

Hospital Financial Aid



**Do Voluntary Guidelines
Protect Utica's
Consumers and Taxpayers?**

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Public Policy and Education Fund of New York

Hospital Financial Aid

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Do Voluntary Guidelines Protect Utica's Consumers and Taxpayers?

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. According to a report from the National Institutes of Health, 18,000 Americans die prematurely each year due to the lack of health insurance.

High medical bills have severe impact on individual's finances. Medical debt is the second most frequent cause of personal bankruptcies. Hospital billing practices exacerbate the crisis. Hospitals bill uninsured patients at a "full charge" rate that is significantly higher than the rates hospitals bill insured patients, whether through private insurance or public insurance programs such as Medicare and Medicaid.

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 and health insurance. The legislation that governs the use of these funds, known as the Health Care Reform Act (HCRA); was renewed by Governor Pataki and the New York State Legislature as part of the State Budget passed in March 2005; it will need to be acted upon again in 2007. 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.

Hospital associations nationally and in New York 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, then 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 (HANYS), 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 guidelines are a step in the right direction, they fall far short of providing adequate consumer protections and, since they are voluntary – lacking the force of law or an enforcement mechanism - do not establish accountability for the use of public dollars. A new national report and regional reports in California, New York City, and Nassau County, NY illustrate the shortcomings of voluntary guidelines:

- ▶ Not all hospitals comply with voluntary guidelines.
- ▶ There is NO consistency in how hospitals define charity care.
- ▶ Consumers face a bewildering array of eligibility criteria and payment plans.
- ▶ Hospitals vary widely in how many people receive low cost or no cost care.
- ▶ Egregious billing and debt collection practices are likely to continue since there is no enforcement mechanism.
- ▶ Without legislation, there is no public accountability.

In contrast to voluntary guidelines, a law with specific requirements, backed up by monitoring/enforcement mechanisms, increases compliance and provides public accountability. Consumers in other states recognized this reality and pressured policy makers to pass laws. Two of New York's neighbors, Massachusetts and New Jersey, require hospitals to comply with statewide eligibility criteria, screening and application process, reporting requirements, and a payment mechanism for charity care.

NYS Comptroller Alan Hevesi noted in a 2004 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 have to report how many uninsured and underinsured individuals they treated using the funds from the indigent care pools. In March 2005, the Legislature and Governor implemented one of the Comptroller's recommendations by including the indigent care pools in the regular State Budget. In the future, these funds will be subject to the same scrutiny and safeguards as other State disbursements because they will be processed through the State Comptroller. In addition, the public will have access to more detailed information on the indigent care pools since they will be included in the monthly reports posted on the Comptroller's website.

In March 2005 the NYS Assembly passed three bills – by wide bi-partisan votes (only 10 or 11 negative votes out of 150 Assembly members) – on legislative proposals that would meet and exceed the Comptroller's recommendation to establish statewide standards. The package of three bills introduced by Assemblyman Alexander "Pete" Grannis would: (1) set statewide eligibility standards; (2) establish a statewide discounted rate for those with incomes under 200% of the federal poverty level; (3) standardize the application process; (4) define covered services; (5) forbid egregious billing and debt collection practices; (6) specify public disclosure on how taxpayers' funds were used; (7) require notices to the public about available financial aid; (8)

instruct hospitals to bill low to moderate-income uninsured patients at the discounted rate paid by other insurers; and (9) create an independent appeals process.

The Governor's 2005 HCRA proposal included some new procedural requirements for hospitals to qualify for funds from the HCRA indigent care pools, procedures that fall far short of the Comptroller's recommendations and the Assembly legislation. The NYS Senate has thus far ignored the Comptroller's 2004 recommendation to establish uniform standards and procedures for providing assistance to those in need.

The current report, *Hospital Financial Aid: Do Voluntary Guidelines Protect Utica's Consumers and Taxpayers?* focuses on comparing hospitals financial aid policy, billing, and collection practices against the statewide standards and consumer protections included in the Grannis legislative package. The report is based on a phone survey of two hospitals in Utica. The verbal responses and written information provided by each hospital were examined to determine a PASS/FAIL grade for each answer to the following twelve questions:

1. Does the hospital provide the public with information about its financial aid program?
2. Does the hospital assist patients with applying for public health insurance programs such as Medicaid, Family Health Plus, and Child Health Plus?
3. Does the hospital have a financial aid policy available to the public telling patients with income levels up to 200% of the federal poverty level (FPL) they can receive care at no or nominal cost? (Public insurance programs cover most New Yorkers with income up to 150% FPL.)
4. Does the hospital have a financial aid policy available to the public telling patients with income levels up to 400% FPL they can receive care on a sliding fee scale?
5. Does the hospital require a Medicaid denial letter even when the patient clearly does NOT qualify for Medicaid or other public insurance coverage?
6. Does the hospital cover at least 3 months of services when it approves a patient for financial assistance?
7. Does the hospital grant financial aid based solely on income levels? If there is an asset test, does it exclude the family's primary residence, family car, farm and equipment, savings for retirement and college?
8. Does the financial aid policy cover all medically necessary services billed by the hospital?
9. Does the hospital delay billing uninsured, indigent patients until after an application for financial aid has been processed?
10. Does the hospital provide patients with at least 90 days after discharge to apply for assistance?
11. Does the hospital print an easy-to-read notice about how to apply for financial aid on each bill sent to patients?

12. Does any financial aid or payment agreement include an accelerator cause requiring full payment immediately if the patient fails to make one payment?

Hospitals in Utica: Report Card on Financial Aid Programs			
Key: P = Pass F = Fail			
A = 11-12 Ps B = 9 -10 Ps C = 7- 8 Ps D = 5 - 6 Ps F = 0 - 4 Ps			
Category ↓	Hospital→	Faxton-St. Luke's	St. Elizabeth's
1. Provides info about financial aid to public		P	P
2. Helps patients apply for insurance programs		F	P
3. 100% discount up to 200% FPL		P	P
4. Sliding fee scale up to 400% FPL		P	F
5. Requires Medicaid denial <i>only if applicable</i>		F	P
6. Approval valid for 3 months or more		P	P
7. Eligibility based only on income, limited assets		F	P
8. NO accelerator clause demands full payment		P	P
9. Allows at least 90 days after service to apply		P	P
10. Covers all charges billed by hospital		P	P
11. Holds bill until application processed		F	F
12. Financial aid info is printed prominently on each bill		F	F
Final Grade		C	B
See pages 20 to 24 for more detailed explanation of this report card.			

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

- A – passed 11 -12 categories
- B – passed 9 -10 categories
- C – passed 7 - 8 categories
- D – passed 5 - 6 categories
- F – passed 0 - 4 categories

Findings: This survey provided evidence that hospitals in Utica have improved their charity care policies in the past two years. Both hospitals have established financial assistance programs that address many of the areas of concern, albeit the programs still fall short in some key areas. Both hospitals press patients for payment even while a financial assistance application is being considered and both fail to notify patients of the

availability of financial assistance on the hospital bill. In addition, policies and procedures vary between the hospitals.

St. Elizabeth's received the higher grade, a "B." St. Elizabeth's falls short because its income eligibility guidelines are too stringent, it continues to bill patients while considering an application for financial assistance and the patient bills do not include a notice that patients can apply for financial assistance.

Faxton-St. Luke's received a "C." Faxton-St. Luke's falls short because it starts by trying to get a payment from the patient, including asking the patient to get a loan to pay the hospital bill. The hospital also has a very restrictive asset test for eligibility, continues to bill patients while they are waiting for approval for financial assistance, and the hospital's bills do not include a notice informing patients they can apply for financial assistance.

The survey found:

- ✓ Hospital employees responsible for administering financial aid programs were willing to answer questions verbally and provided requested documents. The responsiveness at the two hospitals sharply contrasted with the difficulties surveyors experienced when conducting earlier surveys in 2002, 2003, and 2004.
- ✓ St. Elizabeth's has assigned staff to take the initiative in identifying uninsured patients and helping those who might qualify to apply for public health insurance programs like Medicaid, Family Health Plus, and others. The hospital does not require patients who clearly are not eligible to complete the arduous task of applying for and securing a rejection letter from Medicaid before they can be approved for hospital financial assistance.
- ✓ Faxton-St. Luke's requires a Medicaid denial, even if it is clear that the patient is not Medicaid eligible.
- ✓ Both hospitals provided documents about their financial assistance program. Neither have consumer-friendly brochures to notify patients that financial aid is available.
- ✓ St. Elizabeth's provides 100% discount for patients with incomes up to 150% FPL. For those between 151% and 200% FPL, a pre-set co-pay is due each time a service is provided
- ✓ Faxton-St. Luke's patients who have proven they cannot pay their bill receive a 100% discount if their gross income minus daily expenses leaves a balance below 200% FPL. This is more generous than hospitals that ignore expenses and base their discount on income only.
- ✓ Faxton-St. Luke's has a bad assets test that only protects the patient's residence, car, and life insurance, failing to protect assets such as college savings and retirement accounts. St. Elizabeth's does not have an assets test.
- ✓ Both hospitals indicated that financial assistance programs cover all "medically necessary" care billed by the hospital.

- ✓ Neither hospital holds off billing the patient while an application for financial assistance is being considered. Once an approval is given, both accept it for a year when the patient must reapply. Neither hospital requires patients who miss an agreed upon payment to immediately pay the bill in full, but St. Luke's will send it to collections.

In summary, neither of the hospitals meet the financial aid policy, billing and collection practices, and consumer protections included in the Grannis legislative package. Neither could pass the Massachusetts standard for eligibility. 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 requirements, including income criteria, for providing free and reduced-cost care. Hospitals and community health centers must: use standard application information and eligibility criteria, screen patients, assist qualified patients with applying for public health insurance programs, and provide full and partial free care to uninsured and underinsured patients who lack the resources to pay for health 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 fear of accumulating enormous debt or incurring bankruptcy.

Voluntary guidelines fail to provide public accountability and offer no consumer protections. The Senate and the Governor should work with the Assembly to agree on legislation establishing meaningful standards and consumer protections that would make the Bad Debt and Charity Care system in New York State more humane and more accountable.

Hospital Financial Aid

Do Voluntary Guidelines Protect Utica's Consumers and Taxpayers?

Introduction

- *Crisis: 1 of 3 New Yorkers under age 65 lack health insurance*
- *Uninsured rates higher for Latinos and African Americans*
- *Uninsured lack access to needed health care – more likely to die prematurely*
- *Medical debt - a leading cause of personal bankruptcy*
- *More people are underinsured – increases likelihood of medical debt and bankruptcy*
- *Hospital billing and collection practices negatively impact the un- & underinsured*

More than 5.6 million New Yorkers, 1 of 3 people under the age of 65, did not have health coverage for all or part of 2002-2003, according to a Families USA report. Most, 65%, went without health insurance for six months or longer. Census data revealed that 3 million New Yorkers lacked health insurance during all of 2002, but the Families USA expanded analysis of the Census data found that nearly twice as many were uninsured for at least a portion of 2002-2003.¹

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, 3 of 4 uninsured New Yorkers are workers and their families. While 60% earned less than twice the federal poverty level, or \$36,800 for a family of four in 2003, another 40%, or 2.4 million New Yorkers, with higher earnings lacked health insurance for some portion of 2002-2003.

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.

¹ Families USA. 2004. *One in Three, Non Elderly Americans without Health Insurance*. Washington, DC.

Uninsured lack access to needed health care – more likely to die prematurely

Many consumers and elected officials hold firmly to the belief that Americans without health insurance can get health care services when really needed. 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.²

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.”³ A 2004 study by the Center for Studying Health System Change reported that 20% of Americans with chronic conditions such as diabetes, asthma, depression, face difficulty in accessing health care because they cannot pay. Not filling a prescription, delay in going to health care providers, and doing 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.⁴

In May 2005, the Robert Wood Johnson Foundation released a new analysis of government data showing that almost half (45%) of uninsured adults below the age of 65 have at least one chronic illness. They are four times more likely to have unmet healthcare needs than those with insurance.⁵ According to the Center for Studying Health System Change, “Low-income, uninsured working-age adults with chronic conditions were most likely to have cost-related access problems, with nearly 60% reporting they could not afford all their prescriptions.”⁶

More people are UNDERinsured - increases likelihood of medical debt and bankruptcy

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

² Institute of Medicine. 2002. *Care Without Coverage – Too Little, Too Late*. Washington, DC: National Academy Press. pp 3-5.

³ Institute of Medicine. 2003. *A Shared Destiny: Community Effects of Uninsurance*. Washington, DC: National Academy Press. p.2.

⁴ Ha T. Tu. *Rising Health Costs, Medical Debt and Chronic Conditions*. 2004. Issue Brief No. 88, Center for Studying Health System Change. Washington, DC.

⁵ Robert Wood Johnson Foundation. 2005. *Uninsured Americans with Chronic Health Conditions: Key Findings from the National Health Interview Survey*. Press Release. Washington, D.C. May2, 2005.

⁶ Center for Studying Health System Change. 2005. *Prescription Drug Affordability Woes Grow for Americans Unmet Needs Increase for Privately Insured Working-Age People with Chronic Conditions*. News Release. May 18, 2005.

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%.⁷ Americans with private health insurance were most likely to be required to pay more for health care.⁸ **Two of five American adults had trouble paying medical bills in 2003.**⁹

The Access Project reports that medical debt can result in difficulty accessing health care, bad credit ratings, and bankruptcy.¹⁰ Medical debt affects those with and without insurance and is involved in about half of all personal bankruptcies each year “and certain groups—particularly women heads of households and the elderly—were even more likely to report health-related bankruptcy.”¹¹

Harvard University researchers' report confirmed earlier reports that about half of individual bankruptcy filings are due to medical debt. **But the 2005 study revealed a surprise: more than 3 of 4 individuals filing for bankruptcy due to medical debt had health insurance, even “Cadillac” coverage.** High co-payments, deductibles, exclusions from coverage, and other loopholes left many insured individuals liable for thousands of dollars in out-of-pocket costs. Others were too sick to work and lost their jobs and their health coverage. As a result, 2 of 3 went without some health care services; 1 of 3 experienced cut-off of electric, water, and phone services; and 1 of 5 did without food.¹²

Hospital billing and collection practices negatively impact the uninsured

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.

A 1999 change in New York State 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 previously 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

⁷ Families USA. 2004. *Health Care – Are you better off today than you were four years ago?* New York Fact Sheet. Washington, DC.

⁸ Ha. Op. cit.

⁹ The Commonwealth Fund. 2004. *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey.* New York.

¹⁰ The Access Project. 2003. *The Consequences of Medical Debt.* Boston, MA.

¹¹ 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

¹² David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler. 2005. “MarketWatch: Illness And Injury As Contributors To Bankruptcy.” *Health Affairs* Vol. 24. No.1 January/February 2005.

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.¹³ On June 11, 2004, the *Wall Street Journal* reported on several cases where New York hospitals' debt collectors are dunning low-income patients for hospital bills that are more than a decade old.

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.¹⁴ The stories highlighted the huge debts facing individuals and their experiences when hospitals turned them over to collection agencies.

Since 2000, consumer advocates in NYS have issued reports exposing the failure of hospitals statewide to establish financial aid policies.¹⁵ The findings in the various reports demonstrated that:

- Only self-payers, most of whom are low income, uninsured people are charged the highest rate, the "full charge" or "list price."
 - Individuals do not have the clout to negotiate a discount like other payers.
 - HMOs, Medicare, and Medicaid pay much lower, discounted rates.
 - The list price for hospital charges in NY State averages 87% more than cost. (*Wall Street Journal* 3/17/03) Before NYS stopped setting the payment rates for private insurers in 1997, hospitals charged only 30% more than cost.
- Many hospitals bill low-income uninsured patients instead of helping them to apply for existing public insurance programs such as Medicaid, Family Health Plus, Child Health Plus, and other programs.
- Some hospitals require uninsured patients to pre-pay as much as 50% or 100% of the charge before providing non-emergency services.
- Many hospitals do not reduce the amount owed by a patient, even though they have received partial payment from the NYS Indigent Care Pool funded by taxpayers through the Health Care Reform Act (HCRA).
- Some hospitals use aggressive collection practices:
 - Place and execute liens on a patient's residence.
 - Garnish patient's wages.

¹³ Lagnado, Lucette. 2004. *Wall Street Journal*. June 8, 2004.

¹⁴ 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.

¹⁵ See Long Island Health Access Monitoring Project's reports on its website www.lihamp.org; Legal Aid Society's reports on its website www.legal-aid.org; and previous reports by the Public Policy and Education Fund of New York on its website www.citizenactionny.org.

- Attach patient's bank account.
 - Sue patient for full charge plus interest.
 - Require patients, as a condition of a discounted or extended payment plan, to immediately pay the full amount due if they miss paying an installment. (This is called an acceleration clause.)
- Hospitals' collection agents charge 9-10% interest on an outstanding bill.
 - Many hospitals fail to inform patients of the existence of financial aid before turning them over for debt collection and some do not accept applications for a discount after collection proceedings start.

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*
- *Medicare does not require hospitals 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 elderly, disabled, and low-income people, 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, property, 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.¹⁶

Hospital associations nationally and in New York 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."¹⁷

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

¹⁶ See Public Policy and Education Fund of New York report 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

¹⁷ Medicare Provider Manual, Chapter 26, §2602.2(D).

“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 (AHA) 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, then Secretary of Health and Human Services Tommy G. Thompson sent a letter to the AHA president 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."¹⁸

In addition, former 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.¹⁹ 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;

¹⁸ US Department of Health and Human Services. News release February 19, 2004. <http://www.hhs.gov/news/press/2004pres/20040219.html>

¹⁹ See US Department of Health and Human Services.2004. http://www.cms.hhs.gov/FAQ_Uninsured.pdf

- (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.²⁰

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' and policy makers' responses

- *Hospital trade associations issue voluntary guidelines*
- *Hospitals oppose legislation establishing standards*
- *Cost of charitable care is not available to the public*
- *Reports document the weaknesses of voluntary guidelines*
- *NYS Comptroller recommends uniform standards and procedures*
- *NYS Assembly and Governor respond*

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 2003.²¹ AHA asked its member hospitals to commit to these principles and guidelines, particularly in an effort to avoid federal legislation.

"'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?"²²

The AHA website now reports that 4,200 hospitals nationwide have signed a commitment to follow *AHA's Hospital Billing and Collection Practices: Statement of*

²⁰ Medicare Provider Reimbursement Manual Part I, Chapter 3, § 312.

²¹ 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

²² http://www.aha.org/aha/key_issues/bcp/index.html October 14, 2004. (Note: This statement is no longer posted on the AHA webpage.)

Principles and Guidelines. In March 2005, seventy members of ACORN (Association of Community Organizations for Reform Now) organized a peaceful walk-in at the Washington, DC headquarters of the AHA asking for the list of hospitals that have signed.²³ The Access Project's (TAP) new report released on May 12, 2005 documented that the AHA had not made the list of hospitals available.²⁴ TAP, joined by ACORN members, also reported that hospitals across the country were unwilling to provide information about the availability of free or reduced cost care. Soon after, the AHA posted the list of hospitals on its website.²⁵

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 to protect consumers from egregious billing and collection practices.** For example, there are no recommended income eligibility criteria. There is no advice about establishing an appeals process for a patient to use if they cannot pay the hospital's discount rate or extended payment plan. No guideline suggests that hospitals should avoid garnishing wages and placing liens on the primary residence of low to moderate-income patients.

"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

AHA is a partner in a new initiative, the *PATIENT FRIENDLY BILLING*[®] Project led by the Healthcare Financial Management Association (HFMA). The website has several tools for hospitals to use in making their "financial communications to patients clear, concise, and correct."²⁶ One tool is a worksheet that hospitals can use to evaluate their own financial assistance policy and procedures.

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.*²⁷ HANYS released its guidelines to the public in February 2004. Although the HANYS' recommendations are superior to those issued by the AHA, the guidelines do not include sufficient consumer protections. There is no mention of an acceptable discount rate; no suggestion to cover all medically necessary services provided by a hospital; and no hint that it is wise to establish an

²³ Ralph Loos. 2004. "Billing Dispute – ACORN stages walk-in at AHA Headquarters." *Modern Healthcare*. March 14, 2005.

²⁴ Bill Lottero and Carol Pryor. 2005. *Voluntary Commitments: Have Hospitals that signed a Confirmation of Commitment to the American Hospital Association's Billing and Collections Guidelines Really Changed Their Ways?* The Access Project. Boston, MA.

²⁵ http://www.aha.org/aha/key_issues/bcp/content/cocweblis.pdf May 21, 2005.

²⁶ <http://www.patientfriendlybilling.org/> May 21, 2005.

²⁷ 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>

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.

The “Model Patient Notice of Financial Aid” is one example of HANYS’ recommendations that are more specific than the AHA guidelines. It is commendable that HANYS recommends 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.”²⁸ Three of the four paragraphs in the model notice are consumer-friendly; but the third paragraph 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.”²⁹

“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

Such a statement given to 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 seeking 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.”³⁰

Cost of charitable care is not available to the public

No standard requires hospitals to report the total dollar cost of the charitable care they provide. The Preamble to the HANYS guidelines claims that New York hospitals provide “almost \$2 billion a year in uncompensated care.”³¹ It fails to explain if the dollar calculation is based on the full charge rate or the lower, actual cost of care.

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 some of these costs. The federal government provides \$22 billion a year to hospitals nationwide and New York State provides about another billion a year to cover the costs of bad debt and charity care.

²⁸ Ibid. p.4.

²⁹ Ibid. p.7.

³⁰ Ibid. p.1

³¹ Ibid.

The hospitals also fail to mention the dollar value of the significant exemptions they receive for property, school, and sales tax. These exemptions are taxpayer funding for hospitals to provide community benefits. Under New York State and Federal laws, hospitals may and do include a wide array of activities under the headings “uncompensated care,” “charity care,” and/or “community benefits.” The various activities do, in fact, benefit the community but most hospitals fail to state clearly that care for those unable to pay is only a portion of the total dollar amount they report to the public. At least one hospital was more forthcoming; it reported that “care for the poor” in 2003 accounted for about a third, \$8 million, of its “nearly \$25 million in community benefits.” The other two-thirds, \$17 million, covered “under-reimbursement by Medicare and Medicaid, free lectures and health screenings in the community, and the value of volunteer labor.”³²

The Nassau County Department of Health reports that total charges for charity care provided by the 12 hospitals in the county in 2003 were \$68.5 million dollars. In contrast, ***the reported cost of that care was actually one-third lower***, \$45.3 million.³³ There was significant variation from hospital to hospital in the ratio of charges to cost: one hospital reported charges almost 3 times more than its cost and another reported charges only 8% higher than its costs. Even hospitals in the same health system reported very different cost to charge ratios.

Reports document the weaknesses of voluntary guidelines

Some, but not all, of New York’s more than 200 hospitals have or will adopt HANYS voluntary guidelines and improve their financial aid policies and collection practices. The guidelines are a step in the right direction, but they fall far short of providing accountability for the use of public dollars.

National and New York hospital associations oppose legislation since they expect the voluntary guidelines will produce positive change in hospitals’ behavior. But recent national, statewide, and regional reports in California, New York City, and Nassau County record the shortcomings of voluntary guidelines. Key findings include:

► ***Not all hospitals comply with voluntary guidelines.***

California - Health Access, a consumer coalition, surveyed 40 California hospitals to evaluate adherence to the 2004 voluntary guidelines issued by the California Healthcare Association (CHA), the California equivalent of HANYS. Only one of the 40 fully complied with all five elements in the CHA guidelines. Almost half of the hospitals had none of the signage recommended by CHA; only four had signs in all three recommended locations. In San Francisco where there is a local law requiring hospitals to

³² St. Peter’s Hospital. 2004. “Celebrating 135 Years of Caring.” Supplement to the *Times Union*. Albany, New York. November 1, 2004. p.21.

³³ Nassau County Department of Health. 2004. *Fiscal Year 2003 Nassau County Hospital Charity Care Report*. Nassau County, NY. October 2004. Table 2.
http://www.nassaucountyny.gov/official/resources/file/eb00094f5cd4681/CharityCareFY2003Report_10-25-04.pdf

inform patients about financial assistance, the six hospitals were the most likely to have signs posted and staff knowledgeable about the hospital's financial assistance program.³⁴

New York City – The Legal Aid Society surveyed 31 hospitals in all five boroughs to evaluate their implementation of the voluntary guidelines issued by HANYS. One fourth of the hospitals had no financial assistance program. Four of five hospitals failed to post signs about the availability of financial assistance. At more than half (55%) of the hospitals, surveyors had to contact upper management such as the Chief Financial Officer, legal or public relations staff to get any information about financial aid.³⁵

National - The Access Project surveyed 61 hospitals nationwide to determine if they complied with the AHA's voluntary guidelines advising hospitals to provide information about their charity care policies to patients and the public. Only 12 (25%) responded to surveyors after repeated phone calls asking for information about the hospital's financial assistance policy.³⁶

Nassau County, NY - In 2003, the county legislature passed Local Law 1-2003, the Charity Care Ordinance, requiring all twelve hospitals in the county to have a charity care policy and inform the community and patients about the availability of financial assistance. Before enactment of the local law, few hospitals had policies despite pressure from advocates and negative publicity. By 2004, all hospitals in the county had charity care policies and signage in public areas of the hospital.³⁷

► ***There is NO consistency in how hospitals define charity care.***

Nassau County, NY – Hospitals define charity care differently, “due primarily to difficulty in distinguishing between bad debts and charity care.”³⁸ The Health Department report does not describe the content of any hospital's financial aid policy and procedures. A web search reveals that one hospital system posts its financial assistance policy on its website and offers to help community residents and patients to enroll in public insurance programs. The search of other hospital websites yields no information. Anecdotal reports indicate that who can qualify for financial assistance varies from hospital to hospital.³⁹

³⁴ 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>

³⁵ The Legal Aid Society. 2005. *State Secret 2005: How Government Statutes and Hospitals' Voluntary Guidelines Fail to Protect Uninsured and Underinsured Patients*. New York, NY. January 2005. pp. 2-3.

³⁶ Bill Lottero and Carol Pryor. Op. cit.

³⁷ Nassau County Department of Health. Op. cit.

³⁸ Ibid.

³⁹ Personal communication with Donna Kass, Long Island Hospital Access Monitoring Project. May 18, 2005.

► **Consumers face a bewildering array of eligibility criteria and payment plans.**

New York City – Some hospitals did establish financial assistance policies after Legal Aid’s 2003 exposé⁴⁰ and HANYS’ 2004 voluntary guidelines. But hospitals demonstrate great variation in the policies and procedures they adopted to determine who is eligible, how much financial assistance is provided to an individual, the rate of pre-admission deposits, and whether individual low-income patients can negotiate a discount. Low and moderate-income uninsured and underinsured patients would have to exert considerable effort and persistence to determine whether financial assistance is available, whether they qualify, and how to apply.⁴¹

► **Hospitals vary widely in how many people receive low cost or no cost care.**

Nassau County, NY – The first report required by the local law documented that over the course of a year, one hospital provided financial assistance to 136 patients while another hospital provided charity care to 13,724 patients. This variation “cannot be explained by differences in hospital size, discharges, or services offered.”⁴²

► **Egregious billing and debt collection practices are likely to continue since there is no enforcement mechanism.**

New York City – Nine of ten hospitals require a deposit from uninsured patients prior to admission for non-emergency inpatient treatment. Six hospitals require 100% payment upfront and 13 require a deposit equal to 50% of the bill. One of three hospitals refuses to negotiate discounts with low-income uninsured and underinsured patients. All 31 hospitals sue patients who do not pay their bills. Almost half place liens on a patient’s home. Nine of ten hospitals garnish wages and almost 4 of 5 place attachments on patients’ bank accounts.⁴³

► **Without legislation, there is no public accountability.**

Nassau County, NY – The 2003 local county law requiring hospitals to report to the county health department put information in the public domain for the first time. The data confirmed the problems that have been previously listed in multiple reports. The local hospital association, county officials, and advocates are working together to develop an amendment to improve the local county law.

Despite the positive changes that resulted from the Nassau County law, further efforts at the local level are constrained by the county’s limited

⁴⁰ The Legal Aid Society. 2003. *State Secret 2003: How Government Fails to ensure that Uninsured and Underinsured Patients have access to State Charity Care Funds*. New York, NY. 2003.

⁴¹ The Legal Aid Society. 2005. Op. cit. p. 3.

⁴² Nassau County Department of Health. Op. cit.

⁴³ The Legal Aid Society. 2005. Op. cit. p.3.

authority under NYS law to regulate hospitals. Authority to require hospitals to meet minimum standards for providing financial assistance resides with the NYS Legislature and the Governor.

In contrast to voluntary guidelines, a law with specific requirements, backed up by monitoring/enforcement mechanisms, increases compliance and provides accountability. Consumers in other states recognized this reality and pressured policy makers to pass laws. Two of New York's neighbors, Massachusetts and New Jersey, require hospitals to comply with statewide eligibility criteria, screening and application process, reporting requirements, and a payment mechanism for charity care.

NYS Comptroller recommends uniform standards and procedures

In a 2004 report, NYS Comptroller Alan Hevesi noted that funding for indigent care is the largest expense in New York State's Health Care Reform Act (HCRA.)

The disbursements from the Indigent Care Pool have grown by 29% from \$767 million in 2001 to \$990 million in 2004.⁴⁴ Most (98%) of the funds were "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.

In March 2005, the Legislature and Governor corrected the off-budget problem by including the indigent care pools in the regular State Budget. In the future, these funds will be subject to the same scrutiny and safeguards as other State disbursements because they will be processed through the State Comptroller. In addition, the public will have access to more detailed information on the indigent care pools since they will be included in the monthly reports posted on the Comptroller's website.

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 have to report how many uninsured and underinsured individuals they treated using the funds from the indigent care pools. The final recommendation in the Comptroller's 2004 report states: "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***

⁴⁴ 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>

underinsured patients and establish uniform standards and procedures for providing such assistance.⁴⁵ (emphasis added)

NYS Assembly and Governor respond

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 to qualify for funding from HCRA’s Bad Debt and Charity Care (BDCC) pool. In addition, he secured the support of 30 other members of the Assembly who signed on as co-sponsors of his proposal.⁴⁶ This marked the first time that legislation was 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.

At the beginning of the new Legislative Session in January 2005, Assemblyman Grannis reintroduced his package of three bills with more sponsors than last year, most notably a bi-partisan list co-sponsors, a rarity in Albany. The three bills would: (1) set statewide eligibility standards; (2) establish a statewide discounted rate for those with incomes under 200% of the federal poverty level; (3) standardize the application process; (4) define covered services; (5) forbid egregious billing and debt collection practices; (6) specify public disclosure on how taxpayers’ funds were used; (7) require notices to the public about available financial aid; (8) instruct hospitals to bill low to moderate-income uninsured patients at the discounted rate paid by other insurers; and (9) create an independent appeals process. The NYS Assembly passed these bills on March 1, 2005 with overwhelming bi-partisan support, only 10 or 11 negative votes out of 150 Assembly members. This legislative package would meet and exceed the Comptroller’s recommendation to establish statewide standards and procedures.

The Governor’s 2005 HCRA proposal included some new procedural requirements for hospitals to qualify for funds from the HCRA indigent care pools. The procedures fall far short of the Comptroller’s recommendation, the Assembly legislation, and HANYS’ guidelines. There are: (1) NO requirements for what must be included in the charity care policy; (2) NO directive on how much a hospital must discount its prices for those below 200% of the poverty level; (3) NO prohibition against billing low-income uninsured at the “full charge” or “list price”; (4) NO prohibition against other egregious billing practices; (5) prohibits only one outrageous collection practice - selling or foreclosing on the patient’s primary residence. The requirement to provide a discount to any patient at or below 200% of the poverty level could be a hollow promise. Theoretically, hospitals could discount their “full charges” or “list prices” by 5% or even 25% and meet the Governor’s requirement; in such circumstances, patients would still be saddled with

⁴⁵ Ibid. p. 45

⁴⁶ Assemblyman Grannis introduced A 9217, A9218, and A9219 in the NYS Assembly in the 2003-2004 Legislative Session.

huge bills they cannot pay. The Legislature did not agree to enact the Governor's proposal.

The NYS Senate has thus far ignored the Comptroller's 2004 recommendation to establish uniform standards and procedures for providing assistance to those in need.

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, there was NO requirement to provide charity care nor report how many uninsured and underinsured 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) Pools⁴⁷, 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..."⁴⁸ Hospital reporting requirements to the state Department of Health and complex funding formulas for public goods remained in the new deregulated rate setting system. The HCRA legislation was renewed in 1999, 2003, and 2005 and is due for renewal by June 30, 2007.

⁴⁷ NYS Public Health Law § 2807-k and § 2807-w.

⁴⁸ 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.

Two government programs, Medicare and Medicaid, paid more than 56% of gross patient revenues for 179 hospitals in New York State.⁴⁹ 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 2005: \$765 million dollars annually from the Indigent Care Pool⁵⁰ plus \$82 million from the HCRA High Need Indigent Care Adjustment Pool.⁵¹ The recently enacted HCRA 2005 continues to allocate \$847 million per year for the Indigent Care Pools. Despite these large amounts of federal and state taxpayers' dollars, 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.)"⁵² 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..."⁵³
- 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.⁵⁴

However, there is no obligation for hospitals to provide free care or reduced cost care for low-income patients without health coverage, even though they receive public funds for indigent care. Moreover, there is a specific provision in the NYS Public Health Law that prohibits 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.⁵⁵ This statutory prohibition is problematic for individuals and legal advocates who try to get hospitals to reduce the amount of debt owed by a 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,

⁴⁹ 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.

⁵⁰ Hevesi, Alan G. 2003. *The Health Care Reform Act*. Albany, NY: New York State, Office of the State Comptroller. p.14.

⁵¹ NYS Public Health Law § 2807-w

⁵² Community Catalyst. 2000. *Fact Sheet: New York State Requirements Relating to Community Benefits and Free Care.* Boston, MA.

⁵³ NY Pub. Health § 2807-k(9).

⁵⁴ Community Catalyst. Op. cit.

⁵⁵ NY Pub. Health § 2807-k(14).

religion, sex, national origin, disability, sexual orientation or source of payment.”⁵⁶ 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...”⁵⁷ 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.

Hospital Financial Aid Survey Methodology

- *Phone survey protocol*
- *Information gathered to answer 12 questions*

Public Policy and Education Fund (PPEF) staff conducted phone surveys of the two hospitals in Utica in July 2004 with follow-up in spring 2005. Community Catalyst of Boston developed the phone survey format used in this survey and previous PPEF hospital surveys in 2002 - 2004.⁵⁸ A similar form has been used as part of the surveys conducted by the Long Island Health Access Monitoring Project.⁵⁹

The survey protocol specified that each hospital could be called as many as six times in an effort to secure as complete information as possible to answer the questions on the survey form. If there was no response, or some questions were unanswered after the six calls, the hospital was given a failing grade. The first calls were made to the office in the hospital where information was obtained during the 2003 PPEF survey. If there was no response, calls would be 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 or underinsured.

The surveyor used this introductory script for the phone call:

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 find out how the hospital handled its uninsured patients who could not pay for services. Surveyors asked to be transferred to

⁵⁶ NYS Department of Health. http://www.health.state.ny.us/nysdoh/hospital/patient_rights/en/patients.htm

⁵⁷ <http://www.ci.nyc.ny.us/html/hhc/home.html>

⁵⁸ 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

⁵⁹ 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.

someone else in the hospital whenever a hospital employee could not answer any or all of the survey questions. Surveyors also asked for a copy of all hospital documents related to its financial aid policy and procedure. Follow-up questions were asked by phone or email to clarify any information provided verbally or in the documents. If the hospital asked for a written request before sending any documents to PPEF, the following letter was faxed:

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.

This survey focused on gathering information to answer 12 questions:

1. Does the hospital provide the public with information about its own financial aid program?
2. Does the hospital assist patients with applying for public health insurance programs such as Medicaid, Family Health Plus, and Child Health Plus?
3. Does the hospital have a financial aid policy available to the public telling patients with income levels up to 200% of the federal poverty level (FPL) they can receive care at no or nominal? (Public insurance programs cover most New Yorkers with income up to 150% FPL)
4. Does the hospital have a financial aid policy available to the public telling patients with income levels up to 400% FPL they can receive care on a sliding fee scale?
5. Does the hospital require a Medicaid denial letter even when the patient clearly does NOT qualify for Medicaid or other public insurance coverage?
6. Does the hospital cover at least 3 months of services when it approves a patient for financial assistance?
7. Does the hospital grant financial aid based solely on income levels? If there is an asset test, does it exclude the family's primary residence, family car, farm and equipment, savings for retirement and college?
8. Does the financial aid policy cover all medically necessary services billed by the hospital?
9. Does the hospital delay billing uninsured, indigent patients until after an application for financial aid has been processed?

10. Does the hospital provide patients with at least 90 days after discharge to apply for assistance?
11. Does the hospital print an easy-to-read notice about how to apply for financial aid on each bill sent to patients?
12. Does any financial aid assistance or payment agreement include an accelerator clause requiring full payment immediately if the patient fails to make one payment?

Data Collection and Analysis

- *Pass/Fail grading for 12 categories*
- *Final grade, A to F, based on total number of passing grades*

PPEF staff conducted the phone surveys. A pass/fail grade was determined for 12 categories corresponding to the 12 study questions listed under methodology. The criteria for earning a passing grade are described below by category:

- 1 - **Provides info about financial aid to public:** hospital provides the public with information about its own financial aid program and specifies the income level(s) that must be met to qualify for assistance.
- 2 – **Helps patients apply for insurance programs:** hospital assists patients in applying for public health insurance coverage.
- 3 – **100% discount up to 200% FPL:** hospital provides 100% discount for uninsured and underinsured patients with incomes up to 200% of the federal poverty level (FPL). (*Note: Public insurance programs cover most New Yorkers with income up to 150% FPL so hospitals should help enroll them.*)
- 4 – **Sliding fee scale up to 400% FPL:** hospital provides sliding fee scale for uninsured and underinsured patients with incomes up to 400% FPL.
- 5 – **Requires Medicaid denial only if applicable:** hospital does NOT require a Medicaid denial letter for those patients who clearly cannot qualify for any public health insurance program. (*Rationale: applying for Medicaid is a time-consuming and meaningless task for patients who clearly cannot qualify.*)
- 6 – **Approval valid for 3 months or more:** hospital's approval for financial aid is valid for at least the next 3 months of needed services unless patient's financial situation changes significantly.
- 7 – **Eligibility based only on income OR limited liquid assets:** hospital approves financial aid based solely on income. If there is an asset test, does it exclude the family's primary residence, family car, farm and equipment, savings for retirement and college?
- 8 – **NO accelerator clause demands full payment:** hospital does NOT require patient to provide full payment in the event one payment is missed. (*i.e.* no accelerator clause in payment agreement)

- 9 – **Allows at least 90 days after service to apply:** hospital accepts applications for financial aid up to 90 days after services were provided.
- 10– **Covers all charges billed by hospital:** financial aid program covers all medically necessary services billed by the hospital.
- 11 – **Holds bill until application processed:** hospital does not bill the patient while application for financial assistance is processed.
- 12 - **Financial aid info is printed prominently on each bill:** hospital prints an easy-to-read notice about availability of its financial aid program on each bill sent to patients.

Every hospital earns a PASS/FAIL grade for each of the 12 categories. The final grade, ranging from A to F, is based on the total number of categories a hospital passed: A = passed 11 -12 categories; B = passed 9 - 10 categories; C = passed 7 - 8 categories; D = passed 5 - 6 categories; F = passed 0 - 4 categories. All grades are combined in a report card on page 21.

Findings

- *Policies and procedures vary from hospital to hospital*
- *Policies and grades improved since 2003 report⁶⁰*
- *Both hospitals offer assistance, neither meets standards in the Grannis bills*

Summary of Grades

This survey provided evidence that hospitals in Utica have improved their charity care policies in the past two years. Both hospitals have established financial assistance programs that address many of the areas of concern, albeit the programs still fall short in some key areas. Both hospitals continue to press patients for payment even while a financial assistance application is being considered and both fail to notify patients of the availability of financial assistance on the hospital bill. In addition, policies and procedures vary between the hospitals.

St. Elizabeth's has trained a group of financial counselors to meet with patients who do not have insurance coverage to help them apply for existing insurance programs like Medicaid, Family Health Plus, and Child Health Plus. If it is clear the patient will not qualify for any of these programs, payment options and application for financial assistance are discussed. The shortcoming here is that the income guidelines are too stringent to protect modest income patients who face high hospital bills.

Faxton-St. Luke's also meets with uninsured patients, but the financial staff starts by trying to get a payment from the patient. Patients are asked if they can: pay the bill; pay the bill if they get a discount for prompt payment; pay the bill on an installment plan; apply for Medicaid; get a bank loan to pay for the bill. If the patient cannot meet any of

⁶⁰ Public Policy and Education Fund of New York. Op. cit. p.24.

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Key: P = Pass F = Fail Final Grade based on total number of Passing marks received

A = 11-12 Ps B = 9 -10 Ps C = 7- 8 Ps D = 5 - 6 Ps F = 0 - 4 Ps

Category ↓	Hospital →	Faxton-St. Luke's	St. Elizabeth's
1. Provides info about financial aid to public		P	P
2. Helps patients apply for insurance programs		F	P
3. 100% discount up to 200% FPL		P	P
4. Sliding fee scale up to 400% FPL		P	F
5. Requires Medicaid denial <i>only if applicable</i>		F	P
6. Approval valid for 3 months or more		P	P
7. Eligibility based only on income, limited assets		F	P
8. NO accelerator clause demands full payment		P	P
9. Allows at least 90 days after service to apply		P	P
10. Covers all charges billed by hospital		P	P
11. Holds bill until application processed		F	F
12. Financial aid info is printed prominently on each bill		F	F
Final Grade		C	B

Criteria for Earning a Passing Grade in each Category

1. hospital provides the public with information about its own financial aid program and specifies the income level(s) that must be met to qualify for assistance.
2. hospital assists patients in applying for public health insurance coverage.
3. hospital provides 100% discount for uninsured and underinsured patients with incomes up to 200% of federal poverty level (FPL).
4. hospital provides sliding fee scale for uninsured and underinsured patients with incomes up to 400% FPL..
5. hospital does NOT require a Medicaid denial letter for those patients who clearly cannot qualify for any public health insurance program. (*Rationale: applying for Medicaid is a time-consuming and meaningless task for patients who clearly cannot qualify.*)
6. hospital's approval for financial aid is valid for at least the next 3 months of needed services unless patient's financial situation changes significantly.
7. hospital approves financial aid based solely on income. If there is an assets test, it excludes primary residence, family car, farm and equipment, savings for retirement and college.
8. hospital does NOT require patient to provide full payment in the event one payment is missed. (*i.e. no accelerator clause in payment agreement*)
9. hospital accepts applications for financial aid up to 90 days after services were provided.
10. financial aid program covers all medically necessary services billed by the hospital.
11. hospital does not bill the patient while application for financial assistance is processed.
12. hospital prints easy-to-read notice about the availability of its financial aid program on each bill sent to patients.

the 5 options, then the hospital will accept an application for financial assistance. The Faxton-St. Luke's application asks for a copy of the Medicaid denial letter, a process the patient must complete at the local Social Services office.

The final grade for St. Elizabeth's is B and the final grade for Faxton-St. Luke's is C.

Surveyor experiences

PPEF surveyors found that hospital employees responsible for administering financial aid programs were willing to answer questions verbally and provided requested documents. This is a marked change from PPEF's experiences in 2003 when surveyors could get very little information and both hospitals received a final grade of "F."

Financial Aid applications and other hospital documents

St. Elizabeth's provides information about the availability of financial assistance in the admission packet given to patients. It also reports having signs in public locations in the hospital and all 16 off-site clinics. The sign tells patients whom to see and where to call to get assistance; they do not use the threatening paragraph in HANYS' "Model Patient Notice of Financial Aid." Faxton-St. Luke's reports they are developing a brochure.

Faxton-St. Luke's application asks for documentation of Medicaid denial. St. Elizabeth's does not require patients who clearly are not eligible for public health insurance programs like Medicaid, Family Health Plus, and others to complete the arduous task of applying for and securing a rejection letter from Medicaid before they can be approved for hospital financial assistance.

St. Elizabeth's more consumer-friendly procedure includes screening patients to identify those who might need financial aid instead of putting the full responsibility on patients to initiate the request for financial assistance. It has assigned responsibility to specific staff people to do follow-up if a patient is missing some of the documentation that must accompany the application form.

Eligibility for financial aid

It is commendable that St. Elizabeth's allows patients to submit a sworn statement about their income if they do not have other documents; this is comparable to Medicaid but very unusual among hospital assistance programs. Faxton-St. Luke's requires applicants to provide information about income and assets, like bank accounts and pension accounts while St. Elizabeth's evaluates only income and expenses.

St. Elizabeth's provides 100% discount for patients with incomes up to 150% FPL; individuals with incomes below \$14,670 and families of 4 with incomes below \$29,450 would qualify in 2005. This benefit is less generous than it sounds because most adults and all children residing in NYS who could qualify for the free care would in fact qualify for Child Health Plus or Family Health Plus, programs that provide better health coverage AND pay the hospital. For those between 151% and 200% FPL, St. Elizabeth's requires a co-pay for each time a service is provided, starting at \$10.00 for a

clinic visit to as much as \$300 for a hospital stay. There is no individual or family cap on the total amount of the co-pays but the hospital does not initiate collection proceeding if a patient fails to pay. St. Elizabeth's has no assets test. While these eligibility levels are consistent with HANYS 2004 guidelines, they fall short of the standards in the Grannis bills.

A Faxton-St. Luke's patient must jump through all the hoops described above and then the hospital considers all liquid assets (including college savings and retirement accounts) except life insurance. The hospital looks at all income (gross), subtracts daily expenses (food, housing, car, insurance, utilities), and determines the balance. If the balance is below 200% FPL, the hospital provides a 100% discount. This is more generous than hospitals that ignore expenses and base their discount on income only. While the eligibility levels are consistent with HANYS 2004 guidelines, they fall short of the application and assets test standards in the Grannis bills.

Neither hospital mentioned an internal appeals process for those applicants who do not agree with the hospital's decision to deny financial aid.

Medicaid denial required

Faxton-St. Luke's Healthcare requires patients to apply for Medicaid and prove that they are ineligible before they can be considered for the hospital's financial aid program. The application states that a copy of the Medicaid denial letter must be submitted. St. Elizabeth's determines on an individual basis whether a patient will be required to apply for Medicaid first.

Services covered

Both hospitals indicated that financial assistance covers all "medically necessary" care billed by the hospital. Neither 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

Both hospitals bill patients until an application for financial aid has been approved. Patients approved for 100% discount do not receive further bills. Once approval is given, it is valid for a year at both hospitals.

Neither hospital requires patients who miss an agreed upon payment to immediately pay the bill in full, but Faxton-St. Luke's sends the bill to collection.

Neither hospital prints a notice about the availability of financial aid on the hospital bill sent to patients. Both allow patients to apply up to at least 90 days after inpatient discharge or outpatient visit. St. Elizabeth's has assigned specific staff to review all open accounts and all bad debt accounts once a patient has been approved for financial assistance to determine if they should be written off. If an account had been sent to the collection agency, the hospital calls the agency to close the account.

Geographical area requirement

Neither hospital mentioned any geographical restrictions on who could qualify for financial assistance.

Discussion and Recommendations

- *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 and more accountable*

Although New York annually spends \$847 million of taxpayer dollars compensating hospitals for bills that patients do not/cannot 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 hospitals in Utica have improved their charity care policies in the past two years. Both hospitals have established financial assistance programs which address many of the areas of concern and which are available to the public. The programs still fall short in some key areas, including having income guidelines that are too stringent to protect patients who face high hospital bills, pressing patients for payment even while a financial assistance application is being considered and the failure to prominently notify patients of the availability of financial assistance on the hospital bill. In addition, policies still vary between hospitals.

While this survey shows progress, it also provides further evidence for New York to enact standards for the use by hospitals of \$847 million in public funds provided to hospitals to assist patients who are hard-pressed by medical bills. In fact, states such as Maine, Rhode Island, and Washington that do not provide funds to hospitals for charity care, still require hospitals to meet statewide standards for charity care and file reports with the state's Department of Health about the amount of charity care they have provided.

Other states, including our neighbors Massachusetts and New Jersey, have established statewide eligibility and reporting criteria tied to a payment mechanism for charity 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's hospitals prominently display signs throughout the emergency room and patient care area, informing patients about the availability of financial aid.

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.⁶¹

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.

Best Practice Policy Recommendations

Charity Care Policy

- Establish a charity care⁶² and financial assistance policy that takes into account income, family size, and resources.

⁶¹ Public Policy and Education Fund of New York. Op. cit. pp. 26-27.

⁶² “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.

- 100% reduction in charge for patients up to 200% Federal Poverty Level. (Massachusetts’s standard).
- Sliding scale for patients up to 400% Federal Poverty Level. (Massachusetts’s 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
- 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 that 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 introduced and the NYS Assembly has passed a legislative package with most of the best practice policy recommendations. The Senate and the Governor should work with the Assembly to agree on a legislative proposal to establish meaningful standards and consumer protections so the uninsured would know they could get needed health care without fear of incurring huge medical debts. ***If enacted into law, the Grannis legislative package would make the indigent 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

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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 – Do Voluntary Guidelines Protect Utica’s Consumers and Taxpayers? was authored by E. Joyce Gould and edited by Richard Kirsch.

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