of the largest health insurance brokers in the U.S.

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Note: The views of CA or Jeff Smedsrud do not necessarily reflect those of Undue Medical Debt. To learn more about Undue Medical, visit their website @ visit their website: https://unduemedicaldebt.org/