



National
Consumer Law
Center

AN OUNCE OF PREVENTION:

A Review of Hospital Financial Assistance Policies in the States

January 2020

By

Andrea Bopp Stark

National Consumer Law Center®

© Copyright 2020, National Consumer Law Center, Inc. All rights reserved.

ABOUT THE AUTHOR

Andrea Bopp Stark is a staff attorney at the National Consumer Law Center focusing on fair debt collection practices. She also has taught an Introduction to Consumer Rights Litigation practicum course at Boston College Law School. Andrea is a contributing author to NCLC's *Fair Debt Collection* and *Collection Actions* legal manuals. Previously, Andrea was a partner at Molleur Law Office in Biddeford, Maine, and worked as an attorney for Northeast Legal Aid in Lawrence, Massachusetts where she was one of NCLC's first recipients of the John G. Brooks fellowship. Andrea holds a B.A. from the University of Vermont and obtained her J.D. and Masters of Social Work from Boston College. She is admitted to practice law in Massachusetts, Maine, and New Hampshire.

ACKNOWLEDGEMENTS

The author thanks NCLC colleagues Deputy Director Carolyn Carter, Staff Attorneys Jenifer Bosco and April Kuehnhoff, Director of Communications Jan Kruse, Technical Assistant Anna Kowanko, and former legal intern Lindsay Funk, along with Jessica Curtis of Community Catalyst. NCLC also thanks the Annie E. Casey Foundation Inc., whose support of our work made this report and much more possible. The views expressed in the report are solely those of NCLC and the author.



ABOUT THE NATIONAL CONSUMER LAW CENTER

Since 1969, the nonprofit National Consumer Law Center® (NCLC®) has used its expertise in consumer law and energy policy to work for consumer justice and economic security for low-income and other disadvantaged people, including older adults, in the United States. NCLC's expertise includes policy analysis and advocacy; consumer law and energy publications; litigation; expert witness services, and training and advice for advocates. NCLC works with nonprofit and legal services organizations, private attorneys, policymakers, and federal and state government and courts across the nation to stop exploitive practices, to help financially stressed families build and retain wealth, and advance economic fairness. www.nclc.org

TABLE OF CONTENTS

EXECUTIVE SUMMARY	2
INTRODUCTION	3
WHO ARE THE UNINSURED?	3
WHO ARE THE UNDERINSURED?	5
THE AFFORDABLE CARE ACT	6
CONSEQUENCES OF OVERWHELMING MEDICAL DEBT	8
AN OVERVIEW OF STATES' FINANCIAL ASSISTANCE RULES	9
1) Comprehensive State Financial Assistance Policies	9
2) Limited States' Financial Assistance Policies.....	11
States that Mandate Financial Assistance for Nonprofit or Publicly Funded Hospitals Only	11
3) State-run Financial Assistance Programs	11
4) Other Programs or Statutes that May Provide Some Financial Assistance.....	12
a) States that Require Financial Assistance Policies in Exchange for a Certificate of Need.....	12
b) States Where Hospitals Can Seek Reimbursement for Financial Assistance Provided	12
5) No State Mandate but Some Financial Assistance in Practice	13
6) Other States' Programs	13
CONCLUSION	14
ENDNOTES	15
GRAPHICS:	
Table: Federal Poverty Guidelines (Coverage Year 2019).....	4
Chart: Uninsured Adults Ages 19-64 By Percent Of Federal Poverty Level, Race/Ethnicity, And Age.....	5
APPENDICES:	
Appendix A: States that Mandate a Spectrum of Financial Assistance for Nonprofit and For-Profit Hospitals	19
Appendix B: States that Mandate Financial Assistance for Nonprofit and Publicly Funded Hospitals	22
Appendix C: States that Have Their Own Programs for Assistance.....	23
Appendix D: States that Require Financial Assistance for Certificate of Need.....	24
Appendix E: States that Require Specific FAP for Reimbursements	26
Appendix F: No Mandate but Financial Assistance in Practice	29
Appendix G: States that Provide Some Unspecified Assistance.....	30
Appendix H: States that Provide No Requirements for Free Care.....	32

EXECUTIVE SUMMARY

Over 27 million Americans do not have health insurance of any kind while almost half of non-elderly adults have inadequate insurance with high deductibles and significant out-of-pocket costs. The hardest hit population is low income, Latinx adults ages 19-64. The number of uninsured and underinsured is slowly increasing while health care costs continue to rise, therefore it is more important than ever for states to require that all hospitals provide comprehensive financial assistance for hospital care.

The Affordable Care Act requires certain nonprofit hospitals with 501(c)(3) status to provide community benefits, including financial assistance for low-income patients. 26 CFR §1.501(r) (“501(r)”) requirements include establishing a written Financial Assistance Policy (FAP) and a written Emergency Medical Care Policy. However, these requirements apply only to nonprofit hospitals, and the ACA and its implementing regulations do not specify any minimum standards or eligibility criteria for financial assistance. If a nonprofit hospital fails to comply with these requirements, the patient does not have a private right of action under the statute to seek redress for noncompliance, as only the IRS can enforce these requirements.

This report provides a brief overview of the financial assistance policies in each of the 50 states and the District of Columbia, and looks at the level of financial assistance mandated, or not, in each jurisdiction.

Ten states have enacted laws that require hospitals to provide a full spectrum of free and discount care for patients under specific eligibility standards, primarily based on income. In states that do not have a comprehensive financial assistance requirement for all hospitals, other programs provide some assistance. Some states have enacted comprehensive financial assistance laws but only for nonprofit or publicly funded hospitals. Others require certain hospitals to provide assistance to specific low-income patients in exchange for a Certificate of Need to build or expand their facility. Other states that do not mandate the assistance that hospitals must provide have created their own programs that provide some assistance for low-income residents. There are still many states, however, that have little or no financial assistance requirements or guidelines for hospitals caring for low-income patients with no or inadequate health insurance.

States that seek to strengthen their policies and protect more low-income consumers from excessive medical debt can turn to examples in states such as Rhode Island, New Jersey, Maine, New York, Connecticut, California, and Nevada, which have already adopted strong financial assistance policies. At a minimum, states should mandate all hospitals develop a comprehensive policy addressing free and discount care with clear minimum eligibility criteria for uninsured and underinsured patients, and a summary of the type of assistance that is available as set forth in the National Consumer Law Center’s [Model Medical Debt Protection Act](#).

INTRODUCTION

As the number of Americans without health insurance or with insufficient insurance increases, so does the need for comprehensive financial assistance for those who cannot afford medical treatment. In 2018, about 27.5 million people in the United States were uninsured at any point during the year, up from about 25.6 million in 2017.¹

The debt that results from hospital care affects tens of millions of consumers. Twenty percent of Americans have at least one medical debt collection item on their credit reports.² It is one of the most prevalent types of consumer debt; 59% of people contacted by a debt collector say the exchange was over medical bills.³ A recent study found that 66.5% of all bankruptcies (about 530,000 families a year) were tied to the cost of medical care or time lost from work due to an illness or injury.⁴

Medical debt is different from many other types of consumer debt—people do not plan to get sick or get hurt, and health care services are not only necessary, but can be a matter of life or death.

This report is intended to enable community-based organizations, consumer advocates, and others working with vulnerable communities to identify and compare the financial assistance policies that states and hospitals have adopted to address ongoing barriers to health care.⁵ In addition, the National Consumer Law Center’s (NCLC) [Model Medical Debt Protection Act](#)⁶ includes language that could be used in state law to extend financial assistance requirements beyond those required by the federal Patient Protection and Affordable Care Act (ACA). The Model Act contains guidelines for financial assistance policies that would cover more patients, specific financial guidelines for charity care and discounted care, and procedural safeguards to protect consumers from aggressive or unfair debt collection practices.

20% of Americans have at least one medical debt collection item on their credit reports.

WHO ARE THE UNINSURED?

The percentage of Americans who are without health insurance is slowly increasing, rising from 7.9% in 2017 to 8.5% in 2018.⁷ The uninsured have difficulty accessing care and the medical treatment they need. In 2018, one in five uninsured adults went without needed medical care

because of the cost.⁸ The uninsured are less likely to seek preventative care and services for significant health issues and chronic conditions.⁹

Uninsured adults are over three times more likely than those with insurance to *not* visit a doctor or health professional over a 12-month period and are less likely to receive recommended screening treatments such as those that check blood pressure, cholesterol, and blood sugar.¹⁰

While the uninsured do not use emergency hospital care more than insured patients, they do use emergency hospital care much more than they use outpatient care.¹¹ Those who are uninsured visit the emergency room about 30% more than they attend outpatient visits and they average about two outpatient visits per year as compared to six visits per year for those with insurance.¹²

In 2018, one in five uninsured adults went without needed medical care because of the cost.

TABLE: FEDERAL POVERTY GUIDELINES (COVERAGE YEAR 2019)

# in Household	100% FPL	138% FPL	150% FPL	200% FPL	250% FPL	300% FPL	400% FPL
1	\$12,140	\$16,753	\$17,210	\$24,280	\$30,350	\$36,420	\$48,560
2	\$16,460	\$22,715	\$24,690	\$32,920	\$41,150	\$49,380	\$65,840
3	\$20,780	\$28,676	\$31,170	\$41,560	\$51,950	\$62,340	\$83,120
4	\$25,100	\$34,638	\$37,650	\$50,200	\$62,750	\$75,300	\$100,400
5	\$29,420	\$40,600	\$44,130	\$58,840	\$73,550	\$88,260	\$117,680
6	\$33,740	\$46,561	\$50,610	\$67,480	\$84,350	\$101,220	\$134,960
7	\$38,060	\$52,523	\$57,090	\$76,120	\$95,150	\$114,180	\$152,240
8	\$42,380	\$58,484	\$63,570	\$84,760	\$105,950	\$125,140	\$169,520

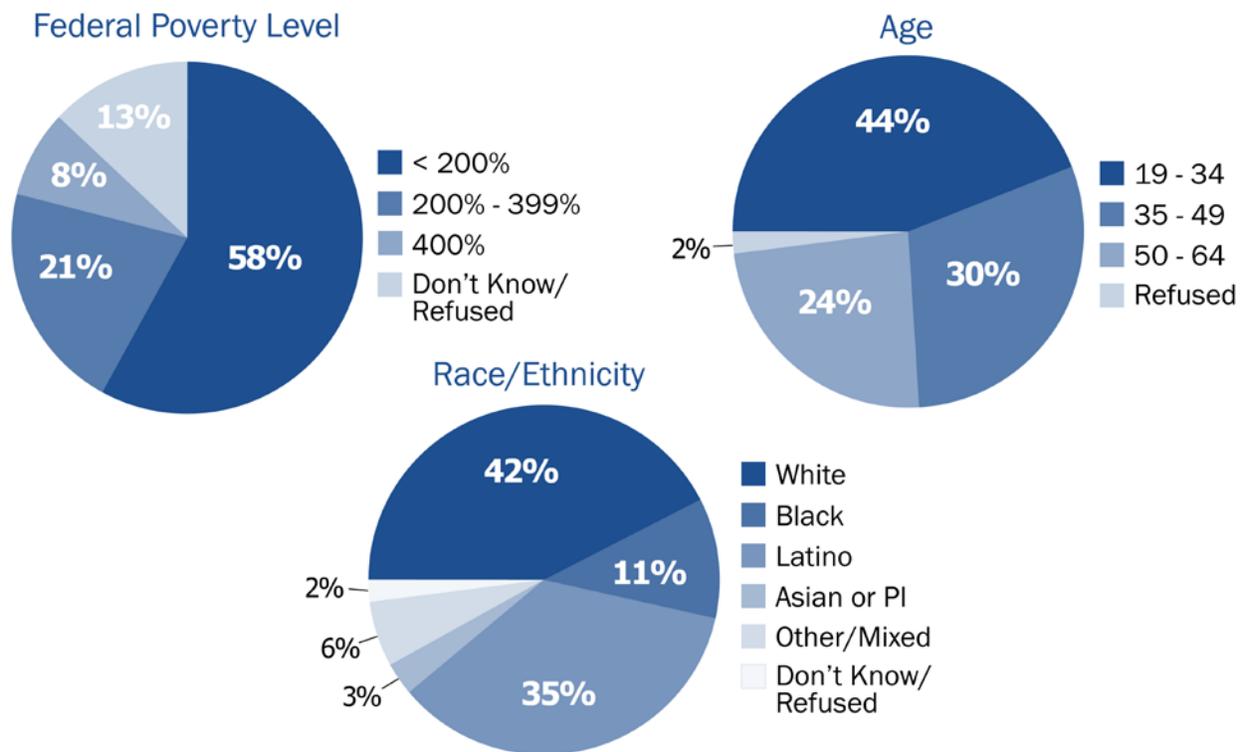
*For households with more than 8, add \$4,320 for each additional person.

Source: Health Reform: Beyond the Basics, [Yearly Guidelines and Thresholds](#), June 2018

In addition to low-income working-age adults, young adults and Latinx adults are disproportionately likely to lack health insurance. Young adults ages 19-34 make up 44% of the uninsured population. Latinx adults represent 35% of all uninsured people, but only 18% of the working-age adult population.¹³ In general, people of color (Black, Latinx, Asian) are at higher risk of being uninsured. While people of color make up 42% of the non-elderly population in the U.S., they account for over half of the total non-elderly uninsured population.¹⁴

While people of color make up 42% of the non-elderly population in the U.S., they account for over half of the total non-elderly uninsured population.

CHART: UNINSURED ADULTS AGES 19-64 BY PERCENT OF FEDERAL POVERTY LEVEL, RACE/ETHNICITY, AND AGE



Source: The Commonwealth Fund, *Who are the Remaining Uninsured, and Why Do They Lack Coverage?*, August 2019

WHO ARE THE UNDERINSURED?

People considered “underinsured” are those with high health insurance plan deductibles, limited insurance coverage, or high out-of-pocket expenses relative to their income. In the 2018 Commonwealth Fund’s latest Biennial Health Insurance Survey, those who were considered underinsured had:

- out-of-pocket costs, excluding premiums, over the prior 12 months of at least 10% of their household income;
- out-of-pocket costs, excluding premiums, of 5% or more of their household income over the prior 12 months (for individuals living under 200% of Federal Poverty Level (FPL), which is \$24,120 for an individual or \$49,200 for a family of four); or
- deductibles of 5% or more of their household income.¹⁵

The underinsured are also more likely to struggle to pay hospital bills or will choose to forego care, such as seeing a doctor or filling prescriptions because of the cost. In addition to being burdened with high out-of-pocket expenses and significant coverage gaps due to high deductibles, the underinsured may be vulnerable to surprise medical bills for out-of-network care that come from health providers outside their insurance plan's network after they received emergency care or medical procedures at in-network facilities.¹⁶ Even if the hospital is in the plan's network, an individual health care provider, such as an anesthesiologist or surgical assistant, may be from outside the plan's network and not covered fully, leaving the patient with unexpected medical debt.¹⁷ Several states, including **New Mexico**,¹⁸ **Washington**,¹⁹ **Colorado**,²⁰ and **Texas**²¹ have recently enacted laws that create additional consumer protections from surprise medical bills and may cover emergency and/or non-emergency services at the in-network level of cost-sharing.²²

Today, 45% of U.S. adults ages 19 to 64 are inadequately insured.

Today, 45% of U.S. adults ages 19 to 64 are inadequately insured.²³ People who purchased health coverage on their own through the individual market or the marketplaces are the most likely to be underinsured, with 42% reporting a lack of adequate coverage in 2018.²⁴

About 65% of the U.S. population under age 65 has health coverage through their employer. The largest increase in the number of underinsured adults is occurring among those in employer health plans.²⁵ With the increase in health care costs nationwide, employers have turned to high deductible and cost-sharing plans to keep premiums down and pass the costs onto their employees.²⁶ Deductibles for employment-based health plans in the U.S. have more than quadrupled in the last 12 years, and over four out of ten workers do not have enough savings to cover the deductible.²⁷ Deductibles for an individual job-based health insurance plan have risen from an average of \$379 in 2006 to \$1,350 in 2018.²⁸ Because of this soaring increase, one in six covered workers has made significant sacrifices, such as taking on extra work or cutting back on food, clothing, or other essentials.²⁹

THE AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act (ACA, sometimes referred to as Obamacare) was enacted on March 23, 2010. The ACA contains a multitude of provisions that affect a wide range of health insurance matters, and created increased options for insurance coverage. Among its reforms, the ACA provides two types of subsidized insurance: Medicaid for adults who earn less than 138% of the FPL in states that expanded Medicaid, and subsidized plans in the ACA marketplaces for those who earn up to 400% of the FPL.³⁰ To date, 36 states and the District of Columbia have adopted the Medicaid expansion, while 14 states³¹ have not.³² Medicaid expansion has improved access to care, utilization of services, the affordability of care, and financial security among the low-income population.³³

Virginia Woman Sued by Nonprofit Hospital

Daisha was uninsured and working part-time at Walmart, making \$11 per hour, under 100% of the FPL. She sought emergency medical care at a nonprofit hospital and was admitted for two weeks. She was not told about financial assistance available for the cost of the care and no one discussed her bill with her. Instead, she was sued for \$12,287.68 and did not know about the lawsuit until her wages were garnished. She was forced to live on \$345 a month after paying rent.*

Source: Simmons-Duffin, “[When Hospitals Sue For Unpaid Bills](#),” NPR, June 25, 2019.

Full coverage may be unavailable or unaffordable for the remaining *underinsured*, who face high deductibles and costs, and *uninsured*. These groups include those who are low-income and live in a state that did not expand Medicaid;³⁴ those who have incomes at or above 400% of FPL and are ineligible for the tax credits that subsidize insurance coverage; and documented immigrants who may be ineligible for Medicaid or subsidized plans.³⁵ For example, in **Georgia**, almost 240,000 adults are stuck in the “coverage gap,” where they have too little income to get financial help to buy health insurance on the ACA marketplace and do not currently qualify for Medicaid.³⁶

While the overall number of uninsured has decreased since the enactment of the ACA, the number of underinsured people has increased.³⁷ Of the U.S. adults who have health insurance through their employer, 28% were underinsured in 2018, up from 17% in 2010.³⁸ There have also been, and likely will be more, attempts in Congress and the courts to roll back the ACA and Medicaid expansion, which, if successful, would lead to more underinsured and uninsured patients, and greater medical debt.

Under the ACA, both publicly and privately owned hospitals with 501(c)(3) nonprofit status³⁹ must fulfill the requirements of section 501(r) of the Internal Revenue Code,⁴⁰ in addition to the general requirements for tax exemption under section 501(c)(3).⁴¹ About 56% of American community hospitals are nonprofit, which means they are exempt from paying taxes and allowed to float tax-exempt bonds.⁴² To maintain this status, these hospitals are required to provide community benefits, including financial assistance for low-income patients. The section 501(r) requirements include establishing a written Financial Assistance Policy (FAP) and a written Emergency Medical Care Policy. A nonprofit hospital organization’s failure to meet these requirements could result in revocation of the organization’s tax-exempt status.

While section 501(r) represents a significant step forward in providing care for low-income populations, it applies only to nonprofit hospitals, and the ACA and its implementing regulations do not specify any minimum standards of financial assistance. Hospitals decide the eligibility and qualifying criteria for the FAP. If a nonprofit hospital fails to comply with the ACA FAP requirements, the patient does not have a private right of action under the statute to seek redress for noncompliance, as only the IRS can enforce these requirements. The requirements also do not apply to for-profit hospitals and other types of large health care provider organizations⁴³ even though for-profit hospitals and hospital chains are widespread and, in some states, outnumber nonprofit hospitals.⁴⁴ There is no federal requirement for profit-driven hospitals to provide similar financial assistance for low- or no-income patients.⁴⁵

CONSEQUENCES OF OVERWHELMING MEDICAL DEBT

While some states have mandates or at least financial incentives for hospitals to provide financial assistance to residents who are at or below a certain percentage of the FPL, the majority of states have no such mandates and merely provide optional policies that hospitals may implement if they choose. This leaves the lowest-income uninsured and inadequately insured patients at risk of incurring huge, debilitating medical debt.

In 2017, 36% of Virginia hospitals sued to garnish the wages of patients who owed medical debt.

Memphis Nonprofit Healthcare Relentlessly Pursued the Poor for Medical Debt

As there is no requirement for hospitals to provide any specific free or reduced care for low-income patients, someone like Carrie Barrett, whose income has not exceeded \$12 per hour, was saddled with tens of thousands of dollars of debt for a life-saving emergency procedure. Due to interest and fees, the \$12,000 debt has grown to over \$30,000 and her meager paycheck was garnished at least 15 times. She was ordered to pay \$100 per month from her earnings of about \$1,000 per month, which at that rate, with no interest added, would take 25 years to pay off. *

Source: Thomas, “The Nonprofit Hospital That Makes Millions,” *MLK50*, June 27, 2019.

Recent media accounts have detailed the practices of some nonprofit hospitals that aggressively pursue patients for overdue medical bills, whether through repeated calls, notices, lawsuits, liens on their property, and/or wage garnishments.⁴⁶ For example, a study conducted by researchers at Johns Hopkins University revealed that Mary Washington Hospital in Virginia filed so many lawsuits against patients for medical debt that the court reserved a morning every month for just its 300 or more cases to be heard.⁴⁷ In 2017, 36% of Virginia hospitals sued to garnish the wages of patients who owed medical debt.⁴⁸ Most of those hospitals were nonprofit entities, and most were located in urban areas. The mean amount garnished from patients was about \$2,500, a significant amount for those making minimum wage at Walmart, Lowe’s, and Amazon, the most common employers of those having wages garnished.⁴⁹ An analysis by *Kaiser Health News* found that, from June 2012 to June 2018, “the UVA health system and its doctors filed 36,000 lawsuits against patients seeking a total of more than \$106 million, seizing wages and bank accounts, putting liens on property and homes and forcing families into bankruptcy.”⁵⁰ Virginia does not have a state mandate requiring hospitals to provide financial assistance for certain patients based on specific income levels or other set standards.

In Memphis, Tennessee, a city where nearly one in four residents live below the poverty line, Methodist Le Bonheur Healthcare, a nonprofit hospital system, filed more than 8,300 lawsuits for unpaid medical debt from 2014 through 2018.⁵¹ Methodist owns a licensed debt collection agency that aggressively pursued unpaid debt through lawsuits and wage garnishments.⁵² Since the ACA does not establish minimum requirements for financial assistance, Methodist and other nonprofit hospitals are free to create bare-bones policies that provide little assistance, leaving many low-income patients with no aid at all. In Tennessee, reimbursements are available for

hospitals providing free or reduced care to low-income patients, but there is no specific aid mandated for patients with specific incomes.⁵³

Recently, however, through the efforts of the communities, advocates, local elected officials, and the press, Mary Washington Hospital agreed to suspend suing patients and to eliminate garnishments, and the UVA system announced that it would increase financial assistance, give bigger discounts to the uninsured, and reduce its reliance on the judicial system to collect debts.⁵⁴ Methodist Le Bonheur Healthcare announced that it would forgive the debts owed by more than 6,500 patients – including Carrie Barrett, whose story is described in the sidebar on page 8 – and that it would stop filing new debt collection lawsuits or garnishment attempts.⁵⁵ The hospitals’ change of practices demonstrates that improvements toward comprehensive financial assistance plans are feasible.

AN OVERVIEW OF STATES’ FINANCIAL ASSISTANCE RULES

The following is an overview of different state plans and not an exhaustive list or description of every free or discount care program available in each state. The tables (see appendices) included describe some of the financial assistance policies available, who is eligible for the assistance, how the assistance is funded, and related citations. For more in-depth information on individual states’ financial assistance policies, see National Consumer Law Center, *Collection Actions* § 9.4.3 (4th ed. 2017), and NCLC [Model Medical Debt Protection Act](#).

States have used different mechanisms to mandate that hospitals provide varying levels of financial assistance, including requirements tied to state licensing, certificates of need, or

The strongest consumer protections in this area are laws or other mandates that require all hospitals to provide a comprehensive financial assistance policy that includes provisions for discount care.

reimbursements for discount care provided. As described further, several states have enacted financial assistance laws to provide assistance that includes free or discount care, and some provide state-funded financial assistance for low-income people (such as the Health Safety Net in Massachusetts). Others have implemented agreements with the state’s attorney general (Minnesota) or created other networks of assistance through community health centers (Arkansas) or through the hospitals voluntarily creating their own free and discount care policies (Vermont). Using certain mechanisms may be more or less feasible or appropriate in each state. Regardless of the mechanism used, however, the strongest consumer protections in this area are laws or other mandates that require all hospitals to provide a comprehensive

financial assistance policy that includes provisions for discount care, including 100% discount or “free care,” with specific, minimum eligibility requirements based on income levels as outlined in the NCLC [Model Medical Debt Protection Act](#).⁵⁶

1) Comprehensive State Financial Assistance Policies

Only a handful of states mandate that both nonprofit and for-profit hospitals provide financial assistance, including a 100% discount, or “free care,” for low-income patients who fall at or below a specific income requirement. The comprehensive financial assistance rules in these

states are examples of immediate and significant steps that states can take to alleviate devastating medical debt that burdens their low-income residents. These states include:

New Jersey and Rhode Island mandate that all hospitals provide a 100% discount for residents with incomes at or below 200% FPL, and discounted care for patients with incomes between 200% and 300% FPL. In **New Jersey**, uninsured patients with family incomes of less than 500% FPL cannot be charged more than 15% above the Medicare payment rate.

Maryland mandates that hospitals provide free care for patients at or below 200% FPL, and reduced cost care for patients with income between 200% and 500% FPL.

Illinois mandates that hospitals provide free care for most patients with a family income at or below 200% FPL, but the patient has to cover the first \$300 of the care. (This could be challenging for many low-income residents, considering that about 40% of Americans would struggle to pay a \$400 unexpected expense.⁵⁷) Care at rural or critical access hospitals must be free for patients at or below 125% FPL, and all hospitals must provide discounted care for uninsured patients with income and assets at or below 600% FPL (or 300% FPL for rural or critical access hospitals). Hospitals also cannot collect more than 35% over their cost of services for any one inpatient or outpatient visit costing more than \$300 for uninsured patients.

Maine requires hospitals to provide free care to Maine residents with income of less than 150% FPL. There is no specific mandate, however, for hospitals to provide financial assistance for patients above 150% FPL, although the statute requires the state to adopt reasonable guidelines for hospitals to provide health care services to patients who are unable to pay.

Nevada requires hospitals with at least 100 beds to provide a minimum amount of free care of 0.6% of their net revenue for patients who are uninsured, are ineligible for public assistance, or have an income of \$438 per month for a single person, \$588 per month for two people, or \$588 plus \$150 per month for each additional family member. It also requires major hospitals to discount the total billed charge by at least 30% for an inpatient who is uninsured, is not eligible for state coverage, and makes a reasonable payment arrangement.

New York mandates that hospitals may charge no more than a nominal fee to patients with incomes at or below 100% FPL, and are to provide discounted care on a sliding scale basis to patients with incomes between 100% and 300% FPL. Hospitals cannot charge uninsured patients whose income is under 300% FPL more than what the hospitals receive from Medicare, Medicaid, or the highest volume payer for that hospital.

Washington mandates that hospitals provide free care for uninsured patients at or below 100% FPL, and discounts of 75% to 25% for patients between 100% and 200% FPL.

California mandates general or acute care hospitals to provide free or reduced care for uninsured patients, or patients with high medical costs who have incomes at or below 350% FPL.

Connecticut mandates that all hospitals screen for eligibility for financial assistance, but only requires discounted care for uninsured patients who do not qualify for Medicaid, Medicare, or

other coverage and with income at or below 250% FPL (see Appendix A for additional information about states that mandate a spectrum of financial assistance for nonprofit and for-profit hospitals).

25% of the bad debt at Mary Washington Healthcare in Virginia and 50% of the bad debt at Methodist Le Bonheur Healthcare in Tennessee involved candidates for free or discounted care.

Twenty-five percent of the bad debt at Mary Washington Healthcare and 50% of the bad debt at Methodist Le Bonheur Healthcare involved candidates for free or discounted care who did not know about the available assistance programs.⁵⁸ Even in Washington State, which has a comprehensive financial assistance mandate, the state's attorney general sued St. Joseph Hospital to stop such practices as failing to offer low-income patients applications for assistance and asking how much the patient could pay that day.⁵⁹ Enforcement and accountability through community involvement, advocacy, and legislative and legal action are imperative to ensure the effectiveness of the financial assistance policies that do exist.

2) Limited States' Financial Assistance Policies

States that Mandate Financial Assistance for Nonprofit or Publicly Funded Hospitals Only

A few states, while lacking a more comprehensive approach, require certain hospitals -- nonprofit hospitals or state-owned hospitals -- to provide financial assistance. **Oregon** requires nonprofit hospitals and clinics to provide full financial assistance to those with household incomes of up to 200% FPL, and assistance on a sliding scale for those with incomes of up to 400% FPL. Although this requirement is limited to nonprofit hospitals, the large majority of hospitals in Oregon are nonprofit entities, so this financial assistance would be accessible for a high proportion of Oregon patients.

Texas requires nonprofit hospitals to provide financial assistance at least to patients with income between 21% and 200% FPL. Fewer than half of Texas hospitals are nonprofit entities.

In **Louisiana**, state-owned hospitals must provide financial assistance to patients with a family income at or below 200% of FPL who are uninsured, or if care expenses exceed 20% of family income in the last 12 months. As of 2017, 27% of hospitals in Louisiana were reported to be state-owned hospitals (see Appendix B for additional information on states that mandate financial assistance for nonprofit and publically funded hospitals).

Implementation and Enforcement of Policies is Essential

Even the most comprehensive financial assistance policies, however, are ineffective unless they are implemented well, and then enforced. Hospitals trying to increase their revenue and expand their services still erect barriers to such assistance, including failing to inform patients about the assistance or help them with what can be a complicated application process. Hospitals must invest in staff training and collaboration with community partners to make sure that existing policies are well understood in the community and among staff, and that there are no unintentional barriers that restrict access to financial assistance. Without strict oversight and enforcement of the programs, many patients who would have qualified for free or discounted care are billed hundreds or thousands of dollars for their medical procedures, and when they can't pay, they are the subject of aggressive collection tactics.

3) State-run Financial Assistance Programs

Some states lack a state law that requires hospitals to provide financial assistance directly to the patient, but provide similar coverage through programs provided through the state. For example, **Massachusetts** does not mandate that hospitals provide financial assistance, but it does pay the cost of care for some patients through its Health Safety Net program. Under that program, it pays the full cost of eligible care at acute care hospitals and community health centers for those whose income is at or below 150% FPL, and pays the cost of care minus a deductible for those with income of 150% and 300% FPL. Hospitals must offer payment plans for bills over \$1,000.

Colorado provides discounted care for state residents who are ineligible for Medicaid and have incomes that do not exceed up to 250% FPL through the Colorado Indigent Care Program.

South Carolina's Medically Indigent Assistance Program covers inpatient hospital treatment and pays for everything Medicaid covers for South Carolina residents who are U.S. citizens or lawful permanent residents with incomes that do not exceed 200% FPL and who meet certain asset requirements (see [Appendix C for additional information on states that have their own programs for assistance](#)).

4) Other Programs or Statutes that May Provide Some Financial Assistance

While the strongest, most beneficial programs are those that mandate comprehensive financial assistance to low-income patients, such as those in section 1), we note that other states that do not provide such mandates may have certain incentives or requirements for hospitals to provide discount care, such as permits to expand or reimbursements.

a) States that Require Financial Assistance Policies in Exchange for a Certificate of Need

In some states, hospitals applying for a Certificate of Need to add on or build a health care facility must demonstrate that they have certain policies in place to provide financial assistance to those patients unable to pay for care.⁶⁰ For example, some states require hospitals to provide financial assistance plans to residents with income of up to 350% of FPL (**Delaware**) or 200% FPL (**District of Columbia**) if they want to construct, develop, or acquire a health care facility. Others mandate that hospitals seeking to expand implement financial assistance policies for certain individuals such as the “elderly...and medically underserved” (**North Carolina**) or indigent patients (**Virginia**). (See [Appendix D for additional information on states that require financial assistance for certificate of need](#).)

b) States Where Hospitals Can Seek Reimbursement for Financial Assistance Provided

Other states require certain specific financial assistance policies in exchange for reimbursements of the cost of care provided to low-income patients through funding sources such as indigent care pools or Medicaid Disproportionate Share Hospital (DSH) payments that are intended to offset hospitals' uncompensated care costs to improve access for Medicaid and uninsured patients, and to preserve the financial stability of safety-net hospitals.⁶¹ These payments are made to qualifying hospitals that serve large numbers of individuals who are insured through

Medicaid or are uninsured.⁶² For example, **Georgia, New York, Oklahoma, and Tennessee** provide reimbursements through state indigent health care pools or funds, while **Ohio's** Hospital Care Assurance Program (HCAP) provides partial reimbursement to hospitals for uncompensated care they provide to low-income individuals, with priority given to those hospitals that provide a disproportionately high share of indigent care in relation to the total care provided by the hospital or in relation to other hospitals.

Kentucky, New York, Ohio, Oklahoma, and Tennessee require hospitals seeking reimbursement to provide financial assistance to individuals with income at or below 100% FPL. **Florida** requires nonprofit hospitals seeking reimbursement to provide free care to individuals with income of up to 100% FPL. **Kansas** requires hospitals seeking matching funds for care to provide health care services to those with incomes of up to 200% FPL. **New Mexico** requires hospitals seeking reimbursements to provide financial assistance to patients with income that is not more than 50% greater than the average per capita personal income for New Mexico. While **Missouri** and **Pennsylvania** provide partial reimbursements for care given to uninsured patients, there are no set financial eligibility standards and hospitals can create their own policies (see [Appendix E for additional information on states that require specific financial assistance policies \(FPL\) for reimbursements](#)).

5) No State Mandate but Some Financial Assistance in Practice

In other states, financial assistance is provided to low-income patients in practice even if it not mandated by state law. For example, in **Vermont**, all hospitals have their own financial assistance care policies based on residency and income levels at or below 200% FPL. In **Arkansas**, community-based health centers provide subsidized care for certain individuals with income of up to 200% FPL.

In **Minnesota**, the Attorney General signed agreements with most hospitals that, for patients with income of less than \$125,000, the hospitals will not charge more for services than the hospitals would be reimbursed by non-governmental insurers. A similar limit on what hospitals can charge uninsured, lower-income patients exists in **Oklahoma**, where a hospital's charge, after the discount, may not exceed the greater of the amount Medicare would pay for the same services or the cost of services as determined by multiplying the hospital's whole cost-to-charge ratio by the billed charges. In **Tennessee**, hospitals are prohibited from requiring an uninsured patient to pay for services in an amount that exceeds 175% of the hospital's cost to provide the services (See [Appendix F for additional information on no mandate but financial assistance in practice](#)).

6) Other States' Programs

In many other states, such as **Alaska, Alabama, Idaho, Indiana, Michigan, Mississippi, Nebraska, North Dakota, Utah, and West Virginia** certain hospitals provide some financial assistance to those who are unable to pay, but the hospitals or counties can create their own policies and eligibility standards (See [Appendix G for additional information on states that provide some unspecified assistance](#)).

Finally, several states, including **Hawaii, Montana, New Hampshire, Wisconsin,** and **Wyoming** impose almost no incentives, guidelines, or requirements for hospitals to provide comprehensive free or discount care to uninsured or underinsured patients (see [Appendix H](#)).

CONCLUSION

Hospital financial assistance can protect patients who lack insurance or adequate insurance -- and their families -- from falling further into poverty, facing bankruptcy, or otherwise dealing with unmanageable and unaffordable medical debt. The ACA requires tax-exempt hospitals to establish a Financial Assistance Plan to assist low-income patients, but the lack of any specific guidelines or eligibility criteria allows some hospitals to provide only a bare minimum of options for those who cannot pay their medical bills. Many states, however, have surpassed the basic requirements of the ACA and enacted comprehensive financial assistance policies for uninsured and underinsured patients. States have used various mechanisms to require hospitals to provide at least some level of financial assistance to low-income, uninsured patients. Through these or other mechanisms, advocates can fight toward the ultimate goal of creating comprehensive financial assistance plans mandated for all hospitals that includes free and reduced-fee care, and specific income requirements for eligibility.

Many resources are available for advocates, community members, and legislators to do this. NCLC's [Model Medical Debt Protection Act](#)⁶³ offers model language that states can build on.

At a minimum, states should create a comprehensive policy addressing free and discount care⁶⁴ that would cover all hospitals and include:

1. A written financial assistance policy that applies to all emergency and other medically necessary health care services offered by the covered health care provider;
2. A plain-language summary of the financial assistance policy, which shall not exceed two pages in length;
3. Clear minimum eligibility criteria for both free and discount care for both uninsured and underinsured patients, and a summary of the type of assistance that is available (as set forth in the [NCLC Model Medical Debt Protection Act](#));
4. The method and application process that patients are to use to apply for financial assistance;
5. The information and documentation that the large health care facility may require an individual to provide as part of the application;
6. The reasonable steps that the provider will take to determine whether a patient is eligible for financial assistance; and
7. The billing and collections policy, including the actions that may be taken in the event of nonpayment.⁶⁵

States can also turn to examples such as **Rhode Island, New Jersey, Maine, New York, Connecticut, California,** and **Nevada**, which have already adopted strong financial assistance policies. State initiatives and policies like these are essential in providing low-income patients with the comprehensive, meaningful financial assistance they need to address burgeoning medical debt.

ENDNOTES

1. Edward R. Berchick, Jessica C. Barnett, and Rachel D. Upton, [Health Insurance Coverage in the United States: 2018](#), U.S. Census Bureau, November 2019.
2. Consumer Financial Protection Bureau, [Consumer Credit Reports: A Study of Medical and Non-Medical Collections](#), December 11, 2014.
3. Consumer Financial Protection Bureau, [Consumer Experiences with Debt Collection: Findings from the CFPB's Survey of Consumer Views on Debt](#) (CFPB survey conducted between December 2014 and March 2015), section 3.2.2, January 2017.
4. Deborah Thorne, "New medical bankruptcy study: Two-thirds of filers cite illness and medical bills as contributors to financial ruin," Physicians for a National Health Program, February 7, 2019,. This article refers to David U. Himmelstein et al., "Medical Bankruptcy: Still Common Despite the Affordable Care Act," *American Journal of Public Health* 9, no. 3 (March 2019): 431-433.
5. An additional resource, listing a range of federal and state rules relating to free or subsidized care, is the [Free Care Compendium from Community Catalyst](#). Note that the Compendium is not fully up to date.
6. Chi Chi Wu, Jenifer Bosco, and April Kuehnhoff, National Consumer Law Center, [Model Medical Debt Protection Act](#), September 2019.
7. Edward R. Berchick, Jessica C. Barnett, and Rachel D. Upton, [Health Insurance Coverage in the United States: 2018](#), United States Census Bureau, November 2019.
8. Jennifer Tolbert, Kendal Orgera, Natalie Singer, and Anthony Damico, [Key Facts about the Uninsured Population](#), Kaiser Family Foundation, Dec. 13, 2019.
9. *Id.*
10. Rachel Garfield Follow, Kendal Orgera, and Anthony Damico, [The Uninsured and the ACA: A Primer - Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act](#), Kaiser Family Foundation, Jan 25, 2019.
11. Ruohua Annetta Zhou, Katherine Baicker, Sarah Taubman, and Amy N. Finkelstein, [The Uninsured Do Not Use The Emergency Department More – They Use Other Care Less](#), Dec. 2017.
12. *Id.*
13. Gunja and Collins, [Who Are the Remaining Uninsured, and Why Do They Lack Coverage?](#)
14. Kaiser Family Foundation, [Key Facts about the Uninsured Population](#) (Figure 6), December 7, 2018.
15. In a 2019 report of findings from the Commonwealth Fund's latest Biennial Health Insurance Survey, the authors note, "This criteria does not include other dimensions of someone's health plan that might leave them potentially exposed to costs, such as copayments or uncovered services. It therefore provides a conservative measure of underinsurance in the United States." Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, [Health Insurance Coverage Eight Years After the ACA](#), The Commonwealth Fund, February 7, 2019.
16. Jack Hoadley, Kevin Lucia, and Maanasa Kona, "State Efforts to Protect Consumers from Balance Billing," The Commonwealth Fund, January 18, 2019.
17. Hoadley, Lucia, and Kona, "State Efforts to Protect Consumers from Balance Billing."

18. [2019 New Mexico S.B. No. 337](#), 54th Leg., 1st Sess.
19. [2019 Washington H.B. No. 1065](#), 66th Leg., Regular Sess.
20. [2019 Colorado H.B. 19-1174](#), 72d Leg., 1st Sess.
21. [2019 Texas S.B. 1264](#), 86th Leg..
22. Karen Pollitz, Matthew Rae, Gary Claxton, Cynthia Cox, and Larry Levitt, Kaiser Family Foundation, “[An examination of surprise medical bills and proposals to protect consumers from them](#),” June 20, 2019.
23. Collins, Bhupal, and Doty, *Health Insurance Coverage Eight Years After the ACA*.
24. The Commonwealth Fund, *Underinsured Rate Rose From 2014-2018, With Greatest Growth Among People in Employer Health Plans*, February 7, 2019.
25. Collins, Bhupal, and Doty, *Health Insurance Coverage Eight Years After the ACA*.
26. Collins, Bhupal, and Doty, *Health Insurance Coverage Eight Years After the ACA*.
27. Noam N. Levey, “[Health insurance deductibles soar, leaving Americans with unaffordable bills](#),” *Los Angeles Times*, May 2, 2019, This article reported on a Los Angeles Times/ Kaiser Foundation survey.
28. Levey, “Health insurance deductibles soar.”
29. Levey, “Health insurance deductibles soar.”
30. Gunja and Collins, *Who Are the Remaining Uninsured, and Why Do They Lack Coverage?*
31. Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming have not passed Medicaid expansion.
32. Kaiser Family Foundation, “[Status of State Medicaid Expansion Decisions: Interactive Map](#),” September 20, 2019.
33. Larisa Antonisse, Rachel Garfield, Robin Rudowitz, and Madeline Guth, *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, Kaiser Family Foundation, August 15, 2019.
34. Gunja and Collins, *Who Are the Remaining Uninsured, and Why Do They Lack Coverage?* This population is eligible only for their state’s current Medicaid program, which is usually available only to children and very low- or no-income parents, or unsubsidized plans in the marketplaces.
35. The authors of a 2019 report note that about 2.5 million poor uninsured adults fall into a “coverage gap” by either earning too much to qualify for Medicaid or not enough to be eligible for the ACA marketplace premium tax credits. Rachel Garfield, Kendal Orgera, and Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, March 21, 2019.
36. Laura Harker, “[Fast facts on Georgia’s coverage gap](#),” Georgia Budget and Policy Institute, January 23, 2018.
37. Collins, Bhupal, and Doty, *Health Insurance Coverage Eight Years After the ACA*.
38. Collins, Bhupal, and Doty, *Health Insurance Coverage Eight Years After the ACA*.

39. Tax-exempt hospitals may be owned by private corporations or public entities, like a state or county government. Because the ACA provisions apply only to private or publicly-owned tax-exempt hospitals, some publicly-owned hospitals are not subject to this set of ACA rules.
40. 26 U.S.C. § 501(r).
41. 26 U.S.C. § 501(c)(3).
42. Jordan Rau, "[Patients Eligible For Charity Care Instead Get Big Bills](#)," *Kaiser Health News*, October 14, 2019.
43. For a discussion of nonprofit and for-profit hospital requirements, see Erin C. Fuse Brown, "Fair Hospital Prices Are Not Charity: Decoupling Hospital Pricing and Collection Rules from Tax Status," 53 *University of Louisville Law Review* 509 (2016).
44. Kaiser Family Foundation, [State Health Facts, Hospitals by Ownership Type](#) (2014).
45. Another federal law, the Emergency Medical Treatment and Active Labor Act (EMTALA), at 42 U.S.C. § 1395dd, includes a prohibition against hospitals turning away a patient in need of emergency medical treatment because the patient may not be able to pay for the care, and it also prohibits delay in providing medical screening or care in order to inquire about payment for care. EMTALA does not require hospitals to provide free or discounted emergency care.
46. John Hancock and Elizabeth Lucas, "['UVA Has Ruined Us': Health System Sues Thousands Of Patients, Seizing Paychecks And Claiming Homes](#)," *Kaiser Health News*, September 10, 2019; Maya Miller and Beena Raghavendran, "[Thousands of Poor Patients Face Lawsuits From Nonprofit Hospitals That Trap Them in Debt](#)," ProPublica, September 13, 2019; Wendi C. Thomas, "[The Nonprofit Hospital That Makes Millions, Owns a Collection Agency and Relentlessly Sues the Poor](#)," MLK50, June 27, 2019; Selena Simmons-Duffin, "[When Hospitals Sue For Unpaid Bills, It Can Be 'Ruinous' For Patients](#)," National Public Radio, June 25, 2019.
47. Simmons-Duffin, "When Hospitals Sue For Unpaid Bills."
48. William E. Bruhn, Lainie Rutkow, Peiqi Wang, "[Prevalence and Characteristics of Virginia Hospitals Suing Patients and Garnishing Wages for Unpaid Medical Bills](#)," *Journal of the American Medical Association*, June 25, 2019. This source is a study performed and published as a research letter for JAMA.
49. Bruhn, Rutkow, and Wang, "Prevalence and Characteristics of Virginia Hospitals."
50. Hancock and Lucas, "'UVA Has Ruined Us.'"
51. Thomas, "The Nonprofit Hospital That Makes Millions."
52. Thomas, "The Nonprofit Hospital That Makes Millions."
53. Tenn. Code Ann. §§ 68-11-262; 68-11-1101 to 68-11-1104.
54. Jay Hancock, Elizabeth Lucas, and *Kaiser Health News*, "[UVA Health System revamps aggressive debt collection practices after report](#)," *The Washington Post*, September 13, 2019.
55. Wendi C. Thomas, "[Nonprofit Hospital That Sued Poor Patients Just Freed Thousands From Debt](#)," National Public Radio, September 25, 2019.
56. While not the focus of this paper, the NCLC Model Act also discusses the importance of limits on medical debt collection and credit reporting. National Consumer Law Center, [Model Medical Debt Protection Act](#), 27-28.

57. Federal Reserve, *Report on the Economic Well-Being of U.S. Households in 2017*, May 2018, 2, 21.
58. Rau, “Patients Eligible For Charity Care Instead Get Big Bills.”
59. Rau, “Patients Eligible For Charity Care Instead Get Big Bills.”
60. For more information about Certificate of Need programs, see Christine Khaikin, Lois Uttley, and Aubree Winkler, *When Hospitals Merge: Updating State Oversight to Protect Access to Care*, MergerWatch, 2016; National Conference of State Legislatures, “CON – Certificate of Need State Laws,” February 2, 2019.
61. 42 C.F.R. § 447.
62. For more information about Disproportionate Share Hospital payments, see *Medicaid and CHIP Payment and Access Commission*, Report to Congress on Medicaid and CHIP, March 2019.
63. National Consumer Law Center, *Model Medical Debt Protection Act*.
64. The *Model Medical Debt Protection Act* also covers other important aspects of a comprehensive assistance plan, including education, language access, limits on creditors, verification of debts, prohibition against collection of medical debt, private remedies for patients, etc.
65. National Consumer Law Center, *Model Medical Debt Protection Act*.

APPENDIX A

STATES THAT MANDATE A SPECTRUM OF FINANCIAL ASSISTANCE FOR NONPROFIT AND FOR-PROFIT HOSPITALS

State	Who is affected?	Who is eligible?	How is it funded?	Statutes
California	Free care mandated for general acute hospitals as requirement for licensure	Free or reduced care for uninsured patients who are at or below 350% FPL or underinsured patients with high medical costs (medical expenses exceed 10% of income in prior 12 months)	Hospitals. Small or rural hospitals can set a lower income-based discount threshold as necessary to “maintain their financial and operational integrity”	Cal. Welf. & Inst. Code §§ 16900 to 16996.2; Cal. Health & Safety Code §§ 127400 to 127466
Connecticut	All hospitals with bed funds	The cost of care covered or reduced for uninsured and underinsured individuals who are unable to pay. All hospitals required to screen for eligibility of assistance under the hospital’s charity care policy and/or the hospital’s “bed fund” - private donations made to the hospital. Hospitals may not collect more than the cost of providing services from certain uninsured patients with a family income of up to 250% Federal Poverty Level (FPL)	Hospitals; private donations	Conn. Gen. Stat. §§ 19a-7d, 19a-509b (“bed fund”), 19a-649, 19a-673
Illinois	All hospitals	Hospital Uninsured Patient Discount Act: uninsured with family income of up to 200% FPL. For rural or critical access hospitals, family income of up to 125% FPL. Receive 100% discount of charges exceeding \$300 for medically necessary services; if 600% FPL and uninsured, discount of amount over \$300; 300% FPL for rural or critical access hospitals. Cannot collect more than 35% over their cost of services for any one inpatient or outpatient visit costing more than \$300	Hospitals: state provides tax exemption for eligible nonprofit hospitals, and property and sales tax credits for eligible for-profit hospitals	210 Ill. Comp. Stat. §§ 89/1 to 89/20

APPENDIX A (Continued)

State	Who is affected?	Who is eligible?	How is it funded?	Statutes
Maine	All hospitals	Up to 150% of FPL, whether insured or not	Hospitals	Me. Stat. tit. 22, § 1716; 10-144 Me. Code R. ch. 150
Maryland	Each acute care hospital and each chronic care hospital in the state	Up to 150% of FPL; beneficiaries or recipients of certain social services programs with means tests are presumptively eligible	State has rate-setting system. Hospitals pay an assessed fee to state for uncompensated care of up to 1.25 % of their total gross operating revenue and put into Hospital Uncompensated Care Fund used exclusively to finance the delivery of uncompensated care	Md. Code Ann., Health-Gen. §§ 19-201 to 19-227; Md. Code Regs. tit. 10, subtitle 37
New Jersey	Acute care hospitals	Income at or below 200% of FPL, or if between 200 and 300% FPL and medical expenses exceed 30% of annual gross income and individual assets do not exceed \$7,500 and family's assets do not exceed \$15,000. Uninsured patients with family incomes less than 500% FPL cannot be charged more than 15% above the Medicare payment rate	Hospitals, disproportionate share hospitals are eligible for reimbursement through the Health Care Subsidy Fund: consists of revenues from various taxes	N.J. Stat. Ann. §§ 26:2H-18.58; N.J. Admin. Code § 10:52-11.8, -11.10
New York	Nonprofit hospitals, all hospitals seeking reimbursement from Indigent Care Pool	Must provide charity care through state law community service plan requirements. All hospitals are reimbursed for providing charity care from the Hospital Indigent Care Pool and must at least provide discounts to residents with incomes below 300% FPL. For patients at 100% FPL or lower, hospitals may charge only a capped nominal amount. For incomes between 100 and 250% FPL, must provide sliding scale. Cannot charge	General hospital assessments	N.Y. Pub. Health Law §§ 2803-l, 2805-a, 2807-c, 2807-k

APPENDIX A (Continued)

State	Who is affected?	Who is eligible?	How is it funded?	Statutes
New York (cont.)		uninsured patients whose income is under 300% FPL more than what the hospitals receive from Medicare, Medicaid, or the highest volume payer for that hospital		
Nevada	Hospitals with at least 100 beds and that are located in a county that has at least two licensed hospitals	Free care for indigent patients: uninsured, ineligible for public assistance, income of \$438/ month for a single person, \$588/ month for two people, or \$588 plus \$150 for each additional family member	Hospitals: 0.6% of net revenue in free care to indigent patients each year then reimbursed by the county for additional care it provides to indigent patients	Nev. Rev. Stat. §§ 439B.300 to 439B.340
Rhode Island	All hospitals - requirement for licensing	Patients with incomes of up to 200% FPL- free care; some hospitals have asset test; patients with incomes between 200% and 300% FPL- discount care	Hospitals	R.I. Gen. Laws § 23-17-43
Washington	All hospitals	Family income less than or equal to 100% FPL and not covered by insurance	Hospitals	Wash. Rev. Code § 70.170.060(5). Wash. Admin. Code §§ 246-453-001 to 246-453-090

[Return to Previous Page](#)

APPENDIX B

STATES THAT MANDATE FINANCIAL ASSISTANCE FOR NONPROFIT AND PUBLICALLY FUNDED HOSPITALS

State	Who is affected?	Who is eligible?	How funded?	Statutes
Louisiana	Designated state-sponsored hospitals.	Indiv. with family income at or below 200% of FPL and uninsured. If not indigent but uninsured if expenses exceed 20% of family income in last 12 months	State: Department of Health and Hospitals	Louisiana Revised Statutes §§ 17:1519.4; 46.6; 46:2761; Louisiana State University Health Care Services Division Policy No. 2525-17 (https://www.lsuhsports.org/docs/2525-17.pdf)
Oregon	Nonprofit hospitals and clinics	Full financial assistance to those with household incomes of up to 200% of Federal Poverty Level (FPL) and a sliding scale up to 400% FPL	Hospitals	HB3076: signed by Governor June 2019- Effective Jan. 1, 2020; Oregon General Laws ch. 497
Texas	Nonprofit Hospitals- to maintain nonprofit status	Nonprofit hospitals must provide charity care and government-sponsored indigent health care. Hospital can establish own eligibility for charity care but has to be at least: income no lower than 21% FPL and no higher than 200% FPL	Hospitals, Counties, State	Tex. Health & Safety Code Ann. § 311.031(11); Tex. Health & Safety Code Ann. § 61.006(b); 61.023

[Return to Previous Page](#)

APPENDIX C

STATES THAT HAVE THEIR OWN PROGRAMS FOR ASSISTANCE

State	Who is affected?	Who is eligible?	How funded?	Statutes
Colorado	All hospitals	Discounted care for medically indigent persons: income up to 250% FPL; CO Indigent Care Program covers insured and uninsured individuals, participants must use a uniform rating system to determine where individuals fall on the State's sliding fee schedules, and must comply with the State's eligibility requirements and application procedures also. The University of Colorado hospital system is obligated to provide a certain amount of care to the medically indigent in exchange for partial reimbursement from the State	State	Colorado Revised Statutes §§ 25.5-3-101 to 25.5-3-112; 10 CCR 2505-10 8.900
Massachusetts	All acute care hospitals and community health centers	Household income is at or below 150% of Federal Poverty Level (FPL), full coverage. Minimal deductible if 150%-300% FPL. Must be MA resident, either uninsured and underinsured and medical hardship.	Health Safety Net Trust Fund through hospital assessments, surcharges on payments to hospitals and ambulatory surgical centers, and state funds	101 CMR 613; 614, 118 Mass. Gen. Laws ch. 118E sec. 66-70
South Carolina	All hospitals	If income does not exceed 200% FPL, resident of SC, US citizen or LPR, \$35k equity limit on home, \$6k equity limit on other real and personal property, and up to \$500 cash, then can qualify for Medically Indigent Assistance Program that pays for everything Medicaid covers	State/Counties	South Carolina Code of Regulations Annotated 126-500 to 126-570

[Return to Previous Page](#)

APPENDIX D

STATES THAT REQUIRE FINANCIAL ASSISTANCE FOR CERTIFICATE OF NEED

State	Who is affected?	Who is eligible?	How funded?	Statutes
Delaware	All health facilities seeking Certificate of Public Review required for the construction, development or other establishment of a health-care facility or the acquisition of a nonprofit health-care facility; expenditure of \$5.8 mil.; or change in bed capacity by more than 10 beds or 10% of capacity' acquisition of major medical equipment.	Delaware residents with a family income of up to 350% of FPL.	Health care facilities	Delaware Code Title 16, §§ 9301 to 9312; Title 29, §§ 7201 to 7204; Delaware Health Resources Board, Certificate of Public Review Health Resources Management Plan (2017)
District of Columbia	New institutional health service or health facility seeking a Certificate of Need that is required for a capital expenditure	Uninsured or underinsured with family income that does not exceed 200% of Federal Poverty Level (FPL) and unable to pay for health care services	the health care facility or health service shall provide uncompensated care in an amount not less than three percent (3%) of the health care facility's or health service's annual operating expenses, less the amount of reimbursements it receives from state or federal govt. programs	District of Columbia Official Code §§ 44-401 to 44-422; District of Columbia Municipal Regulations Title 22, §§ B4400 to B4499
North Carolina	All hospitals seeking Certificate of Need	All hospitals must provide services to meet "the health-related needs of the elderly and of members of medically	Counties oversee the care of indigent persons within their borders	N.C. Gen. Stat. §§131E-183(13); 153A-255

APPENDIX D (Continued)

State	Who is affected?	Who is eligible?	How funded?	Statutes
North Carolina (cont.)		underserved groups" to get a Certificate of Need required to offer a" new institutional health service."		
Virginia	All hospitals seeking a certificate of public need	Must obtain "certificate of public need" to build or add new facility which requires providing a level of charity care to indigent persons or accepting patients requiring specialized care; All VA hospitals have their own free care policies	Hospitals	Va. Code Ann. § 32.1-102.2(C); 12 Va. Admin. Code 5-220-270(A)(i)

[Return to Previous Page](#)

APPENDIX E

STATES THAT REQUIRE SPECIFIC FAP FOR REIMBURSEMENTS

State	Who is affected?	Who is eligible?	How funded?	Statutes
Georgia	Free care mandated for "disproportionate share hospitals" (serves a disproportionate number of low-income patients with special needs) receiving state reimbursement from Indigent Care Trust	Hospital Care for the Indigent Program, free care if income below 125% FPL, and discount care for 125% to 200% FPL	State and counties; Indigent Care Trust Fund	Official Code of Georgia §§ 31-8-30 to 31-8-37; 31-8-1 to 31-8-11; 31-8-150 to 31-8-160; Rules and Regulations of the State of Georgia §§ 111-3-6-.03(4)(f)(10); 290-5-5-.01
Kansas	Certain major hospitals	Assistance for residents of counties having a population between 175,000 and 250,000 who are medically indigent: unable to pay hospitalization and uninsured- decided by county commissioners board	Counties having a population between 175,000 and 250,000 may tax levy for hospital fund	Kansas Statutes §§ 39-415 to 39-418
Kentucky	No mandated free care	Assistance for residents of counties having a population between 175,000 and 250,000 who are medically indigent: unable to pay hospitalization and uninsured- decided by county commissioners board	Counties having a population between 175,000 and 250,000 may tax levy for hospital fund	Kansas Statutes §§ 39-415 to 39-418.
Missouri	No mandated free care	Hospitals are reimbursed generally 89% for the cost of care rendered to uninsured patients. Can set own policies. Must report charity care in annual financial report	State and hospitals; there is also a medically indigent sales tax authorized for St. Louis	Mo. Code Regs. tit. 13, § 70-15.010(18)(B); Mo. Ann. Stat. § 94.1000(1); Mo. Code Regs. tit.19, § 10-33.030

APPENDIX E (Continued)

State	Who is affected?	Who is eligible?	How funded?	Statutes
New Mexico	All hospitals	Hospitals can apply for reimbursement of charity care for indigents: income is not more than 50% greater than the per capita personal income for New Mexico; non-federal health care facilities are required to report detailed information and data regarding charity care policies and utilization	Counties through Health Care Assistance Funds: hospitals can apply to be reimbursed for hospital care rendered to indigents	New Mexico Statutes §§ 27-5-1 – 27-5-18.
New York	Nonprofit hospitals, all hospitals seeking reimbursement from Indigent Care Pool	Must provide charity care through state law community service plan requirements. All hospitals are reimbursed for providing charity care from the Hospital Indigent Care Pool and must at least provide discounts to residents with incomes below 300% FPL. For patients at 100% FPL or lower, hospitals may charge only a capped nominal amount. For incomes between 100 and 300% FPL, must provide sliding scale	General hospital assessments	N.Y. Pub. Health §§ 2807-c and 2807-k; N.Y. Pub. Health Law §§ 2803-l and 2805-a
Ohio	All hospitals that receive Hospital Care Assurance Program funds	Must provide free, basic, medically necessary care to eligible individuals with income at or below the Federal Poverty Level (FPL) to receive partial reimbursement from Hospital Care Assurance Program-HCAP	State and federal funds, and hospitals (through HCAP fee)	Ohio Administrative Code 5160-2-07.17; Ohio Revised Code 5168.14

APPENDIX E (Continued)

State	Who is affected?	Who is eligible?	How funded?	Statutes
Oklahoma	All hospitals	Indigent Health Care Act: reimbursement for hospitals providing medically necessary services to the “medically indigent:” income is at or below 100% of FPL and lacks resources to pay for needed care; uninsured; and the individual has not assigned or transferred property in order to qualify for program within past two years	State and federal funds	Oklahoma Statutes 56 §§ 57-66
Pennsylvania	No mandated free care	Uncompensated Care Program- partially reimburses participating hospitals for the uncompensated care they provide to "patients financially unable or unwilling to pay for services"	State (Tobacco Settlement)	Pennsylvania Statutes Title 35 P.S. §§449.3; 5701.1101-1108.
Tennessee	No mandated free care	Charity care may be available for medically indigent: income is at or below 100% of Federal Poverty Level (FPL), no resources to pay; all hospitals must limit billing to uninsured patients to 175% of cost of services	Disproportionate share hospitals may get reimbursed through the Indigent Health Care Fund	Tennessee Code Annotated §§ 68-11-262; 68-11-1101 – 68-11-1104

[Return to Previous Page](#)

APPENDIX F

NO MANDATE BUT FINANCIAL ASSISTANCE IN PRACTICE

State	Who is affected?	Who is eligible?	How funded?	Statutes
Arkansas	Community health centers	Assistance for medically indigent: "unable to pay part or all of the cost of necessary medical and hospital services," Subsidized community based health care services including hospital care if patient is uninsured between ages 18 and 65, lives or works in the community served by the program; ineligible for government health assistance; has income that does not exceed 200% FPL; and meets other requirements of Board of Directors of the health center. Unsubsidized services are available if between 200-300% of FPL	County in which the indigent patient resides.	Arkansas Code §§ 6-64-501 to 6-64-509
Minnesota	Hospitals who reached agreement with Attorney General (AG)	But AG signed agreements with most hospitals that can't charge more for services than the hospital would be reimbursed by non-governmental insurer. Must have household income > \$125,000	Hospitals	Ex. A: Agreement at ¶32, <i>In the Matter of Kittson Mem'l Hosp. Ass'n</i> , No. C1-05-10586 (Minn. Dist. Ct. 2017)
Vermont	All hospitals	All Vermont hospitals have their own free care policies based on residency and income levels at or below 200% of Federal Poverty Level (FPL)		

[Return to Previous Page](#)

APPENDIX G

STATES THAT PROVIDE SOME UNSPECIFIED ASSISTANCE

State	Who is eligible?	How funded?	Statutes
Alabama	Limited assistance available through Hospital Service Program for Indigents if a resident of Alabama for more than 1 year who is "acutely ill or injured and can be helped markedly by treatment in a hospital, but who is unable to pay the cost of such hospitalization..."	County in which the indigent patient resides	Alabama Code §§ 22-21-210 to 22-21-227; 22-21-290 to 22-21-297
Alaska	Limited relief for "a needy person (not eligible for other aid) with a chronic or acute medical condition;" or someone with a "catastrophic illness" that results in medical expenses of over \$1,000 during a period not to exceed 12 months, after all other sources of payment have been exhausted	State; hospital must allow 3-year repayment plan for remaining balance	Alaska Statutes §§ 47.08.010 to 47.08.150; 47.25.195; 7 Alaska Admin. Code §§ 48.005-48.598
Idaho	Medically indigent patients: patients who are unable to pay the cost of necessary medical services over the next five years	Counties up to \$11,000 per person, per year; State pays rest under CAT Fund. Patient has to pay reasonable portion over time	Idaho Code §§ 31-3501 to 31-3557
Indiana	Hospital Care for the Indigent Program: assistance available if onset of severe medical condition (in Indiana if nonresident) with family income less than 75% of FPL	State	Indiana Code §§ 12-16-2.5 to 12-16-16.5-3 (partially repealed); 470 Indiana Admin. Code § 11.
Michigan	Boards of trustees at public hospitals determine if patient eligible for free care; also over 40 free care clinics run by volunteers in state for uninsured	County hospital fund	Michigan Compiled Laws § 331.167

APPENDIX G (Continued)

State	Who is eligible?	How funded?	Statutes
Mississippi	Hospital boards of trustees may enact rules necessary to protect patients and charity funds and no hospital shall charge payment to indigent patients	Hospitals	Miss. Code Ann. § 41-3-101; 41-7-21 & 35
South Dakota	Medically necessary hospital services may be available for Medically Indigent: requires care; has no insurance that covers cost of hospitalization; has no ability to pay; is not indigent by design; income falls under guidelines: calculate housing cost and add to household income at or below 175% FPL then multiply by 12 to determine ability to pay	Counties; can apply to Catastrophic County Poor Relief Fund for reimbursement if spend over \$20,000 for an individual over 12 months	South Dakota Codified Laws § 28-13-1 to § 28-13-44; § 28-13A-6
Utah	Eligibility requirements not mandated but nonprofit hospitals must have a formalized policy that guarantees free or reduced charge services to indigent persons in accordance with their ability to pay	Hospitals	Property Tax Exemption Standards of Practice, Standard 2, Appendix 2B, Standard II
West Virginia	Nonprofit hospitals must develop charity care plan if base state tax exemption on "charitable use" of facilities	Hospitals	W. Va. Code R. § 110-3-24

[Return to Previous Page](#)

APPENDIX H

STATES THAT PROVIDE NO REQUIREMENTS FOR FREE CARE

State	Who is eligible?	How funded?	Statutes
Hawaii	Patients in need of psychiatric care only through Hawaii State Hospital	State	Hawaii Admin. Rules §§ 11-174-1 to 11-174-8
Montana	Counties may opt to establish their own Indigent Assistance programs, including programs that provide health care, but they are not required to do so.	Counties, through property taxes	Mont. Code. Ann. § 53-3-116
New Hampshire	Reporting requirements only: every 5 years hospitals must report on needs of community, must develop and file with the NH Attorney General plans to address community health care needs	Hospitals	New Hampshire Revised Statutes §7:32-c-j
Wisconsin	All hospitals must have (and file) annual “uncompensated health care service plans” with total number of patients receiving uncompensated care but no set standards imposed	Hospitals	Wis. Admin. Code [HFS] §§120.03, 25
Wyoming	Memorial hospitals must provide free services if person lacks means to pay but resident is deemed to have means to pay if county of residence has a functioning department of public assistance.		Wyoming Statutes §§ 18-8-101 to 18-8-109

[Return to Previous Page](#)

National Headquarters:
7 Winthrop Square
Boston, MA 02110-1245
Phone: 617/542-8010
www.nclc.org



**National
Consumer Law
Center**

*Fighting Together
for Economic Justice*

Washington Office:
Spanogle Institute for
Consumer Advocacy
1001 Connecticut Ave, NW
Suite 510
Washington, DC, 20036
Phone: 202/452-6252