

Hospital Free Care



Can New Yorkers Access Hospital Services Paid for by Our Tax Dollars?

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Public Policy and Education Fund of New York

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Executive Summary

Some three million New Yorkers, including 18% of all state residents and one-in-four New York City residents, lack health insurance for a full year. And even more New Yorkers, five million, are uninsured for some period during a year. When New Yorkers who lack health insurance receive hospital care they will be billed by the hospital, which according to New York law must seek to collect the funds. Moreover, they will be billed at a rate almost invariably higher than a patient covered by Medicare, Medicaid, or private insurance. Such billing practices contribute to medical debt, the second most frequent cause of personal bankruptcies.

On July 16, 2003, the chairman of the Committee on Energy and Commerce of the US House of Representatives sent letters to 20 hospital systems across the country, including three from New York, seeking information on their billing practices for the uninsured. The Congressional investigation was prompted by a series of stories in the *Wall Street Journal* revealing the huge debts facing individuals and their experiences when hospitals turned them over to collection agencies.

The vast majority of hospitals in New York State are nonprofit and therefore qualify for exemptions from income, property, school, and sales taxes. They also are able to solicit tax-exempt donations. In 2001, the Internal Revenue Service (IRS) issued a memo indicating that all nonprofit hospitals would have to prove that they, in fact, provide care to the indigent.

The issue of access to hospital care for the uninsured and underinsured has been a concern for policy makers, advocates, and hospitals in New York and other states for many years. As a result of consumer pressure, some states have passed laws, such as Massachusetts and New Jersey, establishing statewide eligibility criteria and a payment mechanism for charity care.

No such requirements exist in New York law. However, New York hospitals receive \$847 million dollars a year to compensate them for unpaid medical bills. The funds, which were originally called the Bad Debt and Charity Care Pool and are now known as the Indigent Care and High Need Indigent Care Adjustment Pools, come from taxes placed on patient services. The legislation that governs these funds is known as the Health Care Reform Act or HCRA, which was most recently renewed by the New York State Legislature in the 2003 legislative session.

The Long Island Health Access Monitoring Project (LIHAMP) released two surveys, in 2001 and 2003, which revealed that Long Island hospitals failed to inform patients about the availability of charity care. The reports garnered extensive press coverage and prompted the Nassau and Suffolk County Legislatures to enact local laws in 2003,

requiring hospitals in each county to inform every patient about the existence of charity care. Nassau County also requires hospitals to report annually about the amount of charity care they provided.

This report includes a survey of 70 New York hospitals, representing all regions of New York outside of Long Island, to determine whether the hospitals inform patients about the availability of funds to compensate the hospital for indigent care and have established standards that allow uninsured patients to apply for relief from hospital bills. All 70 hospitals surveyed received funds from the “Indigent Care and High Need Indigent Care Adjustment Pools” in 2003. A total of \$410,522,074 was paid to the 70 hospitals in this survey.

In 2002 and 2003, trained surveyors called 70 New York hospitals, asking for information about charity care policies. The surveyors clearly identified themselves on the phone, and by writing if requested, as staff of the Public Policy and Education Fund, indicating that the Fund was collecting information to provide consumers about hospital charity care policies. Surveyors asked for a copy of any documents related to the charity care policies.

The surveyors reported that the hardest part of conducting the survey was trying to find someone to talk to on the phone that could provide information about the hospital’s charity care policy. Surveyors frequently had to keep asking for the information in many different ways, of several different people, in order to find one or more staff that could give any information. Time and persistence were needed to try to navigate automated voice mail menu selections, stay on-hold for ten minutes or more, leave multiple voice messages, call back several times, and transfer from office to office, trying to find someone who could provide information.

The information that was collected was compiled and each of the hospitals was given a grade based on its ability to provide information and the quality of that information. Specifically, hospitals were given a passing or failing grade on five points:

1. Does the hospital have a free/charity care policy available to the public that includes specific income guidelines for receiving financial assistance?
2. Does the free/charity care policy cover in-patient and outpatient services?
3. Does the hospital hold off billing uninsured, indigent patients until after the hospital processed an application for its free/charity care program?
4. Does the hospital provide patients with at least 90 days after discharge to apply for assistance?
5. Does the hospital supply translators for those patients who do not speak English (a requirement of federal law)?

A final grade, ranging from A to F, for each hospital was calculated based on the total number of passing grades received:

- A – passed all 5 categories;
- B – passed 4 categories;
- C – passed 3 categories

- D – passed 2 categories
- F – passed 1 or 0 categories

Most of the hospitals – 49 out of 70 or 70% - earned a failing grade. The best grade awarded was a C, given to 11 hospitals (16%). Ten hospitals (14%) barely passed, receiving a grade of D.

Summary of Findings for 70 General Hospitals in New York State		
Criterion	Number of Hospitals	Percentage of Hospitals
Received final grade of “A”	0	0%
Received final grade of “B”	0	0%
Received final grade of “C”	11	16%
Received final grade of “D”	10	14%
Received final grade of “F”	49	70%

No. with passing grade for public charity care policy with income guidelines	8	11%
No. with passing grade for translators	28	40%
No. with passing grade for charity care policy that covers in-patient & out-patient care	30	43%
No. with passing grade for holding bills until charity care application processed	8	11%
No. with passing grade for allowing up to 3 months to apply for charity care	3	4%

Only eight of the hospitals (11%) provided the surveyors with a policy for providing charity care that includes income eligibility levels for granting financial relief to patients unable to pay their hospital bills. Only one-third (23) of the hospitals were able or willing to provide any written information about their charity care program. An additional 28 hospitals, when pressed for information, admitted that they did have a program for providing charity care. Five hospitals – all of which get taxpayer funds from New York’s indigent care pools – explicitly denied the availability of a charity care program and 14 hospitals did not provide any information to the surveyors.

Even in those instances in which hospitals do have a written, or verbal, charity care policy, the details of that policy are either not available or create obstacles to accessing charity care. Only eight hospitals (11%) agree to process the patient’s charity-care application before billing the patient. Only three hospitals give the patient a reasonable amount of time, three months after discharge, to apply for charity care. Less than half of the hospitals (43%) state that both inpatient and outpatient services are covered by the

charity care policy. And less than half of the hospitals provide translators at the hospital so that non-English speakers can understand hospital policy, despite a specific requirement in federal law.

In contrast, hospital bills in Massachusetts notify patients how to apply for assistance from the Massachusetts free care pool if they cannot afford to pay for their care. When a patient receives a bill from a Massachusetts hospital, the bill prominently informs the patient of the availability of free care; specific income guidelines are sometimes listed on the bill. Massachusetts hospitals prominently display signs throughout the emergency room and patient care area, informing patients about the availability of uncompensated care.

The difference between hospitals in New York and Massachusetts is not a matter of good will, but of law. Massachusetts law and regulation provides detailed guidelines, including income criteria, for providing free-care to uninsured patients who are unable to afford hospital care. The regulations include clear, detailed requirements for hospitals to notify patients of the availability and means of applying for such care. The regulations require Massachusetts hospitals and community health centers to use a standard application and eligibility criteria, screen patients and assist them to apply for government programs, and provide full and partial free care.

Health advocates in New York State have long urged modifying the structure and eligibility requirements for the hospital bad debt and charity care pool so that uninsured and underinsured individuals could access needed care without fears of accumulating enormous debt or incurring bankruptcy. The New York State Health Care Campaign, a coalition of more than 90 organizations, developed a set of state policy recommendations regarding free care at hospitals and clinics receiving bad debt and charity care funds:

- **Statewide standards** - Create consistent statewide standards requiring all hospitals and clinics (article 28 facilities) to provide free care based on a patient's ability to pay, including income level and insurance status;
- **Specify documentation** - Identify what documentation may be requested to prove eligibility;
- **Notify consumers** - Notify people that free care is available during the admitting process; posting language-appropriate information in emergency rooms, hospitals and clinics; doing outreach to low-income communities, and including information on all hospital and clinic bills;
- **Simple standard application** - Use simple, standard, language-appropriate application process available through hospitals and clinics with specified time frames for processing and responding to each application in writing;
- **Sliding fee scale** - Provide a sliding fee scale for partial free care for those with moderate incomes, the underinsured and those with catastrophic illness;
- **Train staff** - Require hospitals to train staff on explaining, distributing, and implementing hospital free care policy;

- **Process application before billing** - Guarantee that patients will not be billed until after a determination of eligibility under the free care policy has been made;
- **Year long approval** - Specify that approval of free care application is good for a year and portable so that an application approved by one hospital or clinic is accepted by other hospitals and clinics;
- **Appeal process** - Authorize appeals to a third party if a hospital denies an application and provide language-appropriate information on how to file an appeal;
- **Comprehensive services** - Include comprehensive services such as in-patient care, doctor and specialist care, prescriptions, lab tests, emergency care, and radiology;
- **Public disclosure** – Require hospitals and clinics to publish in their annual reports the number of uninsured and underinsured, by zip code, they have served, the number denied charity care, and the number they have transferred to other facilities as well as the reimbursements they have received for indigent care; and
- **Vigorous enforcement** - Establish an ongoing enforcement process through the NYS Department of Health with regular auditing of hospital and clinic records and activities related to hospital free care for the uninsured and underinsured with substantial fines for infractions.¹

New York State spends \$847 million dollars a year through the HCRA Indigent Care and High Need Indigent Care Adjustment Pools but there is no accountability by hospitals on how many uninsured and underinsured individuals they treat as a result of receiving funds from the pools. Although hospitals report charity care separately from bad debt, there is no real basis for determining whether they provide care to the neediest patients. New York State needs to follow the path of other states that set clear statewide eligibility standards and application process so the uninsured know how to get health care when they need it without fearing that they will be saddled with huge medical debts.

¹ New York State Health Care Campaign. 2002. "Hospital Free Care." Albany, NY: New York State Health Care Campaign.

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Introduction

- *Growing number of uninsured*
- *Cost shift to insured individuals means more people are underinsured*
- *Medical debt - a leading cause of personal bankruptcy*
- *Recent reports debunk myth of access to needed health care*

A combination of factors – a large percentage of New Yorkers who experience being uninsured at some point during the year PLUS the fear of deteriorating physical and financial health - means that it is extremely important for New Yorkers to know whether they can access affordable health care when they need it.

"My brother lives in New York City; in May... he was in the hospital, and he was uninsured like so many people in New York. He was working 2 part-time jobs; neither job offered any health insurance. His [hospital] bill is for over \$12,000.00. He was told he did not qualify for Medicaid. He wrote the hospital a letter stating he could not afford to pay. The hospital turned his bill over to a collection agency." L.O.

While the lack of health coverage has been a significant problem for a substantial proportion of New Yorkers for decades, the World Trade Center disaster and the lack-luster economy of the last three years have meant that many more New Yorkers do not have health insurance because they lost the jobs that provided coverage. The Robert Wood Johnson Foundation recently released a report prepared by Families USA indicating that nearly 75 million Americans, almost one-third of the population, under the age of 65 were uninsured for all or part of 2001-2002.² Almost 5 million New Yorkers under age 65 were uninsured for all or part of that same period; most (75%) of the uninsured were between the ages of 18 and 65.³ These figures indicate that being uninsured is a problem for almost one out of three of New Yorkers during some portion of a year. The most recent United Hospital Fund report indicates that statewide 18% of New York State residents were uninsured for the entire year in 2001, but 26% of New

² Families USA. 2003. *Going without Health Insurance: Nearly One in Three Non-Elderly Americans*. Washington, DC: Families USA.

³ Ibid. pp. 28-29.

York City residents were uninsured.⁴ The reports by Families USA and the United Hospital Fund indicate that the number of uninsured New Yorkers is above the national average.

The Institute of Medicine (IOM) of The National Academies published four studies between 2001 and early 2003 looking at the uninsured in the United States. The IOM concluded that “Lack of access to health care results in adverse economic, social, and health consequences for uninsured persons and their family members.”⁵ A recent report by The Access Project indicates that medical debt can result in difficulty accessing health care, bad credit ratings, and bankruptcy.⁶ In fact, medical debt is involved in about half of all bankruptcies. “The most recent study [by Melissa Jacoby and colleagues] indicates that nearly half of all bankruptcies in 1999 involved a medical problem, and certain groups—particularly women heads of households and the elderly—were even more likely to report health-related bankruptcy.”⁷

Anecdotal reports illustrate that even those who are insured have been forced to shoulder a larger proportion of the costs for health care or have found that their benefits do not cover the costs of the services they need. In some instances, the co-pays and deductibles have been increased significantly. Others find that their employer requires them to pay a larger portion of the premium. Local news stories periodically highlight the plight of individuals with a serious disease who need expensive treatments that cost more than their insurance will cover. The Access Project reported that medical debt affects even those who have insurance.⁸

Many consumers and elected officials have held firmly to a belief that Americans without health insurance can get health care services when they really need them. A 2002 report by the prestigious Institute of Medicine (IOM) examined research on this topic and concluded that people without health insurance do NOT get care when they need it to prevent illness, prevent complications and progression of a disease, or to treat chronic illness. The IOM Committee concluded that those without insurance are in poorer health and are more likely to die prematurely.⁹

“My brother earns \$6.25 an hour. He is a 44 year-old man [whose] take-home pay is about \$9,940 a year or about \$200.00 a week ... He works ... full time and can hardly make the necessities in life. He is not eligible for anything, not even this [Family Health Plus] health plan. It's just not fair. Why does he need to quit his job so he can get an operation for a hernia? TP

⁴ United Hospital Fund. 2003. *Health Insurance Coverage in New York 2001*. New York: United Hospital Fund. pp. 9

⁵ Institute of Medicine. 2003. *A Shared Destiny: Community Effects of Uninsurance*. Washington, DC: National Academy Press. p.2.

⁶ The Access Project. 2003. *The Consequences of Medical Debt*. Boston, MA: The Access Project.

⁷ Ibid. p. 7. (referring to Melissa B. Jacoby, Teresa A. Sullivan & Elizabeth Warren, “Rethinking the Debates Over Health Care Financing: Evidence from the Bankruptcy Courts.” *NYU Law Review* 76:2 (May 2001)

⁸ Ibid.

- *Growing media interest in higher hospital charges to uninsured*
- *US House of Representatives Investigation*

In the spring of 2003, there was a flurry of reports and news stories pointing out hospital billing practices that affect the uninsured. A *Wall Street Journal* reporter did a series of stories explaining how uninsured individuals who needed care in a hospital were asked to pay charges that are far higher than the fees paid by Medicare, Medicaid or private insurers for the same services.¹⁰ The stories highlighted the huge debts facing individuals and their experiences when hospitals turned them over to collection agencies.

"The hospital where Ms. Nix was treated, New York Methodist in Brooklyn, typically bills HMOs about \$2,500 for an appendectomy with a two-day stay, compared with the \$14,000 – plus doctor's fees – that Ms. Nix was billed. The hospital gets paid about \$5,000 from Medicaid, the state and federal program for the poor, and about \$7,800 from Medicare, the federal program for the elderly, for the same procedure."
Lagnado, Lucette. "One Critical Appendectomy Later, Young Woman Has a \$19,000 Debt." Wall Street Journal. March 17, 2003

A June 2003 report from The Commonwealth Fund sheds some light on how uninsured individuals can end up paying far more for the same care than Medicare, Medicaid, and private insurance companies. Federal laws were enacted to prevent fraud and abuse, overbilling, unnecessary care, kickbacks and other undesirable activities. In many cases, hospitals have standardized their approaches to comply with the multitude of laws. Since the individual laws do not address the uninsured, there can be "unintended consequences" for the uninsured. The interpretation of one Medicare requirement can illustrate the unintended detrimental effect for an uninsured patient. Medicare requires that it be charged the hospital's "usual" fee for any service. Some providers have interpreted this rule to mean that they cannot negotiate a lower fee for an uninsured patient. Therefore the uninsured patient is charged the full "usual" fee, while Medicare pays according to its set fee schedule that is often lower than the "usual" fee.¹¹ So the uninsured person ends up paying more than Medicare and other insurers.

On July 16, 2003, the chairman of the Committee on Energy and Commerce of the US House of Representatives sent letters to 20 hospital systems across the country, including three from New York, seeking information on their billing practices for the uninsured.¹² The formal investigation led by Congressmen Billy Tauzin (R-La.) and

⁹ Institute of Medicine. 2002. *Care Without Coverage – Too Little, Too Late*. Washington, DC: National Academy Press. pp 3-5.

¹⁰ Lagnado, Lucette. 2003. *Wall Street Journal*. March 13, March 17, April 1, and July 7, 2003.

¹¹ Pryor, Carol; Seifert, Robert; Gurewich, Deborah; Oblak, Leslie; Rosman, Brian; and Prottas, Jeffrey. 2003. *Unintended Consequences: How Federal Regulations and Hospital Policies Can Leave Patients in Debt*. New York: The Commonwealth Fund.

¹² Tauzin, W.J. "Billy". 2003. http://energycommerce.house.gov/108/News/07162003_1040.htm

James Greenwood (R-Pa.) will be focusing on problems in the industry, not just the particular hospital systems that received the letters.

Selected federal laws relevant to hospital care of the uninsured

American society has long viewed hospitals as community resources. Society expresses its value for hospitals through funding and tax law. One example of federal funding for hospitals is the 1946 Hill-Burton Act. The enactment of Medicare and Medicaid in 1965, providing health insurance coverage for the elderly and the poor, vastly increased the flow of federal money to hospitals. Although the federal government sets standards for hospitals to participate in the Medicare and Medicaid programs, there are no requirements to provide free or reduced-cost care. But in 1986, the Medicare standards were amended to specify how people who come to emergency rooms must be treated.

The federal and state tax codes have allowed many hospitals to be exempt from income and other taxes. While there are no specific requirements for hospitals to provide free or reduced-cost care in return for getting a tax exemption, the Internal Revenue Service has issued a list of questions to be answered in seeking evidence that a hospital provides care to the indigent.

Hill-Burton Act

In 1946, the federal government enacted the Hospital Survey and Construction Act, sponsored by Senators Lister Hill and Harold Burton. The initial program was directed at funding the modernization of hospital facilities after the Second World War ended. There have been several amendments over the years to this program that is widely known as the Hill-Burton Act. Some of the amendments include specific requirements for uncompensated care. The Hill-Burton requirements for providing free or reduced-cost care are limited to a specific number of years and an annual dollar cap for each hospital. Twenty hospitals, plus more than 30 nursing homes and other health facilities, in New York State have obligations under Hill-Burton as of June 27, 2003.¹³

EMTALA

Because of widespread complaints and media attention to critically ill uninsured individuals who were rejected at the hospital closest to where they took ill, the federal government set up standards for how people who come to the emergency room must be treated regardless of their insurance status.

The federal Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 applies to all hospitals that participate in Medicare AND have emergency rooms. This

¹³US Department of Health and Human Services. 2003. *The Hill-Burton Free Care Program*. <http://www.hrsa.gov/osp/dfcr/about/aboutdiv.htm>

“anti-dumping” law was enacted to assure that uninsured patients who were injured, critically ill or ready to give birth were not sent (“dumped”) to another hospital before evaluating the seriousness of their medical condition.

“I am a 25 year old single mother of one child...I am a day care teacher...Right now I am suffering from a severe ear infection that I can not be treated for because I have no insurance. I may just have to make another trip to the ER and be billed again. I have accumulated over the past years many hospital bills that I cannot afford to pay but I do need medical attention sometimes. The bills are adding up and going against my credit.” ST

The requirements under EMTALA are very limited: hospitals must screen anyone seeking emergency care; they must stabilize the patient’s condition, if necessary; and they may not delay treatment to inquire about insurance status or payment. The current regulations apply to services provided on all hospital property and by all hospital departments. The law requires screening and treatment if an emergency medical condition is found or appropriate transfer to another medical facility; there is NO requirement to provide free or reduced cost treatment.

Penalties for violating EMTALA can include fines up to \$50,000 and/or expulsion from the Medicare program. Individual patients can also sue hospitals if they suffer harm because the hospital broke the law.

In early September 2003, the Bush Administration announced new EMTALA rules that will take effect in November. Hospitals’ responsibilities under EMTALA will be more limited. The federal requirements will apply only to emergency rooms and those “off-campus” hospital locations that provide emergency services. Hospitals will have more flexibility in arranging for “on-call” physicians, especially specialists, to provide emergency screening and treatment. The Administration says that the changes will not weaken patient protections and indicates that the changes were done in response to complaints from hospitals and physicians. Some advocates have voiced concern that patients, especially those who are uninsured, will have more difficulty accessing services and some emergency room physicians have indicated that it may be more difficult to get specialists to be available on-call to treat emergencies.

Internal Revenue Service tax-exemption

The vast majority of hospitals in New York State are nonprofit and therefore qualify for exemptions from income, property, school, and sales taxes. In 2001, the Internal Revenue Service (IRS) issued a field memo to its agents indicating they should look at nonprofit hospitals to determine if they, in fact, provide care to the indigent. This new advisory broadened a 1969 ruling requiring all tax-exempt health care organizations to provide community benefits. The new advisory looks beyond the 1969 concerns with hospital policies, treatment in the emergency room, and accepting Medicare and

Medicaid patients. The 2001 memo includes 14 questions for IRS field service staff to use in looking at the activities of a nonprofit hospital:

1. Does the Hospital have a specific, written plan or policy to provide free or low-cost health care services to the poor or indigent?
2. Under what circumstances may, or has, the hospital deviated from its stated policies on providing free or low-cost health care services to the poor or indigent?
3. Does the hospital broadcast the terms and conditions of its charity care policy to the public?
4. Does the hospital maintain and operate a full-time emergency room open to all persons regardless of their ability to pay?
5. What directives or instructions does the hospital provide to ambulance services about bringing poor or indigent patients to its emergency room?
6. What inpatient, outpatient, and diagnostic services does the hospital actually provide to the poor or indigent for free or for reduced charges?
7. Under what circumstances does the hospital deny health care services to the poor or indigent?
8. Does the hospital operate with the expectation of receiving full payment from all persons to whom it renders services?
9. How and when does the hospital ascertain whether a patient will be able to pay for the hospital's services?
10. What documents or agreements does the hospital require poor or indigent patients to sign before receiving care?
11. What is the hospital's policy on admitting poor or indigent patients as inpatients and outpatients?
12. Under what circumstances does the hospital refer poor or indigent individuals who require services to other hospitals in the area that do admit poor or indigent patients?
13. Does the hospital maintain separate and detailed records about the number of times, and circumstances under which, it actually provided free or reduced-cost care to the poor or indigent?

"My husband is a self-employed tax payer... One hospital stay came to well over \$12,000. I tried negotiating with the hospital to lower the bill but unless we paid it in full we were not getting a break. We received bills from doctors, labs, hospital, prescription, nurses, I can go on and on. We paid what we could...[then] I received a most embarrassing and harassing phone call from a bill collector. She threatened to ruin our credit, take us to court if we didn't pay this bill in full... I told her, it really doesn't matter much, you want something we just don't have... 'We are only human, does the word bankruptcy sound good to you because at this point it will be our next step.' To this day we are still paying those bills and new ones. HRB

14. Does the hospital maintain a separate account on its books that segregates the costs of providing free or reduced-cost care to the poor or indigent? Does this account include any other items, such as write-offs for care to patients who were not poor or indigent?¹⁴

State and local activities related to hospital care of the uninsured

The issue of access to hospital care for the uninsured and underinsured has been a concern for policy makers, advocates, and hospitals for many years. As a result of consumer pressure, some states have passed laws, such as Massachusetts and New Jersey, establishing statewide eligibility criteria and a payment mechanism for charity care. Other states, like Washington and Maine, require hospitals to make information about free care available to the public and provide other information to the state department that oversees hospitals. In Oregon, consumer concern has succeeded in getting voluntary statewide guidelines.

Recently, advocates who have not been able to get statewide policy change have been successful in gaining the support of local policy makers. This new type of initiative requires all hospitals within a city or county to report certain data about the provision of charity care. The first example of this type of local initiative is in California and the second is in New York; neither state has any statewide requirements for charity care.

Maine

Maine's regulations require hospitals to post information about the availability of free care and file a copy of its free care policy with the state Department of Human Services (DHS). Annual reports by each hospital to the DHS must include the amount of free care provided.

Massachusetts

The Massachusetts Uncompensated Care Pool (Pool) is a statewide program with standard eligibility requirements and application forms. The state Division of Health Care Finance and Policy (DHCFP) administers the program originally established in law in 1985. Uninsured and underinsured patients can qualify for full or partial payment from the Pool for inpatient and outpatient services provided by hospitals and community health centers. Applications are screened for eligibility at any hospital or community health center. Information about the program, including eligibility criteria and applications are available on the DHCFP website.¹⁵ There is a toll-free number where individuals can call to get additional information. Annual reports about statewide use of the program are available online.

¹⁴ Internal Revenue Service National Office field Service Advice. 2001. *Exempt Hospitals' Compliance with Treas. Reg. Section 1.501(c)(3)-1(c)*. Washington, DC: Internal Revenue Service. CITE: 2001 TNT 48-45.

¹⁵ http://www.state.ma.us/dhcfp/pages/dhcfp_22.htm July 17, 2003.

The Massachusetts law and regulations are the most thorough in establishing clear, statewide eligibility guidelines for the uninsured and underinsured who are eligible for charity care. Massachusetts also provides a standard application form and requires hospitals and clinics to provide notice to all patients about the availability of financial help. The state provides payment to hospitals and clinics that provide care under the charity care program. See Appendices A and B for examples of billing forms from Massachusetts hospitals providing information to patients about the availability of free care.

New Jersey

In 1997, New Jersey passed a law establishing the Hospital Care Payment Assistance Program. Eligibility requirements, free and reduced fee scale, funding, signage, and application deadlines are established by the state. Information is available online¹⁶ and a toll-free number is available to individuals seeking assistance or answers to questions. Every patient must receive a written notice about the availability of hospital free care payment for inpatient and outpatient services.

Oregon

In 2001, at the urging of consumers, the Oregon Association of Hospitals and Health Systems (OAHHS) issued hospital free care guidelines and urged its member hospitals to adopt and implement the guidelines. The *Financial Assistance Guidelines* booklet from OAHHS included information recommending that member hospitals adopt policies and procedures similar to those in the *Guidelines*. This voluntary system includes recommendations on signage, application, eligibility, staff training, and communication to the public.¹⁷

Rhode Island

The Hospital Conversions Act requires all hospitals to meet a statewide standard for charitable care and to report annually to the state Department of Health (DOH) regarding the amount of free care provided. The reports are submitted to the General Assembly and posted on the DOH website.¹⁸

Washington

In 1989, the state of Washington enacted legislation defining charity care to include both inpatient and outpatient hospital care. The law prohibits any hospital from refusing to treat someone with an emergency due to inability to pay. Each hospital must have a charity care policy and report annually the amount of free care it provided. The state Department of Health (DOH) must compile this information and report annually to the

¹⁶ <http://www.state.nj.us/health/hcsa/ccfactsh.htm> July 17, 2003.

¹⁷ Rutledge, Ken. 2001. Letter to Members. Lake Oswego, Oregon: Oregon Association of Hospital and Health Systems.

¹⁸ <http://www.health.ri.gov/chic/performance/communitybenefits.htm> July 17, 2003.

governor and legislature.¹⁹ Information about the program and the five most recent annual reports are posted on the state's DOH website.

San Francisco

In 2001, the City of San Francisco passed an ordinance requiring all hospitals in the city to notify patients about the availability of free care, submit annual reports about the amount of charity care they provided, and provide a copy of their free care policy to the city Department of Public Health (DPH).²⁰ The DPH prepares a report that is submitted to the San Francisco Health Commission and is posted on the DPH website.

Nassau County, NY

In February 2003, the Nassau County Legislature passed a new law requiring hospitals to report annually to the Nassau County Department of Health (DOH) the amount of free care they provide. The hospitals must also submit a copy of their free care policy and notify patients about the availability of free care.²¹

New York activities related to hospital care of the uninsured

Coverage Programs

New York has a long history of providing a variety of public and private sector initiatives to increase health insurance coverage for New Yorkers. New York's long history in funding "public goods" as part of state legislation for hospitals and other providers has provided opportunities to create or expand new programs to cover inpatient and outpatient services. In the 1990's, three new programs were created and one of the three was expanded. The first new program was the 1991 Child Health Plus (CHP) for young children. This public insurance program proved to be so popular that it was expanded several times. It now includes a wide range of services and is available to all children through age 18 whose family income is at or below 250% of the federal poverty level. Initially this program was solely a New York State program, but its popularity helped create the momentum in 1996 for the creation of a similar federal program, State Child Health Insurance Program (SCHIP), that now helps fund New York's CHP program. As of mid-2003, Child Health Plus enrollment was 400,000.

A public health insurance program for adults between the ages of 19 and 64, Family Health Plus (FHP), was signed into law at the end of 1999. In many ways it is similar to CHP except that the income eligibility levels are far lower. Even though the start-up of the program was problematic, enrollment has soared in the last year. Family Health Plus enrollment, as of the summer of 2003, was 270,000.

¹⁹ <http://www.doh.wa.gov/EHSPHL/hospdata/CharityCare/> July 17, 2003.

²⁰ <http://www.dph.sf.ca.us/Reports/CharityCare/CharCareReport090302.pdf> July 17, 2003.

²¹ <http://www.lihamp.org/> July 17, 2003.

Healthy NY is a state sponsored private sector program offered through HMOs and other approved insurers created at the same time as Family Health Plus. All HMOs in New York State must offer eligible businesses a benefit package with a required set of inpatient and outpatient services that is more restrictive than current state law requirements for benefit packages. In addition, the consumer must pay higher co-payments and deductibles. The state helps to subsidize the cost of the insurance by assuming almost all of the payment for selected high cost claims. Healthy NY aims to increase access to health insurance for employees of small businesses with 50 or less employees and low-income sole proprietors. Healthy New York insured 29,000 New Yorkers as of the summer of 2003.

STATEWIDE FUNDING FOR HOSPITAL CHARITY CARE

Until the mid 1990's, New York State had a long history of setting hospital payment rates for all hospitals. A central part of the payment system recognized "public goods" like charity care, graduate medical education, and health insurance initiatives. Developing the formula and funding mechanisms for one of the public goods, the Bad Debt and Charity Care Pool (BDCC), was an important part of the triennial legislative process to renew the New York Prospective Hospital Reimbursement Methodology (NYPHRM) legislation that set reimbursement rates for all payers.

The BDCC Pool was established to provide financial assistance to hospitals saddled with the costs of charity care provided to the uninsured and bad debt incurred because full payment was not received from insured patients. The law was designed to help the fiscal health of hospitals, NOT to help uninsured individuals. Hospitals received reimbursement based on a complex funding formula that looked at the dollar amount of bad debt and charity care they provided compared to other hospitals. Regular reports about hospital expenditures had to be sent to the New York State Department of Health to qualify for the funding. However, the reports did NOT indicate the number of uninsured or underinsured people who received care.

In 1996, New York State decided to deregulate hospital ratesetting, but retained the concept of funding public goods. The new legislation was called the Health Care Reform Act (HCRA) of 1996 and it transformed the BDCC Pool into "Indigent Care" (IC) Pools²², although most advocates and policy makers still refer to it as BDCC. The pool of funding "for indigent care subsidies, ... is largely supported by assessments on patient service revenues and payor surcharges on payments made for hospital and certain freestanding clinic services..."²³ Hospital reporting requirements to the state Department of Health and complex funding formulas for public goods remained prominent features of the new deregulated ratesetting system. The HCRA legislation was renewed in 1999 and in 2003. Some freestanding clinics, such as community health centers, are also eligible for some funding for indigent care under the HCRA rules.

²² NYS Public Health Law § 2807-k and § 2807-w.

²³ Van Guysling, Mark. June 17, 2003. Letter to Payors and Providers Re: Health Care Reform Act of 2000. Albany, NY: New York State Department of Health.

In 1998, two government programs, Medicare and Medicaid, paid more than 56% of gross patient revenues for all 179 hospitals in New York State.²⁴ In addition to these government program payments for care provided to covered individuals, hospitals can apply for HCRA funds for indigent care. The HCRA allocation for indigent care totaled \$847 million dollars per year from 2000 to 2003: \$765 million dollars annually from the Indigent Care Pool²⁵ plus \$82 million from the HCRA High Need Indigent Care Adjustment Pool²⁶. Despite these large amounts of Medicare, Medicaid, and HCRA funds, there are no “established standards to assure that pool funds are used equitably (such as income eligibility, public notice of availability of free care, uniform application procedures, etc.)”²⁷ Nonprofit general hospitals must meet certain requirements to qualify for HCRA funding for indigent care, such as:

- Implement “minimum collection policies and procedures approved by the commissioner...”²⁸
- Provide prenatal care for needy patients if they have obstetrical services.

In addition, the hospitals must submit a number of reports to the New York State Department of Health:

- Annual mission statement indicating commitment to meet the health needs of the communities they serve.
- Annual Community Service Plan that differentiates the cost of bad debt from the cost of charity care.
- Monthly report about discharges and payments into the IC Pool.²⁹

Interestingly enough, there is no obligation for hospitals to provide charity care.

An uninsured worker in upstate New York reports going without treatment for a painful and progressive condition. “I am an environmental aide at a hospital, but only per diem. Can you imagine this, [I work] at a hospital [but I have] no insurance, or help! Yes I do know that the hospital has [state] funding, however you must be denied Medicaid first and then hope the hospital has funding left [to cover you.] The thing is, you have to get the bills before you can get the [financial] help and that is a shame. It could end up that I get no funding at all and then I would be paying for the rest of my life.” DB

²⁴ Uttley, Lois and Pawelko, Ronnie. 2002. *No Strings Attached – Public funding of Religiously-Sponsored Hospitals in the United States*. Albany, NY: The Education Fund of Family Planning Advocates of NYS. pp.94 and 99.

²⁵ Hevesi, Alan G. 2003. *The Health Care Reform Act*. Albany, NY: New York State, Office of the State Comptroller. p.14.

²⁶ NYS Public Health Law § 2807-w

²⁷ Community Catalyst. 2000. “Fact Sheet: New York State Requirements Relating to Community Benefits and Free Care.” Boston: Community Catalyst.

²⁸ NY Pub. Health § 2807-k(9).

²⁹ Community Catalyst. Op. cit.

Even more curious, there is a specific provision in the Public Health Law to prohibit any individual from claiming that they are not responsible for all or part of a hospital bill, since the hospital can obtain payments from the indigent care pool.³⁰ This statutory prohibition is problematic for individuals and legal advocates who try to get hospitals to reduce the amount of debt owed by specific indigent/low-income individuals. In contrast, case law in New York has long established that eligibility for Medicaid can be used by an individual to defend against debt collection by a hospital.

The second item in the New York Patient Bill of Rights says that any patient in a hospital has a right to “receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation or source of payment.”³¹ For those who are uninsured or underinsured, this statement is considerably weaker than the mission statement of New York City’s Health and Hospitals Corporations (HHC) that aims “to extend equally to all New Yorkers, regardless of their ability to pay, comprehensive health services...”³² Clearly, the public hospital system, HHC, says that it will provide care regardless of the ability to pay for the care. At the same time, state law imposes surcharges (taxes) on hospitals, insurers, and other entities to fund the indigent care pools, but has no requirements to assure the needy will actually get care without regard to their ability to pay.

The Long Island Health Access Monitoring Project (LIHAMP) has surveyed all hospitals in Nassau and Suffolk counties. They have released two reports about access to hospital free care that have garnered extensive press coverage, including in the *New York Times*. The LIHAMP reports secured some changes by the hospitals and urged several local, state, and federal government agencies to take a closer look at the hospitals’ practices in regard to indigent care. Nassau County’s elected officials took action on the issue by passing a local law requiring hospitals in the county to report specific information annually about the people who received charity care.³³ The information collected must be reported to the Nassau County Legislature. These county reporting requirements are in addition to the reports that hospitals must file with the NYS Department of Health.

³⁰ NY Pub. Health § 2807-k(14).

³¹ NYS Department of Health. http://www.health.state.ny.us/nysdoh/hospital/patient_rights/en/patients.htm

³² <http://www.ci.nyc.ny.us/html/hhc/home.html>

³³ Reporting requirements protect the confidentiality of all individual patients.

Hospital Free Care Survey

Methodology

Public Policy and Education Fund (PPEF) staff conducted phone surveys of 70 hospitals throughout New York State with the exception of Nassau and Suffolk counties.³⁴ We used a phone survey format for community organizations developed by Community Catalyst of Boston; a similar form has been used as part of the surveys conducted by the Long Island Health Access Monitoring Project. As many as six phone calls were attempted to each hospital to try to get as complete information as possible to answer the nine (9) questions on the survey form. The first two calls were made to the social services and billing departments to ask about each hospital's policies and procedures for free/reduced-cost care for individuals who are uninsured.

Surveyors used this introductory script:

I am on the staff of the Public Policy and Education Fund. Through my outreach responsibilities, I encounter a good number of people with very limited means who are uninsured and have pressing health problems. As an agency, we are compiling a consumer guide of hospitals with charity or free care. I would like to get information about your hospital's charity care policy.

A series of follow-up questions was asked to try to find out how the hospital handled their uninsured patients who couldn't pay for services. Surveyors asked to be transferred to someone else in the hospital if the first responder couldn't answer any or all of the nine survey questions. Surveyors also asked for a copy of any documents related to the hospital's charity care policy. Those hospitals that required a written request before sending any documents received a letter by fax:

I am on the staff of the Public Policy and Education Fund. As part of my outreach responsibilities I encounter a number of people with very limited means who are uninsured and have pressing health concerns. Our organization (PPEF) is in the process of researching the hospitals in New York State with charity or free care. As a result of this research we will be able to compile a consumer guide of hospitals with free care policies and programs.

Please send a copy of any information regarding the free care policies at the [name of hospital]. This may include an application, and any other written guidelines, procedures, or pamphlets. Please indicate if the material you send is used to determine who is qualified for this free care and whether it is separate from the material given to the patients. For a better understanding of the guidelines, please send both.

The study focused on gathering information to answer five key questions:

1. Does the hospital have a free/charity care policy available to the public?
2. Does the free/charity care policy cover in-patient and outpatient services?

³⁴ The Long Island Health Access Monitoring Project has previously surveyed and reported on all hospitals in Nassau and Suffolk counties. See www.lihamp.org for more information on their findings.

3. Does the hospital hold off billing uninsured, indigent patients until after the hospital processed an application for its free/charity care program?
4. What is the deadline for applying for the hospital's free/charity care program?
5. Does the hospital supply translators for those patients who do not speak English (a requirement of federal law)?³⁵

The data for estimated 2003 HCRA Indigent Care and High Need Indigent Care Adjustment Pool disbursements to individual hospitals were provided by the New York State Department of Health pursuant to a Freedom of Information Act request to the department.

Data Collection and Analysis

Two PPEF staff surveyors called 14 public hospitals, one for-profit hospital, and 55 non-profit hospitals over a one-year period from August 2002 through July 2003. Hospitals that specialize in only a few services were not included in the survey. Surveyors called all general hospitals in Albany, Binghamton, Buffalo, Corning, Dobbs Ferry, Elmira, Jamestown, Mount Vernon, Plattsburgh, Rochester, Syracuse, Utica, Watertown, and White Plains. For New York City, surveyors called all general hospitals in the NYC Health and Hospitals Corporation (HHC) system and all hospitals in the Continuum Health Partners system. Surveyors called the general hospitals based in New York State that are part of the New York-Presbyterian Healthcare System, including hospitals in Middletown, New York City, Newburgh, and Nyack.

A grading scale was developed on a pass/fail basis for five categories corresponding to the five study questions listed under methodology.

- Earning a passing grade for the first category means that the hospital makes the application process for its free/charity care policy available to the public and specifies the income level(s) that must be met to qualify for assistance.
- Under the second category, a passing grade was awarded to hospitals that verbally reported that they have on-site translators available at any time or by appointment.
- For the third category, hospitals had to report that they cover all hospital inpatient and outpatient services, not just emergency care, under their free/charity care policy in order to receive a passing mark.
- A hospital that reported it does not bill the patient until after it determines whether the patient qualifies for financial assistance received a passing grade for the fourth category.

³⁵ Since 2000, federal standards issued by the Department of Health and Human Services require health care providers to provide language assistance services "at all points of contact" to all consumers with limited English proficiency. The standards specify that family and friends should not be used to translate unless the patient asks. See www.OMHRC.gov/CLAS.

- To earn a passing grade in the fifth category, a hospital had to state that it would accept applications for free/charity care up to three (3) months after services were provided.

A final grade, ranging from A to F, for each hospital was calculated based on the total number of passing grades received:

- A – passed all 5 categories;
- B – passed 4 categories;
- C – passed 3 categories
- D – passed 2 categories
- F – passed 1 or 0 categories

The individual hospital grades for each of the five categories, the final grade, and the amount of the estimated 2003 Indigent Care Pool distributions authorized by New York’s Health Care Reform Act (HCRA) are combined in a report card on pages 21 to 24.

Findings

Survey information was collected and compiled for seventy (70) general hospitals. No hospital is doing well in all five categories. The highest final grades received were the 11 (16%) hospitals with a “C.” Ten (14%) hospitals received a “D” as a final grade and 49 (70%) received an “F.”

Summary of Findings for 70 General Hospitals in New York State		
Criterion	Number of Hospitals	Percentage of Hospitals
No. with passing grade for public charity care policy with income guidelines	8	11%
No. with passing grade for translators	28	40%
No. with passing grade for charity care policy that covers in-patient & out-patient care	30	43%
No. with passing grade for holding bills until charity care application processed	8	11%
No. with passing grade for allowing up to 3 months to apply for charity care	3	4%
Received final grade of “A”	0	0%
Received final grade of “B”	0	0%
Received final grade of “C”	11	16%
Received final grade of “D”	10	14%
Received final grade of “F”	49	70%

Surveyor experiences

The surveyors reported that the hardest part of conducting the survey was trying to find someone to talk to on the phone who could provide information about the hospital's charity care policy. Surveyors frequently had to keep asking for the information in many different ways, of several different people, in order to find one or more staff that could give any information. Time and persistence were needed to try to navigate automated voice mail menu selections, stay on-hold for ten minutes or more, leave multiple voice messages, call back several times, and transfer from office to office, trying to find someone who could provide information.

Hill-Burton programs

Four of the hospitals in the survey have Hill-Burton obligations according to the federal website, but only two of them, Mount Vernon and Highland (in Rochester), mentioned that fact. Both of these hospitals promptly forwarded their information about applying for the program; the Highland hospital has a one-page handout for consumers which clearly stated the services that are covered and the financial eligibility criteria. Mount Vernon has a staff person who helps patients complete the application process. Neither Harlem Hospital (part of HHC) nor the two divisions of St. Luke's/Roosevelt Hospital mentioned that they have a Hill-Burton program even though they are on the list of obligated facilities.

Charity care applications and other hospital documents

Twenty-three facilities (33%) sent some type of document about their charity care program. Five of the hospitals included financial eligibility criteria as part of the application materials they give to consumers. Another three hospitals provided a copy of their application and told the surveyor the financial eligibility criteria. That means that only eight of the 70 hospitals (11%) gave enough information to determine whether an uninsured or underinsured individual might be eligible for charity care. An additional eight hospitals (11%) sent copies of their charity care application form. Two hospitals, both HHC facilities, sent copies of their mission statements that included a phrase indicating they provided care regardless of the ability to pay. One hospital sent a copy of its 2003 Community Service Plan; the next to last page of this 10-page document included a reference to the availability of charity care regardless of the ability to pay. One hospital sent a copy of its EMTALA policy and procedure and its procedure for writing-off indigent care. Another hospital sent a one-page handout for patients about fees that included a sentence stating that no one would be turned away because of inability to pay. At the beginning of the application forms from three hospitals, there was a statement that treatment is provided regardless of the ability to pay.

Summary of information provided on charity care programs		
Criterion	Number of Hospitals	Percentage of Hospitals
Provided written information about charity care program	23	33%
Provided copy of application and income eligibility	5	7%
Provided copy of application and verbal information about income eligibility	3	4%
Provided copy of application without income eligibility	8	11%
Provided mission statement or other document	7	10%
Provided limited verbal information about charity care program	28	40%
Said they had no charity care program	5	7%
No response/no information	14	20%

Lourdes Hospital in Binghamton was the only hospital that had a simple, easy-to-understand brochure with a clear title: "Lourdes' Patient Financial Assistance Program." However, Lourdes did not provide any eligibility criteria for its program. The Erie County Medical Center Healthcare Network in Buffalo had a consumer handout that included frequently asked questions about its "Reduced Fee for Care Program." St. Peter's Hospital in Albany had lots of information about its "Mercy Healthcare Benefits Program," but much of the information was in very small type that made it hard to read. Both Erie County and St. Peter's included income eligibility criteria for their programs and stated that the approval covered six months at Erie County and twelve months at St. Peter's.

Eligibility for charity care

In addition to the 23 hospitals that sent documents about their charity care programs, nine (9) of the eleven NYC Health and Hospitals Corporation's hospitals stated that they had a sliding fee scale and/or said the mission of HHC is providing care to everyone regardless of their ability to pay. A tenth HHC hospital, the City Hospital Center at Elmhurst, stated that there was a minimum \$20 co-payment for any service regardless of income level. Only one of the HHC hospitals, Metropolitan Hospital Center, did not respond to the surveyor's calls.

Another 19 hospitals were able to say that they had some type of reduced fee program, but could not or would not give any specifics about who would be covered under their program. Many of these hospitals indicated that they make decisions on a case-by-case basis.

Five hospitals (7%) said they have no charity care program. Sheehan Memorial Hospital in Buffalo said that it is working on developing a sliding fee scale. Flushing Hospital Medical Center in Queens said that it sends uninsured patients to an HHC hospital. The one for-profit hospital surveyed, Parkway Hospital in Queens, and both divisions of Beth Israel Medical Center in New York City, indicated they do not admit patients without insurance, except for emergency care as required by law.

Most of the hospitals required consumers to apply for government insurance programs like Medicaid and prove that they were ineligible before they could be considered for the hospital's charity care program. Many hospitals indicated they would help patients apply for Medicaid or other programs. One hospital, the University of Rochester Strong Memorial Hospital, required applicants to prove that they had applied for a bank loan to pay their hospital bill and had been rejected. For those hospitals that indicated financial eligibility levels, they were generally tied to the federal poverty level that is adjusted annually. Generally, eligibility limits were set at 100% to 200% of the federal poverty level.

Surveyors were unable to get any response from fourteen (14) hospitals (20%) despite multiple phone calls over several days or weeks.

Services covered

St. Peter's Hospital in Albany, Erie County Medical Center in Buffalo, and Highland Hospital in Rochester provided the most information about what services were covered by their charity care programs. Arnot Ogden Medical Center in Elmira said that it did not cover any "routine care services" that cost under \$100. Thirty hospitals reported verbally that their free/charity care policy covered medically necessary in-patient and outpatient services that the hospital billed. None covered the cost of physician services that are billed separately from the hospital bill even if the physicians provided the services in the hospital. Generally, hospitals could not tell the surveyor whether services like prescriptions and laboratory services were covered. Only St. Peter's and Erie County provided consumers with information about obtaining prescription drug coverage.

Billing practices

Eight hospitals indicated that they hold their billing until they have processed a patient's application for free/charity care. Only Elmira's two hospitals, Arnot Ogden Medical Center and St. Joseph's Hospital, gave patients up to six months after services were provided to apply for free/charity care assistance. Most hospitals did not know if they

had an application deadline, but there were hospitals that required patients to apply within as little as 5 to 15 days after receiving care or discharge. Uninsured patients and families facing serious illness would probably have great difficulty complying with such a short deadline. Only Erie County Medical Center in Buffalo stated that it would cover outstanding bills incurred up to three (3) months before the charity care application was submitted IF the patient mentioned the outstanding bills when applying.

St. Peter's Hospital in Albany and Erie County Medical Center in Buffalo were the only two hospitals that indicated that approval was extended over a period of time. The private non-profit St. Peter's granted approval to cover services for a year. The public Erie County Healthcare system stated that approval was valid for six (6) months.

Translation services

Most hospitals reported that they had some type of translator service available. Sometimes they required appointments to arrange for a translator. Many times they use a translation service available by phone. Despite the federal requirements to provide translation services, there were several hospitals that said they had no translators and patients had to make their own arrangements for translators. Several hospitals also told surveyors that they did not know if they had translators or not.

Consistency/inconsistency within a hospital system

The two Buffalo hospitals in the Kaleida Health system, Buffalo General and Millard Fillmore Hospitals, knew that they had a charity care program and referred the surveyor to the central office where the same limited information and application form were available.

As mentioned previously, the public hospitals (HHC) in New York City could communicate their mission to provide services regardless of the ability to pay even though they could not provide any specific information on eligibility criteria.

Continuum Health Partners, Inc. in New York City includes three general hospitals that were included in the survey: Beth Israel; St. Luke's/Roosevelt Hospital Center; and Long Island College Hospital. The three received a total of \$78.5 million from the NYS Indigent Care and High Need Indigent Care Adjustment Pools in 2003. But the information about the availability of charity care varied from hospital to hospital:

- Both divisions of Beth Israel Medical Center stated they do not have a charity care program. They do NOT accept or admit patients who do not have insurance. The center said it would help patients with cancer apply for Medicaid. The two divisions received about \$31 million from the NYS Indigent Care and High Need Indigent Care Adjustment Pools in 2003.

- At the St. Luke's Division of St. Luke's/Roosevelt Hospital Center, the surveyor was told there is a sliding fee scale and reduced fee clinics. No information was available from the Roosevelt Division of the hospital. These two divisions received about \$30 million from the NYS Indigent Care and High Need Indigent Care Adjustment Pools in 2003.
- Long Island College Hospital, the third Continuum partner, said that it provides emergency care according to the law. If it is not an emergency, an uninsured person is sent to the Admissions Office to determine what to do. LICH received more than \$17.5 million from the NYS Indigent Care and High Need Indigent Care Adjustment Pools in 2003.

Payments from NYS Indigent Care and High Need Indigent Care Adjustment Pools

All hospitals throughout New York State reported providing bad debt and charity care in 2001 for which they charged patients \$2.5 billion. Within those amounts, charity care comprised about 76% of the total uncompensated care charges for inpatient services while 24% was allocated to bad debt. For outpatient services, 63% was allocated to charity care and 37% to bad debt. While the charges were \$2.5 billion, the NYS Department of Health recognizes \$1.7 billion dollars as the cost of the uncompensated care provided by the hospitals as the basis for receiving funding for indigent care from the HCRA pools.³⁶ The HCRA Indigent Care and High Need Indigent Care Adjustment Pools covered half (50%) of the total uncompensated cost amount by distributing \$847 million dollars to hospitals in 2003.

The 70 hospitals in the current survey received funds from the NYS Indigent Care and High Need Indigent Care Adjustment Pools in 2003. A total of \$410,982,477 was paid to the 70 hospitals in this survey.

³⁶ NYS Department of Health data for estimated 2003 Indigent Care Pool distributions to individual hospitals based on 2001 data reported by hospitals.

Report Card for Selected New York State Hospitals: Free Care Programs

Key: P = Pass F = Fail Final Grade based on total number of Passing marks received:
A = 5 Ps B = 4 Ps C = 3 Ps D = 2 P's F = 1 P or Less

Hospitals grouped by city; by borough in NYC	Free/charity care policy available to the public ³⁷	Translator: are available on site ³⁸	Covers in-patient and out- patient services ³⁹	Holds bills until application processed ⁴⁰	Time Limit To apply ⁴¹	Final Grade	Amount Received from indigent care pool ⁴²
ALBANY							
Albany Medical Center	P	P	P	F	F	C	\$ 3,621,961
Memorial Hospital of Albany	F	P	P	P	F	C	\$ 429,797
St. Peter's Hospital	P	P	P	F	F	C	\$ 1,418,817
BINGHAMTON							
Our Lady of Lourdes Memorial Hospital*	F	F	P	F	F	F	\$ 1,200,319
United Heath Services Hospitals Inc.	P	F	P	P	F	C	\$ 3,280,146
BRONXVILLE							
Lawrence Hospital	F	F	P	F	F	F	\$ 920,780
BUFFALO							
Erie County Medical Center	P	F	P	F	P	C	\$ 4,171,029
Kaleida Health (Buffalo General & Millard Filmore Hospitals)	F	F	P	F	F	F	\$ 7,746,167
Mercy Hospital	F	F	F	F	F	F	\$ 928,703
Sheehan Memorial Hospital	F	F	F	F	F	F	\$ 974,103
Sisters of Charity	F	F	P	F	F	F	\$ 2,333,683

* Since the survey was done, Lourdes, in meeting with local consumer advocates, has clarified that their policies include income guidelines and time to apply.

³⁷ "Pass" for this category means that the hospital has both an application form available to the public and specifies the income level(s) to qualify for assistance.

³⁸ "Pass" for this category means that the hospital reports it has on-site translators available, includes those hospitals that provide translators by appointment.

³⁹ "Pass" for this category means that the hospital specifically says that it covers all hospital inpatient and outpatient services, not just emergency care.

⁴⁰ "Pass" for this category means that the hospital reports that it will not bill the patient until after it determines whether the patient qualifies for financial assistance.

⁴¹ "Pass" for this category means that the hospital will accept applications for free/charity care up to three (3) months after services were provided.

⁴² Estimated 2003 Indigent Care and High Need Indigent Care Adjustment Pools distribution authorized by New York's Health Care Reform Act (HCRA). Often called "Bad Debt and Charity Care."

Hospitals grouped by city; by borough in NYC	Free/charity care policy available to the public ³⁷	Translator: are available on site ³⁸	Covers in-patient and out- patient services ³⁹	Holds bills until application processed ⁴⁰	Time Limit To apply ⁴¹	Final Grade	Amount Received from indigent care pool ⁴²
CORNING							
Corning Hospital	F	F	F	F	F	F	\$ 911,843
CORTLAND MANOR							
Cortland Manor- Hudson Valley Hospital Center	F	F	F	F	F	F	\$ 983,030
DOBBS FERRY							
Community Hospital at Dobbs Ferry	F	F	F	F	F	F	\$ 250,435
ELMIRA							
Arnot Ogden Medical Center	P	F	P	F	P	C	\$ 581,590
St. Joseph's Hospital of Elmira	P	F	P	F	P	C	\$ 877,266
JAMESTOWN							
Woman's Christian Association Hospital	F	P	P	F	F	D	\$ 1,252,548
MIDDLETOWN							
Orange Regional Medical Center	F	F	F	F	F	F	\$ 1,498,702
MOUNT VERNON							
Mount Vernon Hospital	F	F	P	P	F	D	\$ 7,579,404
NEWBURGH							
St. Luke's Hospital	F	F	F	F	F	F	\$ 1,214,174
NEW ROCHELLE							
Sound Shore Medical Center of Westchester	F	P	F	F	F	F	\$ 7,910,134
NEW YORK CITY - BRONX							
Jacobi Medical Center (HHC)	F	P	P	F	F	D	\$ 8,596,565
Lincoln Medical Center. (HHC)	F	F	F	F	F	F	\$ 9,421,550
North Central Bronx Hospital (HHC)	F	P	P	P	F	C	\$ 4,940,311
St. Barnabas Hospital	F	F	P	F	F	F	\$10,637,743
NEW YORK CITY - BROOKLYN							
Coney Island Hospital (HHC)	F	P	F	F	F	F	\$ 3,857,457
The Brooklyn Hospital Center	F	F	F	F	F	F	\$ 7,570,519
Kings County Hospital Center (HHC)	F	P	F	F	F	F	\$15,013,975

Hospitals grouped by city; by borough in NYC	Free/charity care policy available to the public ³⁷	Translator: are available on site ³⁸	Covers in-patient and out- patient services ³⁹	Holds bills until application processed ⁴⁰	Time Limit To apply ⁴¹	Final Grade	Amount Received from indigent care pool ⁴²
Long Island College Hospital	F	F	F	F	F	F	\$17,618,264
New York Community Hospital of Brooklyn	F	P	F	F	F	F	\$ 922,913
New York Methodist Hospital	F	P	F	F	F	F	\$16,672,719
Woodhull Medical and Mental Health Center (HHC)	F	P	F	F	F	F	\$ 7,637,122
NEW YORK CITY - MANHATTAN							
Bellevue Hospital Center (HHC)	F	P	F	F	F	F	\$14,324,406
Beth Israel Medical Center - Petrie	F	F	F	F	F	F	\$28,852,953
Beth Israel Med. Center-Herbert-Nell Singer Division	F	F	F	F	F	F	\$ 2,059,102
Harlem Hospital (HHC)	F	F	F	F	F	F	\$ 8,554,187
Metropolitan Hospital Center (HHC)	F	F	F	F	F	F	\$ 7,345,640
New York Presbyterian Hospital (NY Weill Cornell Center, Columbia Presbyterian Center, Allen Pavilion, and Westchester Division)	F	P	F	F	F	F	\$60,465,162
St. Luke's Roosevelt Hosp. (St. Luke's & Roosevelt Divs.)	F	F	F	F	F	F	\$30,096,277
NEW YORK CITY - QUEENS							
City Hospital Center at Elmhurst (HHC)	F	F	P	F	F	F	\$ 6,774,681
Flushing Hospital Medical Center	F	P	F	F	F	F	\$ 7,535,817
Jamaica Hospital Medical Center	F	F	F	F	F	F	\$23,080,588
Mt. Sinai Hospital Queens	F	F	F	F	F	F	\$ 870,168
New York Hospital Medical Center of Queens	F	P	P	F	F	D	\$ 8,920,475
North Shore University Hospital at Forest Hills	F	P	P	F	F	D	\$ 2,111,295
Parkway Hospital	F	F	F	F	F	F	\$ 676,811
Queens Hospital Center (HHC)	F	P	F	F	F	F	\$ 6,144,656
NYACK							
Nyack Hospital	F	P	F	F	F	F	\$ 1,245,887
PLATTSBURGH							
Champlain Valley Physicians Hospital	F	P	P	P	F	C	\$ 1,124,886
PORT CHESTER							
New York United Hospital Medical Center	F	P	P	F	F	D	\$ 2,850,539

Hospitals grouped by city; by borough in NYC	Free/charity care policy available to the public ³⁷	Translator: are available on site ³⁸	Covers in-patient and out- patient services ³⁹	Holds bills until application processed ⁴⁰	Time Limit To apply ⁴¹	Final Grade	Amount Received from indigent care pool ⁴²
ROCHESTER							
Highland Hospital	P	F	P	F	F	D	\$ 1,546,057
Park Ridge & Genesee Campuses (Unity Health Care)	F	P	P	F	F	D	\$ 1,539,597
Rochester General Hospital	F	P	F	F	F	F	\$ 2,867,639
Strong Memorial Hospital	P	P	P	F	F	C	\$ 5,828,062
SYRACUSE							
Community General Hospital of Greater Syracuse	F	F	P	P	F	D	\$ 2,947,675
Crouse – Irving Memorial Hospital	F	F	F	F	F	F	\$ 4,023,458
St. Joseph’s Hospital Health Center	F	F	F	P	F	F	\$ 2,717,374
University Hospital-SUNY Health Science	F	F	P	F	F	F	\$ 4,116,766
UTICA							
Faxton- St. Luke’s	F	F	P	F	F	F	\$ 972,353
St. Elizabeth Medical Center	F	F	F	F	F	F	\$ 1,293,696
WATERTOWN							
Samaritan Medical Center	F	P	P	F	F	D	\$ 1,281,286
WHITE PLAINS							
Saint Agnes Hospital	F	P	P	P	F	C	\$ 1,616,645
Westchester County Medical Center	F	F	F	F	F	F	\$ 8,709,412
White Plains Hospital Center	F	F	F	F	F	F	\$ 1,706,968
YONKERS							
Saint Johns Riverside Hospital	F	F	F	F	F	F	\$ 3,347,787

Discussion and Recommendations

New York annually spends \$847 million of taxpayer dollars compensating hospitals for bills that patients do not pay. While these dollars are legally known as “Indigent Care Pool and High Need Indigent Care Adjustment Pool” money, New York law does not require that hospitals have an explicit charity care policy. The law does require annual reporting that distinguishes between: (a) the hospital’s costs related to free care and bad debt of the uninsured and (b) the hospital’s cost representing deductibles and coinsurance for patients with insurance. However, New York State does not obligate hospitals to inform consumers that funds are available to offset the cost of their care if they are uninsured.

In fact, as the current survey demonstrates – as has previous surveys of hospitals on Long Island – hospitals do quite the opposite; by and large they hide the availability of charity care funds from uninsured patients who cannot afford to pay their hospital bills. In this study, two highly trained surveyors made repeated calls to 70 hospitals that receive more than \$400 million in tax dollars to provide uncompensated care. Only eight of the hospitals (11%) provided the surveyors with a policy for providing charity care that includes income eligibility levels for granting financial relief to patients unable to pay their hospital bills. Only one-third (23) of the hospitals were able to provide any written information about their charity care program. An additional 28 hospitals, when pressed for information, admitted that they did have a program for providing charity care. Five hospitals – all of which get taxpayer funds from New York’s indigent care pools – explicitly denied the availability of a charity care program and 14 hospitals did not provide any information to the surveyors.

Given the great difficulty that trained surveyors who clearly identified the purpose of their call had in obtaining information about charity care, one can only imagine the difficulty that a patient who lacks health coverage would have. Actually, one must not just imagine such difficulty. The survey of Long Island hospitals compared the experience of uninsured surveyors and surveyors like those used to gather data for this report. “Uninsured surveyors had a much harder time obtaining responses to their questions than surveyors calling from community agencies...”⁴³

As the stories interspersed in this report of individual New Yorkers who face huge hospital bills illustrate, hospitals routinely engage in aggressive collection activities to collect bills from patients, without determining whether the patient has the ability to pay or providing the patient with an opportunity to apply for relief from the bad debt and charity care funds. In fact, hospitals bill the patient for the procedures at the highest possible rates, well in excess of the amount billed for the same procedure to government or private health plans.

Even in those instances in which hospitals do have a written, or verbal, charity care policy, the details of that policy are either not available or create obstacles to accessing

⁴³ Guercia, Rosemarie and Kass, Donna. 2001. Hospital Community Benefits and Free Care Programs. Hicksville, Long Island, NY: Long Island Health Access Monitoring Project. p.iv.

charity care. Only eight hospitals (11%) agree to process the patient's charity-care application before billing the patient. Only three hospitals give the patient a reasonable amount of time, three months after discharge, to apply for charity care. Less than half of the hospitals (43%) state that both inpatient and outpatient services are covered by the charity care policy. And less than half of the hospitals provide translators at the hospital so that non-English speakers can understand hospital policy, despite a specific requirement in federal law.

In contrast, hospital bills in Massachusetts notify patients how to apply for assistance from the Massachusetts free care pool if they cannot afford to pay for their care. When a patient receives a bill from a Massachusetts hospital, the bill prominently informs the patient of the availability of free care; specific income guidelines are sometimes listed on the bill. Massachusetts hospitals prominently display signs throughout the emergency room and patient care area, informing patients about the availability of uncompensated care.

The difference between hospitals in New York and Massachusetts is not a matter of good will, but of law. Massachusetts law and regulation provides detailed guidelines, including income criteria, for providing free-care to uninsured patients who are unable to afford hospital care. The regulations include clear, detailed requirements for hospitals to notify patients of the availability and means of applying for such care. The regulations require that Massachusetts hospitals and community health centers to use a standard application and eligibility criteria, screen patients and assist them to apply for government programs, and provide full and partial free care. See Appendices A and B for examples of billing forms from Massachusetts hospitals providing information to patients about the availability of free care.

Health advocates in New York State have long urged modifying the structure and eligibility requirements for the hospital bad debt and charity care pool so that uninsured and underinsured individuals could access needed care without fears of accumulating enormous debt or incurring bankruptcy. The New York State Health Care Campaign, a coalition of more than 90 organizations, developed a set of state policy recommendations regarding free care at hospitals and clinics receiving bad debt and charity care funds:

- **Statewide standards** - Create consistent statewide standards requiring all hospitals and clinics (article 28 facilities) to provide free care based on a patient's ability to pay, including income level and insurance status;
- **Specify documentation** - Identify what documentation may be requested to prove eligibility;
- **Notify consumers** - Notify people that free care is available during the admitting process; posting language-appropriate information in emergency rooms, hospitals and clinics; doing outreach to low-income communities, and including information on all hospital and clinic bills;
- **Simple standard application** - Use simple, standard, language-appropriate application process available through hospitals and clinics with specified time frames for processing and responding to each application in writing;

- **Sliding fee scale** - Provide a sliding fee scale for partial free care for those with moderate incomes, the underinsured and those with catastrophic illness;
- **Train staff** - Require hospitals to train staff on explaining, distributing, and implementing hospital free care policy;
- **Process application before billing** - Guarantee that patients will not be billed until after a determination of eligibility under the free care policy has been made;
- **Year long approval** - Specify that approval of free care application is good for a year and portable so that an application approved by one hospital or clinic is accepted by other hospitals and clinics;
- **Appeal process** - Authorize appeals to a third party if a hospital denies an application and provide language-appropriate information on how to file an appeal;
- **Comprehensive services** - Include comprehensive services such as in-patient care, doctor and specialist care, prescriptions, lab tests, emergency care, and radiology;
- **Public disclosure** – Require hospitals and clinics to publish in their annual reports the number of uninsured and underinsured, by zip code, they have served plus those they have transferred to other facilities as well as the reimbursements they have received for indigent care; and
- **Vigorous enforcement** - Establish an ongoing enforcement process through the NYS Department of Health with regular auditing of hospital and clinic records and activities related to hospital free care for the uninsured and underinsured with substantial fines for infractions. ⁴⁴

If enacted, these policy recommendations would make the indigent care system in New York State more humane and more accountable.

Conclusion

It is very clear from this survey that uninsured or underinsured patients at most non-profit hospitals in this survey would have a difficult time trying to determine if free care or reduced cost care is available and how to apply for it. For most hospitals, surveyors had to make multiple calls, transverse phone transfers to many different departments, and piece together information from more than one source in the hospital to determine what financial help, if any might be available. All surveyed hospitals received funding from the HCRA Indigent Care and High Need Indigent Care Adjustment Pools, but none mentioned that this financial assistance was available to the hospitals to help offset the cost of providing free/charity care.

New York State spends \$847 million dollars a year through the HCRA Indigent Care and High Need Indigent Care Adjustment Pools, but there is no accountability by hospitals on

⁴⁴ New York State Health Care Campaign. 2002. "Hospital Free Care." Albany, NY: New York State Health Care Campaign.

how many uninsured and underinsured individuals they treat as a result of receiving funds from the pools. Although hospitals report charity care separately from bad debt, there is no real basis for determining whether they provide care to the neediest patients. New York State needs to follow the path of the states that set clear statewide eligibility standards and application process so the uninsured know how to get health care when they need it without fearing that they will be saddled with huge medical debts.

Appendix A

Part of billing form from Beth Israel Deaconess Hospital in the Boston Metropolitan area of Massachusetts with information about the availability of free care.

BILLING POLICY

Bills are due within 15 days of receipt. If you are unable to forward your full balance at this time please contact our Business Office (phone number on front). Payment plans, free care/reduced fee arrangements, and Public Assistance Programs are available to eligible applicants. Our Account Representatives are available to assist you with any of these alternative payment programs.

As a patient of Beth Israel Deaconess, you may also receive bills for professional services provided by radiologists, pathologists, anesthesiologists, surgeons or other physicians. These bills are in addition to bills from the hospital. If you have any questions regarding these professional bills, please contact those groups directly.

NOTICE OF AVAILABILITY OF PUBLIC ASSISTANCE

The hospital provides financial assistance for medically necessary services for Massachusetts residents who cannot afford to pay. Non-residents may also qualify for assistance.

AVISO OBTENIBLE DE ASISTENCIA FINANCIERA

El hospital provee Asistencia Financiera a los residentes de Massachusetts que no puedan pagar servicios medicos. Pacientes que no son residentes de Massachusetts pueden tambien qualificar para asistencia.

Size of Family Unit No. de personas por familia	Full Free Care up to These income levels Ingreso total	Partial Free Care up to These income levels Ingreso parcial
1	\$17,960.00	\$35,920.00
2	\$24,240.00	\$48,480.00
3	\$30,520.00	\$61,040.00
4	\$36,800.00	\$73,600.00

PLEASE CONTACT US IF YOU WOULD LIKE MORE INFORMATION.

SI USTED QUIERE MAS INFORMACION POR FAVOR COMUNICARSE CON NUESTRA OFICINA.

Appendix B

Part of billing form from Newton-Wellesley Hospital in the Boston metropolitan area of Massachusetts with information about the availability of free care.

If you consider your injury work related, please give us the name of your employer and its workers compensation insurance company above, and we will bill them directly. If your injury is determined to be unrelated to your employment, we will seek payment from you directly or through your health insurance. Therefore, please give us the name of your health insurance company as well.

If you have any questions please call our patient accounting office 617-243-6100.

Please send completed and signed insurance forms for outpatient claims with this statement to your commercial insurance health carrier.

AVAILABILITY OF FREE CARE

The Commonwealth of Massachusetts regulation 114.6 CMR 10.00 specifies that Massachusetts acute hospitals shall provide Free Care to financially eligible persons and/or inform them of the availability of public assistance programs. For further information about such eligibility, call the Patient Accounts Department at 617-243-6100.

ASSIGNMENT OF HOSPITAL AND/OR AUTOMOBILE INSURANCE BENEFITS

I hereby authorize _____ to pay directly To Newton-Wellesley Hospital the benefits specified in my policy and otherwise payable to me, but not to exceed the hospital's regular charges for this period of hospitalization. I understand I am financially responsible to the hospital for charges not covered by the assignment.

SIGNATURE OF POLICYHOLDER

DATE

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