

CONSUMER MEDICAL DEBT SURVEY

Thank you for taking the time to complete this survey. This survey is an attempt to gather information on the problem of medical debt as it affects people in the MetroWest and Worcester areas. Health Law Advocates, Inc. and Health Care For All are non-profit advocacy organizations working to help residents overcome barriers to health care. If you have any questions or want more information, please visit www.healthlawadvocates.org or www.hcfama.org or call us at (617) 338-5241 or our Helpline at 1-800-272-4232. HLA/HCFA are located at 30 Winter Street, Suite 1004, Boston, MA 02108. Your answers will be kept completely confidential.

A. ABOUT YOU AND YOUR HOUSEHOLD

1. What is your gender?
 Male
 Female
2. What is your age? _____
3. Which definition best describes your ethnicity?
 White/Caucasian Portuguese Hispanic
 Black/African American Asian/Pacific Islander Other: _____
4. What language(s) do you read, speak, and understand? (*check all that apply*)
 Portuguese Spanish
 English Other. Please identify: _____
5. What is your total family income (before taxes)? _____
6. How many people (including you) live in your household? _____
7. What is your current employment status? (*check all that apply*)
 Full time Part time (how many jobs? _____)
 Self-employed Student Temporary worker ("temp")
 Seasonal worker Unemployed Other. Please describe: _____
8. What is your zip code? _____

B. MEDICAL DEBT

9. Do you or a household member currently owe any money to any of the following hospitals ("the hospital")? (*circle all that apply*)
 - a. St. Vincent's Hospital/Worcester Medical Center
 - b. MetroWest Medical Center's Framingham Union Hospital
 - c. MetroWest Medical Center's Outpatient Wellness Center in Framingham
 - d. MetroWest Medical Center's Leonard Morse Hospital in Natick
 - e. No, I do not owe money to one of the hospitals listed above but I DO have medical debt from: _____
 - f. No, I do not owe money to any of these hospitals and I DO NOT have medical debt

If YES, you DO owe money at one of these hospitals, please complete the entire survey.
If NO, you DO NOT owe money at one of these hospitals, STOP here. You do not need to complete the rest of the survey. Thank you.

C. HEALTH INSURANCE

10. Did you or a household member not go to the hospital because you were scared of the cost?
- Yes
 - No
11. If Yes, what treatment did you not receive? _____
12. Did you have health insurance when you received treatment that resulted in hospital bills you could not pay?
- Yes **If YES, please complete questions 13-15**
 - No **If NO, go to questions 16-17**

YES, I HAD health insurance when I was treated at the hospital:

13. What kind of health insurance did you have?
- Employer/union
 - COBRA (employer's plan but no longer employed there)
 - Spouse, partner or family member
 - School/university
 - Medicare
 - MassHealth
 - Commonwealth Care (**please check one:** Fallon Community Health Plan, BMC HealthNet Plan, Neighborhood Health Plan, Network Health)
 - CommChoice
 - On my own through an individual plan
 - Medical Security Plan (unemployed)
 - Health Safety Net/Uncompensated Care Pool/Free Care
 - Other:_____
14. Did you have any gaps in your insurance coverage that resulted in hospital bills?
- Yes (Please explain: _____)
 - No
15. How much did you have to pay out-of-pocket before your health insurance covered your medical bills (the amount of your deductible)?
- | | | |
|------------------------------|----------------|------------------|
| a. I don't have a deductible | b. \$0-\$1,999 | c. \$2,000-4,999 |
| d. \$5,000 or more | e. Other:_____ | f. I don't know |

Please go to question #18

NO, I DID NOT HAVE health insurance when I was treated at the hospital:

16. Why didn't you have health insurance? (*circle all that apply*)
- I didn't think I needed it
 - I could not afford to pay for health insurance
 - My employer did not offer me insurance
 - I am offered insurance through my employer but could not afford it
 - I am offered insurance through my employer but did not take it
 - I am self-employed and could not afford to purchase my own plan
 - I didn't submit the paperwork necessary for MassHealth or other insurance program

**Questions? Want more info? Go to www.healthlawadvocates.org and www.hcfama.org
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- h. My insurance coverage was terminated or cancelled and I didn't know it
- i. Other. Please describe: _____

17. Did the hospital ask you to pay money before giving you medical care?
- a. Yes
 - b. No

For the following questions in the survey, we are asking information about the hospital(s) you circled in Question #9 in Section B "MEDICAL DEBT".

D. ABOUT YOUR MEDICAL BILLS

18. How much money do you owe to the hospital(s) for unpaid medical bills?
- a. Less than \$500
 - b. \$500-\$1,000
 - c. \$1,001-\$5,000
 - d. \$5,001-\$10,000
 - e. \$10,001-\$50,000
 - f. \$50,001 or more
 - g. Other: _____
19. Have you ever been denied care at a hospital because you owed money for medical bills?
- a. Yes
 - b. No

E. HOSPITAL ASSISTANCE INFORMATION

20. How did you know that the hospital can help you with your medical bills?
- a. I did not know that the hospital can help
 - b. I saw a public notice or sign in hospital
 - c. I spoke to health care provider at the hospital
 - d. I spoke to financial services at the hospital
 - e. I got information or notice on a medical bill
 - f. I got notices from a collection agency
 - g. I contacted non-hospital advocacy organization
 - h. Other. Please describe: _____
21. When did you learn that the hospital offered financial assistance?
- a. Before I received medical care
 - b. During medical care
 - c. After I received medical care
 - d. After I got a hospital bill
 - e. After the hospital bill went to collections
 - f. I did not learn that the hospital offered financial assistance
 - g. Other: _____
22. What kind(s) of financial assistance did the hospital offer you? (*circle all that apply*)
- a. Debt forgiveness
 - b. Payment plan
 - c. Prompt pay discount or percentage-off charges
 - d. Gave me an application for MassHealth
 - e. Gave me an application for the Health Safety Net/Free Care Pool/Uncompensated Care Pool
 - f. Gave me an application for hospital charity care
 - g. Opportunity to speak with a hospital-based financial counselor

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- h. The hospital did not offer me any assistance
 - i. I did not seek help from the hospital [Why not?: _____]
 - j. Other. Please describe: _____
23. If the hospital gave you any application, did they help you fill it out?
- a. Yes
 - b. No
24. If you spoke with a hospital financial counselor, what did you learn? _____
In what language did they speak to you? _____
25. After getting help, what financial assistance did you get approved for? (*circle all that apply*)
- a. I was enrolled in MassHealth
 - b. I was enrolled in the Health Safety Net/Free Care Pool/ Uncompensated Care Pool
 - c. I was given hospital charity care
 - d. The hospital forgave my debt
 - e. I was put on a payment plan
 - f. Other: _____
26. Were hospital notices of financial assistance provided in a language you understand?
- a. Yes [If Yes, what language? (*check all that apply*): English Spanish Portuguese]
 - b. No

F. HOSPITAL PAYMENT PLANS

27. If you have a hospital payment plan, how did you get it?
- a. The hospital offered it to me without me asking
 - b. I asked the hospital to make a payment plan for me
 - c. I do not have a hospital payment plan (**please skip to question #35**)
28. If the hospital offered you a payment plan, when did they offer it?
- a. Before they billed me
 - b. After they billed me
 - c. When I called about my bill
 - d. Before my bill went to collection
 - e. After my bill went to collection
 - f. The hospital did not offer me a payment plan
 - g. Other: _____
29. What was the total amount of money you originally owed on the payment plan? _____
30. If the hospital offered you a payment plan, what was the minimum monthly payment?
- a. Under \$25 per month
 - b. \$25 per month
 - c. \$26-\$100 per month
 - d. \$101-\$250 per month
 - e. Over \$250 per month
 - f. Other. Please describe: _____

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31. How long is/was your payment plan?
- Twelve month payment plan
 - Twenty four month payment plan
 - Other. Please describe: _____
32. Did the hospital charge interest on your payment plan?
- Yes [If Yes, how much?: 0% 1-3% 3.1-5% 5.1-10% More than 10%]
 - No
 - I don't know
33. If you could not keep up with your payment plan, what happened?
- Late fees were charged
 - Interest accumulated
 - I was asked to make a larger payment
 - Account written off as bad debt
 - Account sent to hospital collection
 - Account sent to other collection agency
 - I have made all the payments on my plan
 - Other. Please describe: _____
34. How much money do you owe now under the payment plan? _____

G. COLLECTION EFFORTS

35. Have you ever been contacted by a collection agency for unpaid hospital bills?
- Yes
 - No (**If No, please go to section G**)
36. If Yes, was the collection agency part of the hospital or an outside collection agency?
- Part of the hospital (hospital staff)
 - Outside collection agency
 - Both
 - I don't know
37. What payment options did the collection agency offer you?
- A payment plan
 - Payment in full only
 - Reducing the amount owed
 - Other. Please describe: _____
38. If you could not make payments, what did the collection agency do? (*circle all that apply*)
- Lien placed on car
 - Lien place on home
 - Wages withheld (paycheck garnished)
 - Reported my bills to a consumer credit bureau agency
 - I was harassed or pressured to make payment
 - Other. Please describe: _____

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H. BASIC INFORMATION

Thank you again for taking time to fill out this survey. This section is **OPTIONAL**. If you choose to provide us with your personal contact information, it will be kept completely confidential. Health Law Advocates and Health Care For All will only contact you if you give us your permission to do so. Your contact information will help us learn how many consumers live in certain cities and towns. You will help us more effectively advocate for appropriate services and programs in these areas.

First Name: _____

Last Name: _____

Street/Mailing Address: _____ Apt/Suite/Office: _____

City: _____ State: _____ Zip Code: _____

May Health Law Advocates and Health Care For All contact you directly if there is a free program and/or organization you might benefit from?

Yes

No

Phone number: _____

Email Address: _____

(Please print clearly)

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