Don't *Lien* On Me

Why the State's Medical Indigency Care Program is Unhealthy for Idahoans

The Idaho Community Action Network
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DON'T LIEN ON ME:

Why the State's Medical Indigency Care Program Is Unhealthy for Idahoans

Idaho Community Action Network

The Access Project

Community Catalyst

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EXECUTIVE SUMMARY

What do you do if you injure your back, come down with the flu, or even have a toothache, but you're uninsured? Do you wait to see a doctor until you save enough money to pay for it? Do you simply hope that the problem gets better on its own? Do you go to the hospital emergency room, risking an expensive hospital bill that you can't afford to pay?

Whenever one of the 200,000 uninsured individuals in Idaho becomes sick, they face this dilemma. They are among the growing ranks of Americans who do not have access to health insurance. The majority of them cannot afford the high cost of health insurance, have been denied health care coverage due to preexisting condition clauses, or are not offered health care coverage through their employers.

What Does It Mean to Not Have Health Insurance?

Health insurance is the most important vehicle for gaining access to health care services in the United States. It makes a substantial difference in the amount and type of services people are able to obtain. The adverse health consequences for people who do not have health insurance are serious: one study found that the uninsured are almost six times more likely than the insured to have postponed health care for a serious condition because they couldn't afford it.[1] Other studies focusing on health outcomes for uninsured individuals found that these people are more likely to die in the hospital, implying that they may postpone care until it is too late.[2]

Although not discussed as frequently as the health consequences themselves, the financial consequences for people who do not have health insurance can be just as devastating to Idaho families. Lack of or limited health insurance can lead to a myriad of financial problems. According to a Kaiser report, the uninsured are more than twice as likely to have had problems paying medical bills in the past year as those who are insured.[3] The majority of these uninsured adults said they had to change their family's way of life significantly in order to pay their

[1] Health Desk, National Survey on the Uninsured, 2000, Newshour with Jim Lehrer/Kaiser Family Foundation, Menlo Park, April 2000.
[2] J. Hadley, E. Steinberg, and J. Feder, "Comparison of Uninsured and Privately Insured Hospital Patients: Condition on Admission, Resource Use, and Outcome," *JAMA*, 265 (1991): 374-379.
[3] Kaiser Commission on Medicaid and the Uninsured, "The Uninsured: A Primer. Key Facts About Americans Without Health Insurance." March 2001.

medical bills.[4] And a study last year by Harvard Law Professor Elizabeth Warren found that over half of people filing for personal bankruptcy in the United States do so because of a medical problem or medical debt.[5] Clearly, a good health insurance policy is a protection against financial ruin.

The County Medical Indigency Care Program in Idaho

Many states have established health care safety nets that include public financing of institutions and programs that serve the uninsured. For the uninsured – whether poor or of moderate income – the existence of a solid health care safety net means getting medical services when you need them and protection from financial ruin in case of a medical catastrophe.

In Idaho, this health care safety net is composed of (1) Medicaid for children and pregnant women, as well as for certain individuals who are aged, blind, or disabled;[6] (2) the County Medical Indigency Care Program; and (3) the Catastrophic Health Care Cost program. This safety net, however, is inadequate. In fact, one major component – the County Medical Indigency Care Program – not only deters Idaho's uninsured from seeking health care services, but also contributes to their financial ruin.

The County Medical Indigency Care Program was created in 1974 to help uninsured Idaho residents pay for medical services. In 1996, the Idaho Legislature enacted significant changes to the program. These changes included the imposition of an automatic lien on program applicants. The lien is placed on the real and personal property of the applicant until the recipient reimburses the county for whatever portion of funds the county decides the applicant should repay. Thus, rather than protecting uninsured Idahoans from financial ruin, the County Medical Indigency Care Program is pushing people over the edge.

ICAN, with support from The Access Project and Community Catalyst, conducted several types of research on the County Medical Indigency Care Program in order to understand how it currently operates and how the lien provision is adversely affecting people who use the program.

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[4] *Id.*
[5] M. Jacoby, T. Sullivan, E. Warren, "Medical Problems and Bankruptcy Filings," *Norton's Bankruptcy Adviser*, May 2000.
[6] Children in families with incomes under 150% of the federal poverty level (for a family of four, the monthly income level is $2,131) are eligible for Medicaid up to age nineteen. Pregnant women with incomes under 133% and Supplemental Security Income (SSI) recipients with incomes up to 74% of the federal poverty level are also eligible for Medicaid. The Henry J. Kaiser Family Foundation. "Idaho: Eligibility Levels for Children Under Medicaid and CHIP as a Percent of Federal Poverty Level, 2000" and "Idaho: Eligibility Levels for Other Medicaid Enrollment Groups as a Percent of Federal Poverty Level, 2000." State Health Facts Online. <http://www.statehealthfacts.kff.org>.

Research Components

The following research was undertaken:

- Interviews with families who have used the program.
- Review of the statutes that created the program.
- Investigation of the effects of liens and medical debt on an individual's credit report and ability to secure future credit.
- Review of information from eleven counties on the implementation of the County Medical Indigency Care Program.

Key Findings

The key findings of this report are:

- The existence of the automatic lien provision of the County Medical Indigency Program is a barrier that prevents families from seeking medical care.
- The lien and the reimbursement provisions of the County Medical Indigency Program actually drive uninsured families into medical debt that seriously affects their credit ratings long after the lien has been removed.
- The amount of money that counties have collected from indigent individuals since the inception of the automatic lien provision in 1996 remains virtually unchanged. This suggests that the automatic lien provision has had no positive economic outcome for the counties.
- Counties underspend the amount of money they have allocated to the County Medical Indigency Care Program, thereby denying uninsured Idahoans relief from burdensome medical bills.
- The automatic lien provision has detrimental financial effects on hospitals and health centers in Idaho because, as consumers decline to apply for the County Medical Indigency Care Program for fear of a lien, health care institutions must foot the bill or pass it along to the insured.
- Although many counties across the country have programs that help uninsured individuals obtain medical services and reimburse institutions that serve the uninsured, Idaho is unique in the country in its use of the automatic lien provision.

Recommendations

Given these findings, ICAN makes the following recommendations for reforming the County Medical Indigency Care Program:

- The state should eliminate the automatic lien provision of the County Medical Indigency Care Program.
- The state should eliminate the reimbursement requirement of the County Medical Indigency Care Program.
- Counties should strive to spend the amount of money that they allocate to the County Medical Indigency Care Program each year.
- The state should shorten and simplify the application for County Health Care Assistance.

SUMMARY OF THE COUNTY MEDICAL INDIGENCY CARE PROGRAM

Counties in Idaho offer a program that provides financial assistance to people who are in need of medical services but cannot afford them. Under this program, counties can pay residents up to $10,000 per claim in the aggregate over a twelve-month period.[7] The programs will only pay for "necessary medical services," which are those services required in order to identify or treat a person's health condition, illness, or injury.[8] Some important medical services are specifically excluded.[9]

Application and Approval Process

To obtain financial assistance, applicants must submit a written, signed and sworn, eight-page application to the county clerk's office. Third parties (such as hospitals) can apply on a patient's behalf. Because a third party may complete and sign an application for assistance, an application can even be submitted without the person's knowledge or consent.[10] This application—known as the Uniform Medical Indigency Application—requires extensive information about the applicant, his or her household, the medical services for which assistance is requested, the individual's health insurance status, residency, earned and unearned income, resources (financial and real/personal property), and monthly expenses. The applicant must also provide proof to support all of the information on the application, including pay stubs, tax returns, application for other programs, and proof of value of all real and personal property.

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[7] Under Idaho's Catastrophic Health Care Cost Program (CHCCP), medical expenses above $10,000 may be paid for by the state. It is not necessary to complete a separate application, above and beyond the Uniform Medical Indigency Application, to receive funds from the CHCCP. Instead, the CHCCP board reviews the application submitted through the county.

[8] The medical services must be: (1) consistent with the symptoms, diagnosis, or treatment of the medical indigent's condition, illness or injury; (2) in accordance with generally accepted standards of medical or surgical practice then prevailing in the community where the services were provided; (3) furnished on an outpatient basis whenever it is safe, efficient, and reasonable to do so; (4) not provided primarily for the convenience of the medically indigent person or the provider; and (5) the standard, most economical service or item that can safely, reasonably, and ethically be provided. Idaho Code §31-3502(18) (A).

[9] Excluded services are: (1) bone marrow transplants; (2) organ transplants; (3) elective, cosmetic and/or experimental procedures; (4) services related to, or provided by, residential and/or shelter care facilities; (5) normal, uncomplicated pregnancies, excluding caesarean section and childbirth well-baby care; (6) Medicare co-payments and deductibles; and (7) services provided by, or available to, an applicant from state, federal, and local health programs. Idaho Code §31-3502(18) (B).

[10] *See* Idaho Code §§31-3502(15) and 31-3504(2) ("If a third party application is filed, the application shall be as complete as practical…").

Applications for *nonemergency* medical services must be filed 10 days prior to receiving services from the provider. Application for *emergency* medical services can be made at any time within 31 days beginning with the first day of the provision of services from the provider or, in the case of hospitalization, 31 days beginning with the date of admission.

Once the application is complete, the county clerk personally interviews the applicant and investigates the information provided on the application, along with all other required information. Applicants have a duty to cooperate with the county investigation, by providing documentation, submitting to an interview, and otherwise helping the county ascertain eligibility. Applicants also must notify the county if they receive additional resources after an application has been filed.

The county clerk must complete the investigation of an application for nonemergency necessary medical services within 20 days (45 days in case of a medical emergency). Once the interview and investigation is complete, the clerk files a statement of findings with the Board of County Commissioners, which must make an initial determination of eligibility. Interestingly, the law provides no guidelines for eligibility—eligibility is determined solely at the board's discretion. In cases where the board determines a person is not eligible for assistance, there is recourse for an appeal by the applicant, in which case the board must hold a hearing. If, on appeal, the board again denies financial assistance, judicial review is available. Arbitration is also available if a county determines that a service is not a necessary medical service.

Automatic Lien

As soon as he or she files for financial assistance, an automatic lien is placed on all of the real and personal property of the applicant and on insurance benefits to which the applicant may become entitled in the future.[11] If the county approves the application for assistance, the lien remains in place until the applicant's financial obligation to the County is satisfied. Although the application does state that the automatic lien will attach to the applicant's property, if a third party applied on behalf of a patient, it is quite possible that the patient would not know about the lien until after it was attached.[12]

[11] If an application for assistance is denied, the lien will be released within twenty-eight days from the date of denial. *See* <http://www.co.bonner.id.us/assistance/indig.htm>.

[12] In fact, while conducting research for its St. Luke's Charity Care Campaign in 1999, ICAN came across families who were not clearly notified that an automatic lien would be placed on their property. *See* "Public Health or Private Wealth? Who's Cashing in on St. Luke's Riches?" June 1999.

Reimbursement

People who receive financial assistance are required to reimburse the county for any portion of the financial assistance and for any period of time that the board decides is reasonable. If the amount of financial assistance is over $10,000 – and, thus, the applicant receives assistance from both the county and from the state, through the Catastrophic Health Care Cost Program – reimbursed amounts are supposed to be prorated between the county and the state in proportion to the amount each has paid. If the board finds that a person has additional resources, it can require additional reimbursement. Conversely, it can also reduce the amount of reimbursement if it finds that there has been a substantial change in an applicant's circumstances. If an applicant feels that the reimbursement amount or rate is excessive, he or she can seek judicial review.

STORIES FROM THE FIELD:
THE IMPACT OF THE LIEN PROVISION ON UNINSURED IDAHO FAMILIES

A. Driving Families into Debt

Uninsured families face serious financial consequences when seeking health care services in Idaho. The problems associated with the County Medical Indigency Care Program are best illustrated by the personal stories of families who have used or are afraid to use the program because of the liens.

Idaho's Medicaid program currently operates at the lowest possible income threshold that is allowed by the federal government.[13] Many poor working families make too much money to qualify for the state's Medicaid program—in fact, an adult who works more than seventeen hours a week at a minimum wage job will exceed the income limits for the state's Medicaid program. Many families are provided no relief for their medical expenses and do not have access to health insurance through their employers. As a result, the county program is often the only way for families to get needed medical services. By law, the County Medical Indigency Care Program is the payer of last resort; however, the current program offers no clear income guidelines to determine who qualifies for help.

Beverly and Hugh Shrank, Burley, Idaho

In 1991, Hugh Shrank was working as a truck driver and his wife, Beverly, was a full-time student. The couple had no health insurance because Hugh's employer did not provide coverage. That year, Hugh suffered from an allergic reaction to a prescription drug he was taking and was rushed to Cassia Regional Medical Center. Upon arrival, Beverly told the hospital that they had no health insurance and could not afford to pay for care. The hospital suggested they seek aid from the County Medical Indigency Care Program to cover their $3,000 medical bill.

[13] *See* Kaiser Commissioner on Medicaid and the Uninsured. "Medicaid Eligibility for Families and Children." September 1998.

The Shranks applied to the program, but they were denied coverage. According to the county, Hugh's job paid him enough to afford the cost of medical care. At the time, Hugh was still too sick to return to work. After the county rejected the Shrank's application, the hospital allowed Hugh and Beverly to set up a monthly payment plan of $20.

Hugh's illness and subsequent slow recovery made their already precarious financial situation even worse. Because Hugh missed a great deal of work due to his illness, he was fired from his job. As soon as he was well enough, Hugh was able to find another job, but it didn't last long—he was soon laid off. The Shranks were barely keeping their heads above water financially, and as the bills mounted they were unable to pay the $20 a month to the hospital. The hospital sent the Shranks' bill to a collection agency. The bill grew even bigger as interest accrued. Finally, in 1995, the Shranks decided that their only option was to file bankruptcy.

"We felt like we were drowning in debt and the only lifeguard we had to save us was to file."

In conducting its research, ICAN found that many families refuse to apply for the program based on the fear of what would happen to their homestead. Families would rather deal with the consequences of claiming bankruptcy than lose their homes. Although no county in Idaho has yet foreclosed on a person's house, the perception that this could happen has a chilling affect on people applying for the program.

Georgia and Jesse Smith, Declo, Idaho

Georgia Smith and her husband, Jesse, moved from California to Idaho ten years ago. They live in Declo with Tiffany, the youngest of their five children. They feel like a part of their community and like to help others, so they volunteer at the Burley Food Program and at New Life Tabernacle. They also volunteer for Shilo Christian Counseling Services in Boise.

Georgia has always been a stay-at-home mom, taking care of the Smiths' five children. Jesse, who is now retired, used to work for Magic Valley Foods. Today, with social security and the money he makes from occasionally hauling livestock, the family's income totals about $1,500 a month.

Until 1996, when Jesse retired, the family had health insurance through his work. When he retired, the family thought they'd be able to keep coverage through the company plan, but as the cost of coverage increased their income fell and, after a few months, they were forced to drop the coverage.

Since Jesse and Georgia were both a few years shy of 65, they were not eligible for Medicare. And an income of $1,500 a month made them ineligible for Medicaid, since, under Idaho's current law, a family of three must make less than $382 a month to qualify for this program.[14]

In March 1997, Georgia, who had been experiencing episodes of severe abdominal pain and nausea, had an attack so severe she was rushed to the hospital emergency room. Doctors found she had a tumor the size of a softball attached to one ovary and performed an emergency hysterectomy.

Because Georgia was uninsured, the Smiths were faced with a hospital bill of $18,827. They tried without success to work out a payment plan with the hospital. Ten months after surgery, the hospital sent the bill to a collection agency. They refused to go to the county to apply for the County Medical Indigency Care Program for fear of what would happen to their home and credit if they applied for the program. Soon thereafter, they were forced to declare bankruptcy.

Today, at age 67, Jesse is eligible for Medicare. Georgia, however, is not. And so she is still completely uninsured.

"I think our state needs a better medical plan for working families," Georgia states. "Right now I need glasses, I'll guess I'll have to wait until I'm 65. Even though we had to claim bankruptcy, at least we still have our home. I didn't want a lien placed on my home."

Stories such as the Shranks' and Smiths' can be heard in many communities across the state. ICAN contends that the county program, which is paid for by county taxpayers, punishes those same families for accessing a program that they initially funded.

B. The Financial Impact of a Lien

The County Medical Indigency Care Program's practice of automatically attaching a lien to any real or personal property of program beneficiaries has several immediate and long-term consequences for a family's or individual's financial situation.

1. **Liens create barriers for families when selling property or when attempting to use that property as collateral when seeking additional credit.**

ICAN polled various financial institutions in the state to ascertain what effect a lien would have on an individual who attempted to sell his or her home or to use the home as

[14] IDAPA 16.03.08, page 17, Rule 251.

collateral when seeking additional credit. The exact responses varied from institution to institution, but all institutions agreed that the lien represents a significant barrier when selling property or applying for additional credit. Although the lien cannot prevent a person from selling or using that property as collateral, judging by the responses below, it can create a large administrative and financial headache for a family trying to obtain additional credit or cash resources.

Name of Institution	Date of Interview	Response from loan/title officer
Bank of America	3/1/01	"A person can sell their house. Part of the proceeds would have to go to pay off the lien."
Farmers & Merchants State Bank	3/2/01	"It could make the situation very complicated for the individual. The only way we would loan to that person is if the county waived the lien. I doubt that would happen."
Idaho Central Credit Union	2/27/01	"Lien would have to be paid off before the person sells their house. We wouldn't use it as collateral."
Home Federal Savings and Loan	2/26/01	"It would definitely be one of the first things that we would look at…it raises quite a flag when a lien is present."
Pioneer Title Company of Ada County	3/1/01	"It would make it difficult to sell or obtain additional credit. We deal with these every day. They [the liens] are not fun."

2. Liens harm one's credit score and place a derogatory mark on one's credit report.

Almost every adult in the United States has a credit file with the three major national credit bureaus: Experian, Equifax, and Trans Union. A credit file contains basic personal information, including social security number, birth date, current and former addresses, and employers. The file collects and lists, individually, the basic account information of all debts. This includes a code that explains whether the account is current, thirty days past due, sixty days past due, ninety days past due, or if it involves a repossession, charge-off or other collection activity. Most major creditors subscribe to at least one credit bureau. Creditors continuously supply the credit bureau with current account information in exchange for the right to find out information about other credit applicants.

A *credit report* from a credit bureau will include a summary of past credit experiences, such as the number of times a person's account was past due, the date of the most recent delinquencies and the date of the most severe delinquency. *Credit scores* are "numerical scores generated by a credit bureau or lender that are used to predict a borrower's risk of delinquency or default."[15] These scores are based on the information in the credit report. Fair, Isaac and Company, Inc., developed the most widely used software to generate credit scores, which explains why credit scores are widely referred to as "FICO" scores. The factors used to generate FICO scores had been a well-guarded secret, but as of June 2000 they have been divulged to the public. The FICO scoring factors and relative weight of each factor are:

- Payment history—35% of score.
- Amounts owed—30% of score.
- Length of credit history—15% of score.
- New credit—10% of score.
- Types of credit in use—10% of score.[16]

Liens fall within the "payment" or "credit" history factor in the FICO credit scoring system, the description of which states:

> Public record and collection items—reports of events such as bankruptcies, judgments, suits, liens, wage attachments, and collection items. *These are considered quite serious, although older items will count less than more recent ones.* [17]

This FICO category is the only one that contains an explicit statement of a lien's importance to the credit score. Further, the Fair Isaac website includes general recommendations for improving one's credit score. Although these recommendations cover most of the factors that make up the credit score, they do not indicate how to offset the damaging existence of a lien.[18] As a result, the practice of attaching liens to a consumer's property affects a consumer both while the lien is attached and after the lien is removed because the history remains in the consumer's credit report for the rest of his or her life.

4. Credit reports and scores are widely used to screen applicants for employment, rental housing, and the extension of credit.

Freddie Mac has a worksheet for underwriters to assess the risk associated with providing a mortgage to a particular individual. The worksheet lists a lien under the category of "Worst ever derogatory credit file entry" along with other extreme risk factors such as bankruptcy, foreclosure, and repossession.

While credit scoring systems have been around since the 1950s, their importance in the lending world has increased dramatically in recent years. Since 1995, FICO scores have played an important role not only in the mortgage lending world, but also in nonmortgage

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[15] *See* <http://www.fairisaac.com>.
[16] *See* <http://www.myfico.com> ("What a FICO Score Considers").
[17] *Id.* (emphasis added).
[18] K. Harney. "How to Boost a 'Score' For Lower Mortgage." The Washington Post. November 7, 1998 <http://www.fairisaac.com/servlet/SiteDriver/Content/686>.

lending and credit card transactions. According to a National Consumer Law Center Report on consumer credit: "Lenders and collectors use scores not only to evaluate applications, but also to decide whether to increase or decrease lines of credit, determine collectability of accounts, and even to project the likelihood of bankruptcy."[19] A press release issued during the recent publication of FICO's scoring factors states that "FICO scores are used by US lenders to make billions of credit decisions each year, including more than 75% of mortgage loan originations."[20]

Credit reports and credit scores are increasingly being used in new settings. For example, employers commonly use credit reports and scores when conducting background checks of job applicants and employees seeking promotions or reassignments.[21] Landlords review credit reports and scores when screening prospective tenants.

Because credit reports contain information that has been collected for decades, the County Medical Indigency Care Program's policy of attaching liens harms a consumer's credit for a long time.

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[19] "Consumer Credit and Usury Edition," *NCLC Reports*, Volume 18, May/June 2000.
[20] Fair Isaac and Company Press Release. "Fair Isaac 'Demystifies' FICO Scores with List of Score Factors, Web-based Explanation Service," June 8, 2000 <http://www.fairisaac.com>.
[21] D. Kitamura and D. Loonin, "Getting Credit Where Credit is Due: Helping Welfare-to-Work Clients Address Credit-Reporting Issues." *Clearinghouse Review,* July-August 2000.

LOOKING AT THE NUMBERS:
IS THE LIEN PROGRAM REALLY EFFECTIVE?

Throughout much of 2000, ICAN collected data from eleven individual county programs in diverse geographic areas across the state. The counties that ICAN researched are: Ada, Canyon, Cassia, Gooding, Idaho, Jerome, Lewis, Minidoka, Nez Perce, Owyhee, and Twin Falls. Through a combination of letters and phone calls, ICAN asked for the following information from each county:

(1) The amount each county budgeted for the Medical Indigency Care Program (1994-2002);
(2) The amount each county spent on the Medical Indigency Care Program (1994-2002);
(3) The amount each county recovered from Idahoans who had used the Medical Indigency Care Program (1994-2002);
(4) Systems of collection; and
(5) The number of times the county had foreclosed on a lien.

The data gathered is set forth in Appendix B.

Based on this research a number of conclusions can be drawn:

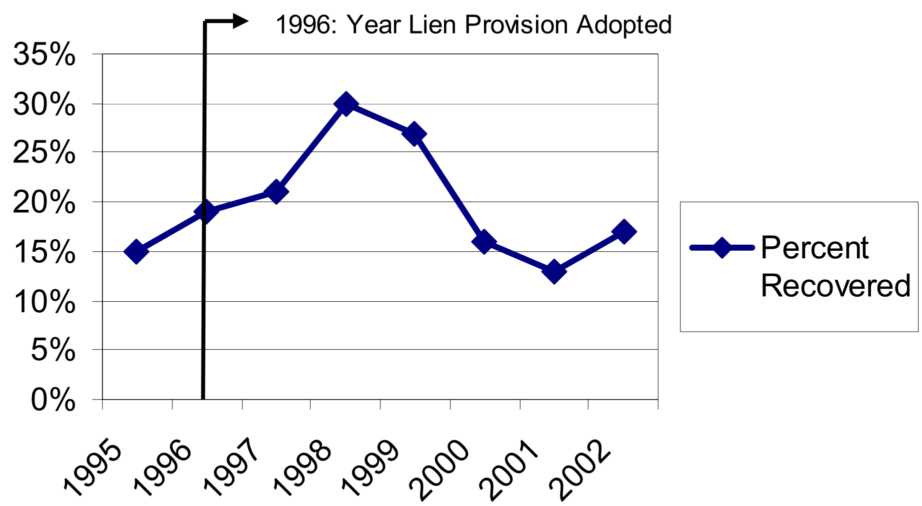
- Much of the money that is to be used for health care is never spent. For instance, in Ada County in 2000, 27 percent of the funds allotted for the program went unspent. In 2002, that figure was14 percent, or nearly $1 million, that could have been used for uninsured or underinsured families. In Idaho County, in 2001, 27 percent of the funds went unspent. With the exception of Gooding County in 1995 and Cassia County in 1996, not one county that ICAN investigated used its entire yearly allotment of funds for the program.

- Counties use different systems of collection, making a program that is already administratively confusing even more so. All of the counties, however, required indigent recipients to sign agreements promising to repay the county for funds borrowed. Four of the counties specifically identified the use of promissory notes. Cassia, Jerome, and Twin Falls counties admit to sending accounts to collection services.

- Although the potential to foreclose on property certainly exists, no county in the survey has actually foreclosed. Thus the lien provision seems to be an unnecessary administrative burden.

- Even with the enactment of the lien provision, there is no evidence that counties have increased their ability to recover funds. In fact, in some years, the amount of money collected by the counties actually declined. For example, in 1994, Cassia County collected $78,486; in 1999 it collected $60,348. In 1994, Idaho County collected $56,251; in 1998 it collected $44,113. Recovery rates fluctuate from year to year in each county; the lien provision seems to have had no impact.

Percent of Idaho Indigency Fund Recovered
1995 to 2002 (7 Counties Reported)[22]



[22] Counties in this chart are Canyon, Cassia, Gooding, Idaho, Jerome, Lewis, and Nez Perce.

IDAHO COMMUNITY ACTION NETWORK'S RECOMMENDATIONS FOR CREATING A FAMILY-FRIENDLY MEDICAL INDIGENCY CARE PROGRAM

The funds allocated by each county for the Medical Indigency Care Program are derived from a tax levied on Idahoans. Because these funds are specifically earmarked for health care, they must be used for health care. However, ICAN's survey of eleven counties has found that in virtually every county, the funds allocated are not being fully utilized. Because these dollars hold the promise of providing access to health care services and preventing financial ruin for the over 200,000 Idahoans without adequate health insurance coverage, it is imperative that all dedicated funds be used to address the needs of the medically indigent. It is ICAN's belief that the Medical Indigency Care Program could fulfill this promise if it was modified in three key respects:

1. Remove the Lien Provision

The lien provision of the County Medical Indigency Care Program is a major barrier to getting medical services for many uninsured in Idaho. Further, property liens can disastrously affect an individual's credit rating even long after the debt has been repaid and lien removed. Hospitals and health centers are also affected by the lien provision. As consumers decline to apply for the County Medical Indigency Care Program for fear of ruining their credit, health care institutions are not immediately reimbursed for the care they provide. Finally, the lien provision has not significantly improved the counties' efforts at collecting payment from individuals who have used the County Medical Indigency Care Program. For these reasons, ICAN recommends eliminating the lien provision of the County Medical Indigency Care Program.

2. Modify the Reimbursement Provision

Currently, the County Medical Indigent Care Program requires those who receive financial assistance to reimburse the county from which the assistance was received. Both the reimbursement amounts and the timeline in which to pay them are devised entirely at the counties' discretion. Counties are also given discretion to adjust the amount of reimbursement as an individual's or family's income or assets changes. Requiring low-income families to reimburse the county for medical debt creates serious financial consequences. Debt that is 30 days or more overdue adversely affects a family's credit report and score. Medical debt also constrains the already tight budgets of most low-income families, forcing people to choose between paying for food and shelter or paying their medical debt. In its eleven-county survey, ICAN learned that there are great disparities in how counties implement this provision of the law. ICAN recommends that the reimbursement provision of the law be standardized to require no reimbursement of county funds unless a family's income or assets increases in a three-year period following the receipt of county funds. If there were a considerable increase in income or assets, the county would form a reimbursement agreement with the indigent family.

3. Streamline the application process

The current application for the County Medical Indigency Care Program is eight pages long and includes many questions on income, expenses, and assets that are difficult for families to complete. A lengthy and complicated application also creates barriers for health care providers who are applying on behalf of indigent consumers. ICAN proposes adoption of a new application that is similar to the standard public assistance application that is used for the CHIP, food stamp, cash assistance, and Medicaid programs.

4. Establish Eligibility Guidelines

Under the current Medical Indigency Care Program, there are no clear standards for determining eligibility. Instead, the counties have discretion to determine eligibility on a case-by-case basis. This leads to confusion and, potentially, to the denial of assistance to individuals in need. ICAN recommends that a gross income test be used to screen applicants. The gross income test would be set for families or individuals who are at or below 200% of poverty level. In addition, these families also would only be eligible for the program if they didn't already qualify for existing public health programs.

Appendix A: Summary Data of 11 Counties' Medical Indigency Care Program

		1995	1996	1997	1998	1999	2000	2001	2002
Ada	Budget	$5,454,350.00	$5,803,995.00	$5,859,672.00	$5,781,615.00	$5,847,415.00	$ 6,248,802.00	$5,786,672.00	$ 6,585,123.00
	Spent	$4,268,770.00	$5,028,338.29	$5,045,054.99	$3,783,305.27	$5,021,438.24	$ 4,563,863.26	$5,299,121.71	$ 5,661,834.89
	Recovered	NA	NA	$320,212.91	$298,530.41	$438,395.46	$ 337,313.45	$ 510,492.72	$ 468,231.26
Canyon	Budget	$1,352,000.00	$135,2000.00	$1,352,000.00	$1,352,000.00	$1,352,000.00	$ 2,424,425.00	$2,434,754.00	$ 2,338,530.00
	Spent	$1,279,431.88	$1,211,543.82	$1,061,983.55	$638,695.22	$799,901.79	$ 1,559,382.63	$1,948,339.80	$ 2,294,637.00
	Recovered	$142,252.00	$270,280.00	$171,175.00	$241,318.00	$164,548.00	$ 151,425.75	$ 150,141.82	$ 196,989.68
Cassia	Budget	$383,067.99	$342,000.00	$360,000.00	$410,000.00	$282,509.33	$ 342,000.00	$ 360,000.00	$ 410,000.00
	Spent	$354,993.81	$355,759.17	$310,344.17	$283,917.62	$254,590.58	$ 338,810.57	$ 359,476.35	$ 399,439.07
	Recovered	$112,061.91	$55,094.89	$68,213.15	$68,213.15	$60,348.47	$ 60,041.71	$ 60,041.71	$ 60,041.71
Gooding	Budget	$315,410.02	$320,932.05	$338,520.20	$319,009.88	$342,846.75	$ 353,694.00	$ 363,702.00	$ 383,498.00
	Spent	$330,976.40	$320,930.62	$263,027.63	$236,282.58	$224,950.77	$ 254,275.00	$ 275,164.00	$ 354,216.00
	Recovered	$77,216.05	$63,046.50	$67,692.91	$60,479.80	$102,220.38	$ 62,336.00	$ 45,267.00	$ 185,379.00
Idaho	Budget	$397,508.00	$383,798.00	$428,095.00	$354,730.00	$357,917.00	$ 383,321.00	$ 386,385.00	$ 392,270.00
	Spent	$252,786.50	$166,636.72	$182,941.41	$150,166.49	$284,052.28	$ 258,368.77	$ 281,879.17	$ 336,609.31
	Recovered	$43,868.23	$15,117.09	$28,433.21	$44,113.43	$92,824.96	$ 24,339.96	$ 71,252.72	$ 89,341.93
Jerome	Budget	$410,000.00	$420,000.00	$370,000.00	$375,000.00	$330,000.00	$ 420,066.00	$ 461,814.00	$ 458,266.00
	Spent	$389,113.80	$334,018.24	$323,516.57	$252,339.31	$164,675.48	$ 313,415.47	$ 315,177.04	$ 428,218.19
	Recovered	$63,697.55	$72,133.05	$129,255.82	$73,159.39	$51,351.16	$ 57,294.32	$ 63,263.73	$ 62,308.34
Lewis	Budget	$89,239.00	$123,364.00	$124,439.00	$121,562.00	$122,959.00	NA	NA	NA
	Spent	$59,747.15	$89,987.82	$103,308.60	$102,553.41	$98,534.70	$ 102,477.19	$ 99,903.11	$ 102,458.11
	Recovered	$584.44	$9,106.21	$6,966.82	$9,864.46	$5,115.86	$ 49,464.62	$ 24,251.17	$ 6,968.78
Minidoka	Budget	NA	NA	NA	NA	NA	$ 420,220.00	$ 411,550.00	$ 394,730.00
	Spent	NA	NA	NA	NA	NA	$ 362,024.00	$ 358,083.00	$ 375,841.00
	Recovered	$45,194.62	$52,417.70	$83,794.46	$99,036.71	$132,000.00	$ 103,175.00	$ 174,303.00	$ 120,000.00
Nez Perce	Budget	$670,900.00	$671,620.00	$674,120.00	$507,620.00	$423,220.00	$ 388,720.00	$ 441,720.00	$ 441,720.00
	Spent	$440,660.65	$338,064.34	$455,339.25	$319,577.40	$231,682.47	$ 299,769.00	$ 290,986.00	$ 436,011.00
	Recovered	$41,485.50	$39,708.68	$90,974.46	$88,093.47	$85,842.29	$ 86,057.00	$ 64,972.00	$ 139,410.00
Owyhee	Budget	NA	NA	$239,632.00	$239,635.00	$239,650.00	$ 246,839.00	$ 259,335.00	$ 259,492.00
	Spent	NA	NA	NA	NA	$165,833.53	$ 163,689.22	$ 142,162.74	$ 146,867.34
	Recovered	$36,883.23	$24,241.24	$20,270.01	$36,652.89	$58,280.05	$ 66,114.00	$ 72,908.00	$ 26,976.00
Twin Falls	Budget	NA	NA	NA	NA	NA	NA	NA	NA
	Spent	NA	NA	NA	NA	NA	NA	NA	NA
	Recovered	$ 214,175.42	$ 221,810.14	$ 272,847.15	$ 332,554.02	$ 352,744.19	$ 208,087.71	$ 205,670.00	NA

Appendix B: Medical Indigency Care Program Acceptance Rates for 10 counties

		Applicants	Recipients	Approval Rate
Ada	***2000***	2578	1432	56%
	2001	2413	1337	55%
	2002	2475	1343	54%
Canyon	***2000***	787	395	50%
	2001	1012	553	55%
	2002	1116	688	62%
Cassia	***2000***	108	58	54%
	2001	123	60	49%
	2002	156	79	51%
Gooding	***2000***	91	44	48%
	2001	88	40	45%
	2002	95	46	48%
Idaho	***2000***	55	37	67%
	2001	68	47	69%
	2002	82	56	68%
Jerome	***2000***	167	66	40%
	2001	191	64	34%
	2002	207	80	39%
Lewis	***2000***	28	14	50%
	2001	19	9	47%
	2002	29	20	69%
Minidoka	***2000***	76	57	75%
	2001	95	57	60%
	2002	136	68	50%
Nez Perce	***2000***	166	101	61%
	2001	144	88	61%
	2002	161	100	62%
Owyhee	***2000***	31	12	39%
	2001	31	16	52%
	2002	46	17	37%

About the organizations releasing this report:

The **Idaho Community Action Network** (ICAN) is a statewide nonprofit that works with low-income families and in communities of color around social and economic justice issues. ICAN also runs a statewide food program that allows low-income families to stretch their monthly food budgets.

The **Northwest Federation of Community Organizations** (NWFCO) is a regional federation of five statewide, community-based social and economic justice organizations located in the states of Idaho, Montana, Oregon, and Washington: Idaho Community Action Network (ICAN), Montana People's Action (MPA), Oregon Action (OA), and Washington Citizen Action (WCA). Collectively, these organizations engage in community organizing and coalition building in fourteen rural and major metropolitan areas, including the Northwest's largest cities (Seattle and Portland) and the largest cities in Montana and Idaho.

The Access Project is a program of the Center for Community Health Research and Action of the Heller School for Social Policy and Management at Brandeis University. It has served as a resource center for local communities working to improve health and healthcare access since 1998. The mission of The Access Project is to strengthen community action, promote social change, and improve health, especially for those who are most vulnerable.

Community Catalyst is a national advocacy organization that builds consumer and community participation in the shaping of our health care system to ensure quality affordable health care for all. Community Catalyst helps state and local consumer health groups develop the legal, policy, and organizational tools needed to cope with changes in health care.

To prepare this report, NWFCO and ICAN gathered data from the counties and stories from uninsured individuals who have had difficulty accessing health care in Idaho. The Access Project and Community Catalyst provided funding and technical support for this report. Based on this research, ICAN developed the recommendations that follow in this report.

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