

Hospital Financial Aid



**Can New Yorkers
in the Capital District
Access Hospital Services
Paid for by Our Tax Dollars?**

November 2004

Public Policy and Education Fund of New York

Hospital Financial Aid
Can New Yorkers in the Capital District
Access Hospital Services
Paid for by Our Tax Dollars?

Table of Contents

Executive summary.....	ii
Introduction.....	1
Good News from Federal Government.....	3
Hospitals' Response.....	5
New York Funding for Hospital Charity Care of the Uninsured.....	9
Other Activities in New York.....	11
Hospital Financial Aid Survey Methodology.....	12
Data Collection and Analysis.....	13
Findings.....	14
Report Card for Capital Region.....	19
Discussion and Recommendations.....	20
Conclusion.....	24
Appendix A: Massachusetts hospital bill with free care information.....	26
Appendix B: Massachusetts hospital bill with free care information.....	27
Appendix C PPEF Best Practices Compared to HANYS Guidelines.....	28

Hospital Financial Aid

Can New Yorkers in the Capital District

Access Hospital Services

Paid for by Our Tax Dollars?

Executive Summary

More than 5.6 million New Yorkers, one-out-of-three people under the age of 65, did not have health coverage for all or part of 2002-2003, according to a June 2004 report released by Families USA. Most of these New Yorkers, 65%, went without health insurance for six months or longer.

The report also found that Latinos and African Americans in New York were more likely to be uninsured than whites. More than half (56%) of Latinos and 43% of African Americans did not have health insurance for a portion of 2002 and 2003, compared to 23% of whites. Still, white New Yorkers made up the highest number of uninsured, 2.3 million.

When one third of New Yorkers under the age of 65 have gone without health insurance in the past two years, it's a crisis. According to a report from the National Institutes of Health, 18,000 Americans die prematurely each year due to the lack of health insurance.

When New Yorkers who lack health insurance need care at a hospital, they will be billed by the hospital, which according to New York law, must seek to collect the funds. Moreover, they will usually be billed at the "full charge" rate rather than the discounted rate paid by Medicare, Medicaid, and private insurance. Such billing practices contribute to medical debt, the second most frequent cause of personal bankruptcies.

Hospital associations long maintained that Medicare required them to bill the uninsured at the "full-charge" rate and try to collect the debt. On February 19, 2004, U.S. Secretary of Health and Human Services Tommy G. Thompson sent a letter to the president of the American Hospital Association disagreeing with the hospital associations' interpretation of Medicare regulations by writing: "Nothing in the Medicare program rules or regulations prohibit such discounts."

In response to negative publicity and a Congressional investigation into hospital billing and collection practices, the American Hospital Association (AHA) issued voluntary guidelines to its member hospitals in December 2003. The Healthcare Association of New York State (HANY), the statewide hospital association, approved its own set of

guidelines *Financial Aid/Charity Care Policy at New York's Not-for-Profit Hospitals* in January 2004. While the HANYS' recommendations are superior to AHA's, HANYS fails to recommend sufficient consumer protections.

The HANYS guidelines are a step in the right direction, but there is no enforcement power if a hospital fails to abide by the recommendations. So, access to hospital care for the uninsured and underinsured continues to be a concern for patients and advocates. 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.

New York hospitals receive \$847 million a year of taxpayer dollars to compensate them for unpaid medical bills. The funds, usually called the Bad Debt and Charity Care Pool, come from taxes placed on patient services. The legislation that governs these funds is known as the Health Care Reform Act (HCRA); this law was most recently renewed by the State Legislature in 2003 and will need to be renewed again by June 20, 2005. In addition to HCRA funds, almost all hospitals qualify for exemptions from income, property, school, and sales taxes because they are non-profit. Despite this public financial support, New York law does not require hospitals to meet standards for providing charity care as Massachusetts and New Jersey do.

Public Policy and Education Fund (PPEF) staff conducted on-site surveys of the eight hospitals in Albany, Rensselaer, Saratoga, and Schenectady counties to gather information about their financial aid policies. We used the same survey form to collect data as was used for a PPEF phone survey of hospitals in 2002-2003. The information collected was compiled and each hospital was given a passing or failing grade for its answers to five questions:

1. Does the hospital have a financial aid policy available to the public that includes specific income guidelines for receiving financial assistance?
2. Does the financial aid policy cover in-patient and outpatient services?
3. Does the hospital delay billing uninsured, indigent patients until after the hospital has processed an application for its financial aid 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

The final grades for the eight hospitals were: one “B,” two “C,” three “D,” and two received an “F.” All hospitals, except St. Mary’s in Renssalaer County, provided some type of document about their financial assistance program. Two hospitals, St. Peter’s and Saratoga, had consumer-friendly brochures to explain their financial aid programs. Ellis and Samaritan hospitals used a one-page flyer for consumers that explained where and how to get more information on financial aid.

Only one hospital, St. Peter’s in Albany, included easy-to-understand financial eligibility criteria as part of the application materials given to consumers. Another hospital included financial eligibility criteria in its consumer brochure, but few if any patients would know whether they qualify for “twice the Federal Poverty Level.”

Patients at five hospitals could get a copy of the financial aid application without any other information describing what services are covered nor the income eligibility requirements. When asked, three of these hospitals provided PPEF with additional information that included financial eligibility criteria.

Report Card for Capital District Hospitals’ Financial Aid Programs							
Key: P = Pass F = Fail A = 5 Ps B = 4 Ps C = 3 Ps D = 2 Ps F = 0 or 1 P							
Hospitals grouped by county	Income guidelines & policy available to the public	Translators on site	Covers in-patient and out-patient care	Holds bills until application processed	Time limit to apply	Final Grade	Amount Received from Indigent Care Pool
ALBANY							
Albany Medical Center	P	P	F	F	F	D	\$ 3,621,961
Albany Memorial (part of Northeast Health)	P	F	P	F	P	C	\$429,797
St. Peter’s Hospital	P	P	P	F	P	B	\$ 1,418,817
SARATOGA							
Saratoga Hospital	P	P	F	F	F	D	\$556,327
SCHENECTADY							
Ellis Hospital	F	P	P	F	F	D	\$1,229,254
St. Clare’s Hospital	F	F	F	F	F	F	\$811,877
RENSSELAER							
Samaritan Hospital (part of Northeast Health)	P	F	P	F	P	C	\$682,556
St. Mary’s Hospital (part of Seton Health)	F	F	F	F	F	F	\$841,115
See full report, pages 12 to 19, for more detailed explanation of this report card.							

None of the hospitals met the Massachusetts standard where all hospital bills prominently inform the patient of the availability of free care and specific income guidelines are sometimes listed on the bill. Massachusetts's hospitals prominently display signs throughout the emergency room and patient care area to inform patients about the availability of financial aid.

The difference between hospitals in New York and Massachusetts is not a matter of good will, but of law. Massachusetts's law and regulation provides detailed guidelines, including income criteria, for providing free and reduced cost-care to uninsured and underinsured patients who are unable to afford hospital care. The regulations require Massachusetts hospitals and community health centers to use standard application information and eligibility criteria, screen patients and assist them with applying for government programs if they qualify, and provide full and partial free care for those without the resources to pay for 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.

NYS Comptroller Alan Hevesi notes in a recent report that funding for indigent care is the largest expense in HCRA, almost a billion dollars a year. Although hospitals report charity care separately from bad debt, there is no basis for determining whether they provide care to the neediest patients. Hospitals do not report how many uninsured and underinsured individuals they treated using the funds from the indigent care pools. The Comptroller recommends putting the indigent care funds into the regular state budget so this large fund will be subject to the same scrutiny and safeguards as other state disbursements and recommends that policymakers establish uniform standards and procedures for providing assistance to those in need.

NYS Assemblyman Alexander "Pete" Grannis has introduced legislation that would put New York State on the path to follow other states. His proposals set statewide eligibility standards and application process so the uninsured know how to get health care when they need it without fearing they will be saddled with huge medical debts. If enacted into law, these legislative proposals would make the Bad Debt and Charity Care system in New York State more humane and more accountable.

Hospital Financial Aid

Can New Yorkers in the Capital District Access Hospital Services Paid for by Our Tax Dollars?

Introduction

- *Rising number of uninsured New Yorkers*
- *Latinos and African Americans more likely to be uninsured*
- *Lack of access to needed health care*
- *More people are underinsured*
- *Medical debt - a leading cause of personal bankruptcy*

More than 5.6 million New Yorkers, one-out-of-three people under the age of 65, did not have health coverage for all or part of 2002-2003, according to a June 2004 report released by Families USA. Most of these New Yorkers, 65%, went without health insurance for six months or longer. The Families USA report entitled *One in Three, Non Elderly Americans without Health Insurance*, expands upon census data, which reports annually the number of Americans who are uninsured for the entire previous calendar year. Census data revealed that 3 million New Yorkers lacked health insurance during all of 2002, but *One in Three* took a closer look and found that nearly twice as many families-were uninsured for at least a portion of 2002-2003. The complete Families USA report is available at www.familiesusa.org.

The report also found that Latinos and African Americans in New York were more likely to be uninsured than whites. More than half (56%) of Latinos and 43% of African Americans did not have health insurance for a portion of 2002 and 2003, compared to 23% of whites. Still, white New Yorkers made up the highest number of uninsured, 2.3 million.

According to the report, three-out-of-four people who were uninsured in New York are working. While 60% made less than two times the federal poverty level, or \$36,800 for a family of four in 2003, another 40%, or 2.4 million New Yorkers, earned more than two times the federal poverty level but still went without health insurance for some portion of 2002-2003.

Many consumers and elected officials hold firmly to the 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 each year 18,000 Americans die prematurely because they lack health insurance.¹

The IOM published four studies between 2001 and early 2003 looking at the uninsured and concluded that “Lack of access to health care results in adverse economic, social, and health consequences for uninsured persons and their family members.”² A recent study by the Center for Studying Health System Change reports that 20% of Americans with chronic conditions such as diabetes, asthma, depression, have difficulty accessing health care because they have trouble paying for medical care. Not filling a prescription, delaying care, and going without health care were the most common access-to-healthcare problems among the uninsured with chronic conditions. But even those with insurance coverage did without needed care if they had already incurred medical bills they couldn’t pay.³

Many reports document that those who are insured have been forced to shoulder a larger portion 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. The average New York worker paid 39.7% more for health insurance premiums in 2004 than he/she paid in 2000. The average New Yorker’s earnings grew at one-third that rate during the same period, rising only 13.1%.⁴ Americans with private health insurance were most likely to be required to pay more for health care.⁵ Two out of five American adults had trouble paying medical bills in 2003.⁶

The Access Project reports that medical debt can result in difficulty accessing health care, bad credit ratings, and bankruptcy.⁷ Medical debt affects those with and without insurance and 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

¹ Institute of Medicine. 2002. *Care Without Coverage – Too Little, Too Late*. Washington, DC: National Academy Press. pp 3-5.

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

³ Ha T. Tu. *Rising Health Costs, Medical Debt and Chronic Conditions*. 2004. Issue Brief No. 88, Center for Studying Health System Change. Washington, DC.

⁴ Families USA. 2004. *Health Care – Are you better off today than you were four years ago?* New York Fact Sheet. Washington, DC.

⁵ Ha. Op. cit.

⁶ The Commonwealth Fund. 2004. *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth fund Biennial Health Insurance Survey*. New York.

⁷ The Access Project. 2003. *The Consequences of Medical Debt*. Boston, MA.

involved a medical problem, and certain groups—particularly women heads of households and the elderly—were even more likely to report health-related bankruptcy.”⁸

When one third of New Yorkers under the age of 65 have gone without health insurance at some time during the past two years, it’s a crisis. It’s a crisis for working families, many of whom have low or modest incomes. When New Yorkers who lack health insurance receive care at a hospital, they will be billed by the hospital, which according to New York law, must try to collect. Moreover, the uninsured will likely be billed at the “full charge” rate rather than the discounted rate paid by Medicare, Medicaid, or private insurance. Such billing practices contribute to medical debt, the second most frequent cause of personal bankruptcies.

Since the spring of 2003, news stories have described how hospital billing and collection practices affect the uninsured. A *Wall Street Journal* series of reports explained how uninsured low-income individuals who needed care in a hospital were billed at rates far higher than the fees paid by Medicare, Medicaid, or private insurers for the same services.⁹ The stories highlighted the huge debts facing individuals and their experiences when hospitals turned them over to collection agencies.

Good news: Federal government makes it clear that hospitals can offer free care and discounted rates to the uninsured

- *Hospitals do not risk lower Medicare payments*
- *Hospitals are not required to collect debt from indigent patients*

American society has long viewed hospitals as community resources. Society expresses its value for hospitals through funding and tax law. 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.

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 tax exemptions, the Internal Revenue Service has issued a list of questions to be answered in seeking evidence that a hospital provides care to the indigent.¹⁰

⁸ 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)

⁹ Lagnado, Lucette. 2003 and 2004. *Wall Street Journal*. March 13, March 17, April 1, June 10, July 7, October 30, and December 17 in 2003 and February 20 and June 8 in 2004.

¹⁰ See Public Policy and Education Fund of New York for a discussion of relevant federal laws. 2003. *Hospital Free Care - Can New Yorkers Access Hospital Services Paid for by Our Tax Dollars?* http://www.citizenactionny.org/reports/Hospital_Free_Care_Report_Final.pdf

Hospital associations long maintained that Medicare would decrease their reimbursement rates if they offered free care or steeply discounted rates to uninsured patients. They insisted that the federal government had to take action despite the fact that the Medicare Provider Manual explicitly permits hospitals to provide “free care or care at a reduced charge to patients who are financially indigent.”¹¹

A second issue the hospital associations have used to defend their billing and collection practices is that Medicare prohibited them from using less aggressive collection tactics on low-income uninsured patients. Although Medicare requires providers to make a “reasonable collection effort” to pursue debts, the Medicare Provider Reimbursement Manual clearly allows a hospital to determine that a patient is “indigent” or “medically indigent” and therefore the hospital need not try to collect from that patient.

In December 2003, the American Hospital Association sent a letter to the federal agency that administers Medicare outlining the hospitals’ concerns that they would conflict with Medicare if they billed uninsured indigent patients differently than other uninsured patients. The federal government disagreed with the hospital associations’ interpretation of Medicare regulations regarding free care/reduced rates and aggressive collection practices. On February 19, 2004, Secretary of Health and Human Services Tommy G. Thompson sent a letter to the president of the American Hospital Association saying:

Your letter suggests that HHS regulations require hospitals to bill all patients using the same schedule of charges and suggests that as a result, the uninsured are forced to pay "full price" for their care. That suggestion is not correct and certainly does not accurately reflect my policy. The advice you have been given regarding this issue is not consistent with my understanding of Medicare's billing rules. To be sure that there will be no further confusion on this matter, at my direction, the Centers for Medicare & Medicaid Services and the Office of Inspector General have prepared summaries of our policy that hospitals can use to assist the uninsured and underinsured. ***This guidance shows that hospitals can provide discounts to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing obligations. Nothing in the Medicare program rules or regulations prohibit such discounts. (emphasis added)*** In addition, the Office of Inspector General informs me that hospitals have the ability to offer discounts to uninsured and underinsured individuals and cost-sharing waivers to financially needy Medicare beneficiaries.

With this guidance as a tool, I strongly encourage you to work with AHA member hospitals to take action to assist the uninsured and underinsured and therefore, end the situation where, as you said in your own words, "uninsured Americans and others of limited means are often billed and required to pay higher charges."¹²

¹¹ Medicare Provider Manual, Chapter 26, §2602.2(D).

¹² US Department of Health and Human Services. News release February 19, 2004. <http://www.hhs.gov/news/press/2004pres/20040219.html>

In addition, Secretary Thompson sent a six-page document responding to sixteen questions about charges for the uninsured. The letter and the Q & A document were released to the public and posted on the government's website.¹³ Secretary Thompson's letter confirms that Medicare rules allow individual hospitals to set their own policies for determining who is indigent and who is "medically indigent" (underinsured). Medicare's guidelines require the hospitals to establish a system for determining indigence that meets these four criteria:

- (1) the provider determines that the patient is medically indigent;
- (2) the provider takes into account the patient's total resources (including assets – but only those that are convertible to cash and unnecessary for daily living), liabilities, income, and expenses;
- (3) the provider determines that there is no other source besides the patient that is legally responsible for the bills; and
- (4) the provider keeps a file documenting how indigence was determined and copies of information used to determine the individual patient's indigence.¹⁴

The Medicare Manual states that after this process is concluded, an uninsured person's "*debt may be deemed uncollectible*" and the hospital is not required to pursue an indigent patient in any attempt to collect the debt.

These long standing guidelines in the Medicare Manual and the additional detailed guidelines from Secretary Thompson mean that New York State need not worry that hospitals will receive less funding from Medicare if state law establishes protections for uninsured and underinsured patients who might otherwise face exorbitant hospital bills and/or onerous hospital debt collection activities.

Hospitals' response

- *Hospital trade associations issue voluntary guidelines*
- *Hospitals oppose legislation setting criteria for financial aid and billing practices*
- *California survey illustrates the weakness of voluntary guidelines*
- *NYS Comptroller recommends uniform standards and procedures*

Amid ongoing negative publicity about hospital billing and collection practices in *The Wall Street Journal* and newspapers across the country, The American Hospital Association (AHA) issued a set of principles and guidelines for hospital billing and collection practices in December 2003.¹⁵ AHA asked its member hospitals to commit to these principles and guidelines, particularly in an effort to avoid federal legislation. The AHA website reported in mid-October 2004 that 3,900 hospitals nationwide have said

¹³ See US Department of Health and Human Services.2004. http://www.cms.hhs.gov/FAQ_Uninsured.pdf

¹⁴ Medicare Provider Reimbursement Manual Part I, Chapter 3, § 312.

¹⁵ Full text of the American Hospital Association's principles and guidelines is available at http://www.aha.org/aha/key_issues/bcp/content/guidelinesfinalweb.pdf

they are committed to following *AHA's Hospital Billing and Collection Practices: Statement of Principles and Guidelines*.

"If they get to 5,000, we won't have to legislate.' That was the comment from Representative Jim Greenwood (R-PA), chairman of the Energy & Commerce Committee's Subcommittee on Oversight and Investigations, at the June 24, [2004 Congressional] hearing into hospital billing and collection issues, when told that more than half of the nation's hospitals had signed the [American Hospital Association's] Confirmation of Commitment. Congress is paying attention! Have you signed and returned yours?"¹⁶

The AHA guidelines are very broad statements that recommend hospitals establish a financial aid policy and tell patients about it. The guidelines also address patients' responsibilities to pay something toward their care, **but there are no guidelines addressing consumer protections**. For example, there is no guideline recommending that a hospital establish an appeals process for a patient to use if they cannot pay the hospital's discount rate or extended payment plan. Also there is NO guideline suggesting that hospitals limit certain collection practices for low-income patients; garnishing wages and placing liens on a primary residence are widely-used collection practices that are especially detrimental to those with low incomes.

In January 2004, the Healthcare Association of New York State (HANYS), the statewide hospital association, approved its own set of guidelines *Financial Aid/Charity Care Policy at New York's Not-for-Profit Hospitals*.¹⁷

HANYS released its guidelines to the public in February 2004. While the HANYS' recommendations are superior to those issued by the American Hospital Association (AHA), the guidelines still do not include sufficient consumer protections that recommend covering all services provided by a hospital and establishing an appeals process. The specific income guidelines are a welcome improvement over the AHA generalities. HANYS also recommends that financial aid apply to both uninsured and underinsured patients of modest means.

"It is never easy to undertake critical self-examination... [But] upon internal scrutiny, many member [hospitals] have found that their policies need updating." – Daniel Sisto, president of the Healthcare Association of New York

Times Herald-Record, Middletown, January 31, 2004

HANYS added several items not covered by AHA; the "Model Patient Notice of Financial Aid" is one example of HANYS' more specific recommendations to its member hospitals. It is commendable that the guidelines recommend posting signs "in key public areas" and giving patients notice about the availability of financial aid "in consumer-friendly terminology and in a language they can understand."¹⁸ Three of the

¹⁶ http://www.aha.org/aha/key_issues/bcp/index.html October 14, 2004.

¹⁷ See Healthcare Association of New York's website for the full text of the guidelines. <http://www.hanys.org/publications/upload/Financial-Aid-Charity-Care-Policy-at-New-York-s-Not-for-Profit-Hospitals-Guidelines-from-the-Healthcare-Association-of-New-York-State.pdf>

¹⁸ Ibid. p.4.

four paragraphs in the model notice are consumer-friendly. But the third paragraph in the model patient notice is an unnecessary threat:

“It is important that you let us know if you will have trouble paying your bill; federal and state laws require all hospitals to seek full payment of what they bill patients. This means we may turn unpaid bills over to a collections agency, which could affect your credit status.”¹⁹

Such a statement given to the patients in writing and/or posted on a sign just reinforces and escalates patient fears of incurring medical debt. Patients already know they will receive bills for hospital care. That fact makes many avoid getting needed care until a crisis forces them to go to the emergency room. This paragraph also violates the first principle in the HANYS guidelines: “Fear of a hospital bill should never get in the way of a New Yorker receiving essential health services. Hospitals should convey this message to prospective patients and local community service agencies.”²⁰

“When CEOs went back to their hospitals and saw what was really happening, they said there was room for improvement” -Monica Mahaffey, Healthcare Association of New York spokeswoman

*Times Union,
Albany, February 7, 2004*

HANYS Preamble to its guidelines claims that New York hospitals provide “almost \$2 billion a year in uncompensated care.”²¹ It is important to note that there is NO mention of federal and state governments’ provision of significant amounts of taxpayers’ dollars to hospitals every year to offset these costs. The federal government provides \$22 billion a year to hospitals nationwide and New York hospitals receive an additional \$847 million a year to cover the costs of bad debt and charity care. The

hospitals also fail to mention the dollar value of the significant tax exemptions they receive. These exemptions are taxpayer funding for hospitals to provide community benefits, like care for the uninsured and underinsured.

The HANYS guidelines are a step in the right direction even though the consumer protections they recommend are weak. Some, but not all, of New York’s 260 hospitals will adopt these voluntary guidelines and improve their financial aid policies and collection practices. But, HANYS has no enforcement power if a hospital fails to abide by its recommendations.

Health Access, a consumer coalition in California, recently reported on a survey of 40 California hospitals to evaluate whether or not the hospitals are complying with the voluntary guidelines issued in February 2004 by the California Healthcare Association (CHA), the California equivalent of HANYS. Health Access evaluated whether hospitals complied with the five elements in one section of the CHA guidelines on “Communications of Financial Assistance Policies with Patients and the Public.”

¹⁹ Ibid. p.7.

²⁰ Ibid. p.1

²¹ Ibid.

Key findings of the Health Access survey conducted more than six months after the voluntary guidelines were issued by CHA were:

- √ Only one of the 40 hospitals fully complied with all five elements in the CHA guidelines.
- √ Nearly half (19) of the hospitals had none of the signage recommended by the CHA guidelines.
- √ Only 4 hospitals had signs in the three recommended locations: the emergency room, the admitting/registration area, and the billing area.
- √ San Francisco has a local law requiring hospitals to inform patients about financial assistance; the 6 hospitals in San Francisco were the most likely to have signs posted and staff knowledgeable about the hospital's financial assistance program.²²

Not surprisingly, the survey illustrates the weaknesses of voluntary guidelines and the benefits of increased compliance if there is a law with specific requirements plus a monitoring/enforcement mechanism.

In a new report, NYS Comptroller Alan Hevesi notes that funding for indigent care is the largest expense in HCRA. The disbursements from the Indigent Care Pool have grown by 29% from \$767 million in 2001 to \$990 million in 2004.²³ Most (98%) of the funds are “off-budget,” meaning that the receipts and disbursements for indigent care are not included in the State’s Financial Plan. Therefore, the Comptroller does not have the opportunity to approve all disbursements the way he does for other state expenditures that are “on budget.”

The Comptroller does not have access to reports that document which hospitals have received money from the pool so he cannot report that information to legislative leaders or the public. A change in HCRA 2003 requires the private contractor that administers HCRA for the NYS Department of Health to provide the comptroller and legislative leaders with regular reports that summarize cash flow for the HCRA “off-budget” funds. Before that change in law, neither policymakers nor consumers had access to information about the HCRA pools. Now, the HCRA cash flow is part of the comptroller’s monthly report posted on his official website.

The Comptroller ends the report with this recommendation: “Despite the efforts of providers and federal regulators to ensure appropriate access to affordable health care, ***policymakers should consider proposals to raise awareness of the availability of indigent care funding for uninsured or underinsured patients and establish uniform standards and procedures for providing such assistance.***”²⁴ (emphasis added)

²² Anthony Wright and Beth Capell, Ph.D. 2004 “Give us a Sign.” Health Access Foundation, California. pp.8 and 12. <http://www.health-access.org/docs/HospitalOverchargingReport.doc>

²³ Alan G. Hevesi. 2004. *The Health Care Reform Act (HCRA)*. Office of the New York State Comptroller. Albany, NY. pp. 40-41. <http://www.osc.state.ny.us/reports/health/hcra102104.pdf>

²⁴ Ibid. p. 45

New York State funding for hospital charity care

- *Bad Debt and Charity Care funded by New York taxpayers*
- *Hospitals receive \$847 million a year for bad debt and charity care*
- *No requirements for hospitals to provide financial assistance*

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. 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 about twenty years ago 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 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 rate setting, 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) Pools²⁵, 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..."²⁶ Hospital reporting requirements to the state Department of Health and complex funding formulas for public goods remained prominent features of the new deregulated rate setting 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.

²⁵ NYS Public Health Law § 2807-k and § 2807-w.

²⁶ 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 179 hospitals in New York State.²⁷ 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 Pool²⁸ plus \$82 million from the HCRA High Need Indigent Care Adjustment Pool²⁹. 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.)”³⁰ Non-profit 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...”³¹
- Provide prenatal care for needy patients if they have obstetrical services.
- 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.³²

Interestingly enough, there is no obligation for hospitals to provide free care or reduced cost care for those who are indigent.

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.³³ This statutory prohibition is problematic for individuals and legal advocates who try to get hospitals to reduce the amount of debt owed by an individual indigent/low-income patient. 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,

²⁷ 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.

²⁸ Hevesi, Alan G. 2003. *The Health Care Reform Act*. Albany, NY: New York State, Office of the State Comptroller. p.14.

²⁹ NYS Public Health Law § 2807-w

³⁰ Community Catalyst. 2000. “*Fact Sheet: New York State Requirements Relating to Community Benefits and Free Care*.” Boston, MA.

³¹ NY Pub. Health § 2807-k(9).

³² Community Catalyst. Op. cit.

³³ NY Pub. Health § 2807-k(14).

religion, sex, national origin, disability, sexual orientation or source of payment.”³⁴ 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...”³⁵ 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, bills to uninsured patients, 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.

Other activities in New York State

- *Change in law makes it easier to collect old hospital debt*
- *Legislation introduced to establish statewide criteria for hospital financial assistance*

On June 11, 2004, the *Wall Street Journal* reported on several cases where New York hospitals are dunning low-income patients for hospital bills that are more than a decade old. According to the report, a 1999 change in the law made it easier for collection agencies to track down the bank accounts of patients who have outstanding court judgments for hospital debt. The debt collection firms formerly had to search for one patient at a time at a local branch of each bank. Now the firms can send one request with a long list of names to each bank asking if any former patients with unpaid court judgments have an account at the bank. If there are any matches, the bank uses the old court judgment to freeze funds in the patient’s account. The amount frozen is equal to twice the amount of the judgment. For low and modest-income patients, this can be a personal disaster; they can’t get money from their account to pay for food, rent, medicines, and other necessities of life.³⁶

In November 2003, NYS Assembly Insurance Committee Chairman Alexander “Pete” Grannis introduced a legislative proposal to require hospitals to meet certain standards regarding their billing, collection, and financial assistance practices for low-income uninsured and underinsured patients. In March 2004, Mr. Grannis amended his proposal to require hospitals to meet specific standards in order to apply for funding from the NYS BDCC pool. In addition, he secured the support of 30 other members of the Assembly who signed on as co-sponsors of his proposal.³⁷ This marks the first time that legislation has been introduced to direct BDCC funds to the neediest New Yorkers and to require hospitals to be transparent and accountable for how they use \$847 million a year of taxpayer funding.

³⁴ NYS Department of Health. http://www.health.state.ny.us/nysdoh/hospital/patient_rights/en/patients.htm

³⁵ <http://www.ci.nyc.ny.us/html/hhc/home.html>

³⁶ Lagnado, Lucette. 2004. *Wall Street Journal*. June 8, 2004.

³⁷ Assemblyman Grannis introduced A 9217, A9218, and A9219 in the NYS Assembly in the 2003-2004 Legislative Session.

Hospital Financial Aid Survey Methodology

- *On-site surveys*
- *Information gathered to answer 5 questions*

Public Policy and Education Fund (PPEF) staff conducted on-site surveys of the eight hospitals in Albany, Renssalaer, Saratoga, and Schenectady counties. We used the same survey form to collect data as was used for a PPEF phone survey of hospitals in 2002-2003.³⁸

The surveyor used this introductory script:

I am a college student doing a course study that benefits the Public Policy and Education Fund. The agency encounters many people who are uninsured, of limited means, and have pressing health problems. I am helping the agency compile a consumer guide of hospitals with charity or free care. I'd like to get information about your hospital's charity care policy.

Although one visit was planned to each hospital, two hospitals were visited twice because they said they did not have information about their financial assistance programs on the first visit, but could supply information the next week. When information was not available on the second visit, PPEF staff asked for the phone number of someone else to call who could provide information. Both hospitals provided this information, but only one responded to the call.

The surveyor started each on-site visit at the hospital's main information desk. If no information was available, the surveyor asked to be referred to someone else in the hospital. If the hospital had a Financial Counselor's Office somewhere within the building, the surveyor went there. In addition, the surveyor looked for signs in the general waiting area, the ambulatory surgery waiting area, the emergency room, and some clinics. In each of these locations, except the emergency room, the surveyor also spoke to one or more hospital staff members in an effort to get answers to the nine questions on the survey and ask for a copy of any documents related to the hospital's financial aid policy.

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

1. Does the hospital have a financial aid policy available to the public?
2. Does the financial aid policy cover in-patient and outpatient services?
3. Does the hospital delay billing uninsured, indigent patients until after the hospital has processed an application for its financial aid program?
4. What is the deadline for applying for the hospital's financial aid program?

³⁸ Public Policy and Education Fund of New York. 2003. *Hospital Free Care - Can New Yorkers Access Hospital Services Paid for by Our Tax Dollars?* Albany, NY. p. 13.
http://www.citizenactionny.org/reports/Hospital_Free_Care_Report_Final.pdf

5. Does the hospital supply translators for those patients who do not speak English (a requirement of federal law)?³⁹

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

- *Pass/Fail grade for five categories*
- *Final grade, A to F, based on total number of passing grades*

One surveyor collected data by visiting eight not-for-profit hospitals during the late spring and summer of 2004. The grading scale developed for PPEF's 2002-2003 phone survey of seventy hospitals was used again for this survey. A pass/fail grade was determined 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 financial aid 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 least some of the 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 financial aid 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.
- To earn a passing grade in the fifth category, a hospital had to state that it would accept applications for financial aid up to three (3) months after services were provided.

The individual hospital grades for each of the five categories, the final grade, and the amount of the estimated 2004 Indigent Care Pool distributions authorized by New York's Health Care Reform Act (HCRA) are combined in a report card on page 19. The 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.

³⁹ 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.

Findings

- *Consumers still likely to have difficulty getting financial assistance*
- *St. Peter's best with a "B" and covering the most services*
- *St. Clare's and St. Mary's receive an "F"*
- *Services covered vary from hospital to hospital*
- *Albany Medical Center covers fewest services*

Surveyor experiences

The surveyor reported that the hardest part of conducting the survey was trying to find someone to talk to who could provide information about the hospital's financial aid policy. There were few signs or brochures in the main patient waiting areas to inform patients about where or how to apply for financial assistance. After visiting a few hospitals, the surveyor learned which locations in the hospital were more likely to have someone who could provide verbal or written information.

It took a variety of explanations and the use of different terminology for hospital employees to recognize what type of information the surveyor was seeking. Some of the terms that hospital staff was more likely to recognize were: charity care; uncompensated care; financial assistance; and financial aid for uninsured patients. Time and persistence were needed to walk around a hospital looking for someone who could provide the desired information.

Income eligibility for financial aid

All seven hospitals that provided information require most patients to apply for government insurance programs like Medicaid and prove that they are ineligible before they can be considered for the hospital's financial aid program. Only three hospitals indicated that they would use their discretion in determining that some patients might not be required to apply for Medicaid first (Albany Medical Center, Albany Memorial and Samaritan Hospitals). All hospitals required applicants to provide information about their assets, like bank accounts and property.

Four of the five hospitals that provided their income guidelines set the eligibility level at 200% of the Federal Poverty Level (FPL) as recommended by HANYS. In 2004, individuals with incomes below \$18,620 and families of 4 with incomes below \$37,700 would qualify for the 200% FPL. One hospital varied its income eligibility levels from 130% to 300% of FPL. The other three hospitals did not provide information on income eligibility.

Services covered

St. Peter's financial aid program covers the most comprehensive set of services. It was the only hospital to provide consumers with information about obtaining prescription

drug coverage and dental services. Saratoga Hospital's program covered its nursing home in addition to its hospital services, but it was the only hospital to set annual limits on the number of services covered. Individuals could have 2 approvals a year and a family could have a total of 5 approvals a year.

The Albany Medical Center's program covered the most limited range of services, only "emergent care;" that is, care provided in the emergency room or inpatient care for a patient admitted through the emergency room. There is no financial assistance for transplants, orthopedic implants, and obstetrics except related to an emergency room service.

Six hospitals indicated that financial assistance programs covered "medically necessary" care billed by the hospital. No hospital covered the cost of physician and other services that are billed separately from the hospital bill even if the services were provided in the hospital.

Billing practices

One hospital, St. Peter's, advises patients to apply for its financial aid program before seeking services. Once approved, patients are to enroll in one of the ambulatory care sites where they can use the financial aid approval letter and will not be billed. One hospital, St. Clare's, requires the patient to receive a bill before submitting an application for financial assistance. Once care was provided, no hospital indicated it would delay billing until a patient's application for financial aid had been processed.

Five of the eight hospitals discount up to 100% of the patient's bill based on ability to pay. Two more require every patient to pay something monthly and discount up to 90% of the patient's bill. Six hospitals offer sliding fee scales. Only two hospitals, Ellis and Albany Medical Center, offer a discounted rate for those patients who do not qualify for a 100% discount. Ellis offers a 50% discount to anyone who pays the entire amount they owe within 45 days; this discount applies to patients paying on a sliding scale as well as those self-pay patients who do not qualify for any financial assistance. Albany Medical Center charges patients its Medicaid rate if a patient does not qualify for a 100% discount.

St. Peter's, Samaritan, and Albany Memorial hospitals indicated that their approval for financial assistance covered 6 months of service before patients had to reapply. These same hospitals would cover bills for services rendered up to 3 or 4 months before the patient applied for financial assistance. Other hospitals did not provide information or did not know if they had an application deadline.

Translation services

Four hospitals reported that they had translators on staff or could make an appointment for a translator to be present for an interview with a patient. The other four hospitals said that they used a phone translation service or had no translation available. Since

2000, federal standards issued by the U. S. 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.⁴⁰

Charity care applications and other hospital documents

All hospitals, except St. Mary’s in Rensselaer County, provided some type of document about their financial assistance program. Two of the hospitals, St. Peter’s and Saratoga, had consumer-friendly brochures to explain their financial aid programs. Ellis and Samaritan hospitals used a one-page flyer for consumers that explained where and how to get more information on financial aid. Albany Medical Center’s policy said that its bills included information on how to apply for financial assistance, but this was not verified. Several hospitals indicated they offered on-site assistance to help patients apply for public insurance programs like Medicaid, Family Health Plus, and Child Health Plus.

Only one hospital, St. Peter’s in Albany, included easy-to-understand financial eligibility criteria as part of the application materials given to consumers. It is also very easy to find the patient brochure and application form on St Peter’s website since “Charity Care” is a link on its home page. Another hospital did include financial eligibility criteria in its consumer brochure, but few if any patients would know whether they qualify for “twice the Federal Poverty Level.”

Patients at four hospitals could get a copy of the financial aid application without any other information. When asked, three of these hospitals provided PPEF with additional information that included financial eligibility criteria. Three hospital websites had minimal information but did at least provide a paragraph on how to get more information about financial assistance.

Criterion	Number of Hospitals
Provided written information about financial assistance	7 of 8
Provided copy of application and income eligibility	5 of 8
Provided copy of application and verbal information about income eligibility	0 of 8
Provided copy of application without income eligibility	2 of 8
Easy to find information about financial assistance on the hospital’s website	1 of 8
Said they had no charity care program	0
No response/no information	1

⁴⁰ See www.OMHRC.gov/CLAS.

Summary of Grades

Survey information was collected and compiled for eight hospitals in Albany, Rensselaer, Saratoga, and Schenectady counties. The final grades for the eight hospitals were: one “B,” two “C,” three “D,” and two received an “F.”

Criterion	Number of Hospitals
No. with passing grade for public charity care policy with income guidelines	5 of 8
No. with passing grade for translators	4 of 8
No. with passing grade for charity care policy that covers in-patient & out-patient care	4 of 8
No. with passing grade for holding bills until charity care application processed	0
No. with passing grade for allowing up to 3 months to apply for charity care	3 of 8
Received final grade of “A”	0
Received final grade of “B”	1 of 8
Received final grade of “C”	2 of 8
Received final grade of “D”	3 of 8
Received final grade of “F”	2 of 8

Geographical area served

St. Peter’s Hospital and Albany Medical Center limited their program primarily to patients residing in selected counties. Both hospitals did include an option for individuals outside their primary service area to apply for financial assistance if the service they needed was not provided where they lived. None of the other hospitals mentioned their service area.

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 recognized \$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.⁴¹ 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 8 hospitals in this survey received funds from the NYS Indigent Care and High Need Indigent Care Adjustment Pools in 2003. A total of \$9,591,704 was paid to the 8 hospitals in this survey

⁴¹ 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 Capital District Hospitals: Financial Aid 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 county	Income guidelines & policy available to the public ⁴²	Trans- lators on site ⁴³	Covers in- patient and out- patient care ⁴⁴	Holds bills until appli- cation pro- cessed ⁴⁵	Time limit to apply ⁴⁶	Final Grade	Amount Received from indigent care pool ⁴⁷		
ALBANY									
Albany Medical Center	P	P	F	F	F	D	\$ 3,621,961		
Albany Memorial ^a (part of Northeast Health)	P	F	P	F	P	C	\$429,797		
St. Peter's Hospital	P	P	P	F ^b	P	B	\$ 1,418,817		
SARATOGA									
Saratoga Hospital	P	P	F ^c	F	F	D	\$556,327		
SCHENECTADY									
Ellis Hospital	F	P	P	F	F	D	\$1,229,254		
St. Clare's Hospital	F	F	F	F	F	F	\$811,877		
RENSSELAER									
Samaritan Hospital ^d (part of Northeast Health)	P	F	P	F	P	C	\$682,556		
St. Mary's Hospital ^e (part of Seton Health)	F	F	F	F	F	F	\$841,115		

^a Application available on-site; rest of information obtained by calling corporate headquarters.

^b Can apply for financial aid before seeking care; no bill sent if approval letter is provided when seeking services.

^c Covers only 2 approvals per year for an individual and 5 per year for a family, includes nursing home bills.

^d Information obtained after second visit and a phone call.

^e No information provided despite 2 on-site visits and a phone call to collections manager.

42 "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.

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

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

45 "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.

46 "Pass" for this category means that the hospital will accept applications for financial aid up to three (3) months after services were provided.

47 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."

Discussion and Recommendations

- *Patients will have difficulty getting information at 7 of the 8 hospitals*
- *Massachusetts law requires hospitals to tell patients about financial aid*
- *No public accountability for \$847 million of taxpayers' funds*
- *Best Practice Policy Recommendations*
- *Make NYS's system more humane*

Although New York annually spends \$847 million of taxpayer dollars compensating hospitals for bills that patients do not pay, the law does not require hospitals to have an explicit financial aid policy. The law does require annual reporting to the NYS Department of Health 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 unpaid 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 or underinsured.

This survey provided evidence that at least one hospital, St. Peter's, in the Capital Region is making it easier for patients to find out about financial assistance. St. Peter's uses multiple ways to notify patients and community advocates about the availability of financial assistance:

- Signs in public areas to notify patients where to seek assistance,
- A consumer-friendly brochure and application form with easy-to-understand financial eligibility levels,
- Clear list of what services are covered and which are not,
- Staff in different locations knew about the availability of financial aid,
- Staff could refer the surveyor to the correct person in the hospital who could assist a patient with applying for assistance, and
- All relevant information, including the application, was easy to find on its website.

It would be much harder for consumers to get information about financial assistance in the other seven hospitals in this survey. Since there were few or no signs, it took perseverance on the part of the trained surveyor to keep walking around each hospital asking various staff for information until she found someone who could help. Staff in a couple of hospitals referred her to individuals who specialize in assisting patients to enroll in public health insurance programs, but the enrollers had no idea whether the hospital had a financial assistance program for those who did not qualify for the insurance programs.

In contrast, 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 financial aid.

The difference between hospitals in New York and Massachusetts is not a matter of good will, but of law. Massachusetts's law and regulation provides detailed guidelines, including income criteria, for providing free and reduced cost-care to uninsured and underinsured patients who are unable to afford hospital care. The regulations require Massachusetts hospitals and community health centers to use standard application information and eligibility criteria, screen patients and assist them with applying for government programs if they qualify, and provide full and partial free care for those without the resources to pay for 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. In 2002, the New York State Health Care Campaign (NYSHCC), 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.⁴⁸

In 2003, PPEF, in consultation with the Health Law Unit of the Legal Aid Society based in New York City, developed a checklist of "best practices" consistent with NYSHCC's recommendations. PPEF provided the "best practice" list to HANYS before it issued its voluntary guidelines in 2004. Some of the individual best practices are based on financial aid and charity care reporting requirements in the laws or regulations of other states. Some best practices are based on a Nassau County law and some are based on the financial assistance programs of individual hospitals in New York and across the country. See Appendix C for a chart comparing HANYS recommendations to the PPEF best practice recommendations.

State policy should require hospitals to adopt these best practices before receiving any funds from the NYS Bad Debt and Charity Care pool. This would make it easier for consumers to learn about the availability of financial aid and level the playing field among hospitals since they would all have to follow the same rules. The best practice policy recommendations listed below address four areas: charity care policy; notice to patients and community; billing and collection policies; and quality improvement and public information.

⁴⁸ Public Policy and Education Fund of New York. Op. cit. pp. 26-27.

Best Practice Policy Recommendations

Charity Care Policy

- Establish a charity care⁴⁹ and financial assistance policy that takes into account income, family size, and resources.
- 100% reduction in charge for patients up to 200% Federal Poverty Level. (Massachusetts standard).
- Sliding scale for patients up to 400% Federal Poverty Level. (Massachusetts standard).
- Patients have at least 3 months after receiving service to apply for charity care.
- Specify that approval of charity care application is good for a year for any service delivered by the hospital system, unless patient's financial situation changes.
- Use simple, standard, language-appropriate application – one page is best.
- Include all services provided in the hospital, including in-patient care, outpatient services, prescriptions, lab tests, emergency care, radiology and physician.
- Patients who cannot pay deductibles and co-pays should be eligible for charity care
- Verification of income should be limited to one of the following: two most recent pay stubs, current year's IRS tax return, Social Security and pension income, unemployment benefits or sworn declaration of income (used in Medicaid).

Notice to patients and the community

- Every bill issued by the hospital should include notices that meet language and literacy concerns about the availability of charity care, eligibility guidelines, and information about how to apply.
- Notify people that charity care and financial assistance is available during the admitting process.
- Post language-appropriate information about the availability of charity care in emergency rooms, registration areas, waiting rooms, billing offices, etc. of every facility that is associated with the hospital.
- Do outreach to inform people in low and moderate income communities about the availability of charity care
 - Distribute easy-to-understand materials
 - Provide language-appropriate information

⁴⁹ "Charity care" is used in this checklist to include any financial aid program for patients who need assistance paying hospital bills, such as free care programs, sliding fee scale programs, discount programs, and extended payment plans.

- Write notice in language that avoids using terminology like “charity care” because it could discourage patients from applying.
- Train a wide-range of front-line billing, clerical, social services, clinical, and collection agency staff who have contact with patients about how to explain, distribute, and implement the hospital’s charity care policy.
- Put information about the availability of charity care, eligibility criteria, sliding fee scale, and how to apply on the homepage of the hospital’s website and any other web pages that talk about patient billing.

Billing and Collection Practices

- All self-pay patients should be screened for eligibility for public insurance programs and charity care program.
- Guarantee that patients will not be billed until after a final determination of eligibility under the charity care policy has been made.
- Bills to self-pay/uninsured patients whose gross income is at or below 400% of the poverty line should be based on the lowest rate charged for services.
- Establish an appeal process for applicants to use if they are denied charity care; provide language-appropriate information on how to file an appeal.
- If an assets test is used, the following resources should NOT be considered assets when determining eligibility for charity care: primary residence; retirement savings accounts; college savings accounts; car(s) used regularly by patient or family members; any items used by patient or family members as part of job or business activity.
- Patients who are screened for Medicaid, Family Health Plus, and Child Health Plus and determined ineligible should not be forced to receive a formal Medicaid denial in order to apply for charity care.
- Send written information about the charity care program to all self-pay patients; mark the outside of the envelope with “This is Not a Bill.”
- Before sending patient to a collection agency, call them to be sure they know about the charity care program.
- Individualize payment plans based on ability to pay, existing debt load, and anticipated need for on-going health care services; limit interest on payment plan to the lesser of 5% per year or the Consumer Price Index.
- Do not pursue collection or legal actions for non-payment of bills against patients or their family members who have clearly demonstrated that they lack sufficient income or assets to meet their financial obligations.
- The hospital’s governing board will approve every wage garnishment, foreclosure, and property lien collection action.

- No lien will be placed on a patient's primary residence without approval of the hospital's board of directors.
- Assure that any external collection agency contracted to obtain payment from patients will provide information about how to apply for the charity care program.

Quality Improvement and Public Information

- Conduct self-monitoring to determine staff's ability to consistently implement charity care policy.
 - Send "test patients" through intake process.
 - Make "blind" telephone calls to hospital departments asking for assistance.
 - Send "test patients" through collection process.
- Include the following in the hospital's annual report:
 - Copy of the hospital's charity care policy, including eligibility criteria and sliding scale.
 - The number of uninsured and underinsured people by zip code, the hospital has served, the number denied charity care, plus the number transferred to other facilities.
 - The total amount of HCRA reimbursements the hospital received for indigent care (in addition to current requirements to report the amount of charity care provided.)
- The hospital's governing board will annually:
 - Review the data about the number of uninsured and underinsured who were treated, the number not approved for charity care, the number refused service or referred to other providers.
 - Review the number of collection actions that included foreclosures, property liens, and/or wage garnishments.

NYS Assemblyman Grannis has introduced legislative proposals that embody most of the best practice policy recommendations. If enacted into law, these policy recommendations would make the indigent care system in New York State more humane and more accountable.

Conclusion

Based on this survey, uninsured and underinsured patients at seven of the eight non-profit hospitals in this survey would find it difficult to determine if financial aid is available and how to apply for it. The eight hospitals received a total of nine-and-a-half million dollars in 2003 from the HCRA Indigent Care and High Need Indigent Care Adjustment

Pools, but none mentioned that this financial assistance was available to help offset the hospital's cost of providing care to the uninsured and underinsured.

The Healthcare Association of New York State (HANYs), the statewide hospital association, encouraged its member hospitals to follow financial aid guidelines approved by the HANYs board January 2004. The HANYs guidelines are a step in the right direction, but they fail to recommend sufficient consumer protections and there is no enforcement power if a hospital fails to abide by the recommendations.

None of the hospitals met the Massachusetts standard where all hospital bills prominently inform the patient of the availability of free care and specific income guidelines are sometimes listed on the bill. Massachusetts's hospitals prominently display signs throughout the emergency room and patient care area to inform patients about the availability of financial aid.

The difference between hospitals in New York and Massachusetts is not a matter of good will, but of law. Massachusetts's law and regulations provide detailed guidelines, including income criteria, for providing free and reduced cost-care to uninsured and underinsured patients who are unable to afford hospital care. The regulations require Massachusetts hospitals and community health centers to use standard application information and eligibility criteria, screen patients and assist them with applying for government programs if they qualify, and provide full and partial free care for those with limited resources. See Appendices A and B for examples of billing forms from Massachusetts hospitals with information about free and reduced cost care.

NYS Comptroller Alan Hevesi notes in a recent report that funding for indigent care is the largest expense in HCRA, almost a billion dollars a year. Although hospitals report charity care separately from bad debt, there is no basis for determining whether they provide care to the neediest patients. Hospitals do not report how many uninsured and underinsured individuals they treated using the funds from the indigent care pools. The Comptroller recommends putting the indigent care funds into the regular state budget so this large fund will be subject to the same scrutiny and safeguards as other state disbursements and recommends that policymakers establish uniform standards and procedures for providing assistance to those in need.

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 fear of accumulating enormous debt or incurring bankruptcy. New York State needs to follow the path of the states that set clear statewide eligibility standards, application process, and sensible billing practices.

NYS Assemblyman Alexander "Pete" Grannis has introduced legislation that would put New York State on the path to follow other states. His proposals set statewide eligibility standards and application process so the uninsured know how to get health care when they need it. If enacted into law, these legislative proposals would make the Bad Debt and Charity Care system in New York State more humane and more accountable.

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

PLEASE CONTACT US IF YOU WOULD LIKE MORE INFORMATION.

SI USTED QUIERE MAS INFORMACION POR FAVOR COMUNICARSE CON NUESTRA

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

BI.STMT.006 (4/03)

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

<p align="center">Guidelines from the Healthcare Association of New York State (HANYS)</p>	<p align="center">Comparison to “best consumer practices” recommended by Public Policy and Education Fund of New York</p>
<p>Preamble</p> <ul style="list-style-type: none"> Hospitals provide “almost \$2 billion a year in uncompensated care.” “Hospitals are committed to treating all patients with compassion, from the bedside to the billing office.” All patients are expected to contribute to the cost of their care based on their ability to pay. Committed to advocate expanded “health care coverage for all New Yorkers.” 	<p><u>Good:</u></p> <ul style="list-style-type: none"> Principles clearly state that hospitals are committed to serving people regardless of insurance status. Supportive of expanding health care coverage to all. <p><u>Bad:</u></p> <ul style="list-style-type: none"> Fails to mention that hospitals get almost \$1 billion annually from the Indigent Care Pools funded by taxes. The guidelines are <i>recommendations</i> to member hospitals; there is <u>no legal requirement</u> and <u>no penalty</u> if a hospital fails to adopt and follow the guidelines.
<p>Eligibility for Financial Aid recommendations:</p> <ul style="list-style-type: none"> Plainly state eligibility criteria for obtaining assistance. Provide assistance to those under 200% of the federal poverty level; hospitals “may consider” providing assistance to those at higher income levels. Define what “essential services” are covered. Define any limitations in service area. 	<p><u>Good:</u></p> <ul style="list-style-type: none"> States clear income eligibility level for assistance, but would be better if there were recommendation to provide free care at the lowest income level. <p><u>Bad:</u></p> <ul style="list-style-type: none"> Fails to define “essential services” as medically necessary emergency, inpatient, and outpatient care. Fails to recommend providing financial assistance on a sliding scale up to 400% of federal poverty level. Fails to recommend that emergency care be covered regardless of the hospital’s service area restrictions.
<p>Discount/Payment Policy recommendations:</p> <ul style="list-style-type: none"> Payment discounts should reflect the mission and values of the hospital. “Determine sliding scale discounts...based on what low-income patients can afford to pay.” Clearly state any required minimum payment. Include extended payment options. 	<p><u>Good:</u></p> <ul style="list-style-type: none"> Sliding fee scales. Extended payment plans. <p><u>Bad:</u></p> <ul style="list-style-type: none"> Fails to recommend the lowest rate charged to an insured pt. Fails to recommend that low-income individuals should be exempt from any required minimum payment. Fails to recommend a limit on nominal charge (e.g. \$0 to \$200) for low-income uninsured.

<p align="center">Guidelines from the Healthcare Association of New York State (HANYS)</p>	<p align="center">Comparison to “best consumer practices” recommended by Public Policy and Education Fund of New York</p>
<p>Communicating the Availability of Financial Aid recommendations:</p> <ul style="list-style-type: none"> • Write information in “consumer-friendly terminology” and language patient can understand. • Include information in hospital bills. • Post information in key public places. • Educate patients about their responsibilities. • Refer to a facilitated enroller for NYS insurance programs. 	<p><u>Good:</u></p> <ul style="list-style-type: none"> • Paragraphs 2 & 4 of the “Model Patient Notice” are clear, easy to understand, and include the name and phone number of the person to call for more information. • Posting information in public places as well as providing in writing. • Does not use the words “charity care” in notice to public. <p><u>Bad:</u></p> <ul style="list-style-type: none"> • Paragraph 3 of the “Model Patient Notice” includes intimidating, and inaccurate, language about federal and state laws requiring “all hospitals to seek full payment” from patients. • Fails to recommend putting information about the availability of financial aid <u>ON</u> the bill, something Massachusetts has required for more than a decade.
<p>Recommendations for Educating and Training Staff to Meet the Expectations of the Hospital:</p> <ul style="list-style-type: none"> • Train staff that interacts with patients to explain the availability of financial aid and how to direct patients to financial aid staff. • Applicants should be treated with “courtesy, confidentiality, and cultural sensitivity.” • Translation should be available as necessary. 	<p><u>Good:</u></p> <ul style="list-style-type: none"> • Training a wide range of front-line staff. • Courteous and sensitive treatment of applicants. • Translation services. <p><u>Bad:</u></p>
<p>Recommendations for Administering Financial Aid Policies Fairly, Respectfully, Consistently:</p> <ul style="list-style-type: none"> • “Promote appropriate access to care.” • “Documentation requirements should be easy to follow.” • Financial aid decisions should be made correctly and consistently. 	<p><u>Good:</u></p> <p><u>Bad:</u></p> <ul style="list-style-type: none"> • Fails to recommend simple one-page application. • Fails to recommend an appeal process, for example to the hospital’s CEO or board of trustees, if a financial aid application is rejected. • Fails to define timeframe for approving or denying application.

<p align="center">Guidelines from the Healthcare Association of New York State (HANYS)</p>	<p align="center">Comparison to “best consumer practices” recommended by Public Policy and Education Fund of New York³</p>
<p>Collections Policy recommendations:</p> <ul style="list-style-type: none"> • Establish reasonable payment plan with patient. • May take legal action if there is evidence the patient has the resources to pay hospital bill. • Do not foreclose on patient’s primary residence to pay for medical bill. • Do not use “body attachment” to make patient appear in court. • Review inpatient record to be certain financial aid was offered before any collection agency assignment. • Direct collection agency to follow these guidelines. 	<p><u>Good:</u></p> <ul style="list-style-type: none"> • <u>No</u> foreclosure on primary residence. • <u>No</u> “body attachment.” • Reviewing record before starting collection proceedings. • Requiring the hospital’s collection agency to follow the guidelines. <p><u>Bad:</u></p> <ul style="list-style-type: none"> • Fails to recommend refraining from billing until a decision has been made on a financial assistance application. • Fails to recommend giving patients at least 3 months after hospital discharge or receiving emergency/outpatient services to apply for financial assistance. • Fails to exclude putting lien on primary residence. • Fails to exclude other essential assets like cars used for transportation, retirement accounts, and children’s college savings accounts.
<p>Accountability/Advocacy recommendations:</p> <ul style="list-style-type: none"> • Hospital board should annually review financial aid policy and recommend changes. • Provide community service agencies with information about the availability of financial aid. • Work to “address the underlying problem that too many New Yorkers lack health insurance.” 	<p><u>Good:</u></p> <ul style="list-style-type: none"> • Annual hospital board review. • Provide information to community agencies. <p><u>Bad:</u></p> <ul style="list-style-type: none"> • Fails to recommend conducting self-monitoring to determine that staff consistently implements the financial aid policy. • Fails to recommend that a hospital receiving Indigent Care Pool funds annually provide a public report with the number of uninsured and underinsured people served, the number that applied for financial aid, and the number denied aid. • Fails to recommend that a hospital tell the public annually the total amount of Indigent Care Pool funds received for care to the uninsured.

Hospital Financial Aid – Can New Yorkers in the Capital District Access Hospital Services Paid for by Our Tax Dollars? was authored by E. Joyce Gould and edited by Richard Kirsch. Emily Charlap surveyed the hospitals.

© 2004 Public Policy and Education Fund of New York, 94 Central Avenue, Albany, New York 12206; 518-465-4600.

<http://www.citizenactionny.org/>.

Support for the Public Policy and Education Fund's research on health coverage issues comes from the Robert Sterling Clark Foundation.