National Consumer Law Center
Fighting Together for Economic Justice

AN OUNCE OF PREVENTION

A REVIEW OF HOSPITAL FINANCIAL ASSISTANCE POLICIES IN THE STATES

By Andrea Bopp Stark, Jenifer Bosco, and Berneta Haynes

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EXECUTIVE SUMMARY

More than 27 million Americans do not have health insurance of any kind. A further 43% of non-elderly adults have inadequate insurance, which may have high deductibles or other significant out-of-pocket costs. In the meantime, health care costs and rates of medical debt continue to rise. 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 nonprofit hospitals with 501(c)(3) tax-exempt status to provide certain community benefits, including financial assistance for low-income patients. Requirements under 26 CFR §1.501(r) ("501(r)" 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 minimum standards or eligibility criteria for this 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.

States have the authority to fill this gap by passing state laws that add financial assistance protections that supplement the ACA or by strengthening their existing laws that preceded the ACA. This report provides a brief overview of the financial assistance laws in each of the 50 states and the District of Columbia and looks at the level of financial assistance, if any, mandated in each jurisdiction.

Twelve states have enacted laws that require hospitals to provide a broad 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 may provide some assistance. Some states have enacted comprehensive financial assistance laws but only for nonprofit or publicly funded hospitals. Others require certain hospitals to financially assist some low-income patients in exchange for a Certificate of Need to build or expand facilities. There are still many states, however, that have few or no guidelines for hospitals caring for patients who may not be able to pay.

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 California, Connecticut, Illinois, Maryland, and Washington, which have adopted strong financial assistance laws. At a minimum, states should mandate that 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.

The National Consumer Law Center's Model Medical Debt Protection Act provides model statutory language to accomplish these goals.

Stronger financial assistance laws and enforcement can help reduce medical debt for low-income patients. While there are many other steps that policymakers can take to address medical debt, financial assistance laws mitigate medical debt by protecting low-income patients from unaffordable hospital bills.

INTRODUCTION

Despite the implementation of the Patient Protection and Affordable Care Act (ACA), many Americans still lack health insurance, are underinsured, or have insurance coverage with high cost-sharing responsibilities. In 2021, about 27.2 million people in the United States did not have health insurance at any point during the year, down from about 28.3 million in 2020.[1,2] The COVID-19 pandemic has led to further churn in the health insurance market.[3]

17.8% of Americans have at least one medical debt collection item on their credit reports.

The debt that results from hospital care affects tens of millions of consumers. Total medical debt in the United States is estimated to exceed $140 billion,[4] with 41% of all adults—insured or uninsured—currently burdened by medical or dental debt.[5] According to recent estimates, 17.8% of Americans have at least one medical debt collection item on their credit reports.[6] It is one of the most prevalent types of consumer debt; people report being contacted about medical bills more than any other type of debt.[7]

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.[8] In addition, the National Consumer Law Center's (NCLC) Model Medical Debt Protection Act[9] includes language that could be used in state law to extend financial assistance requirements beyond those required by the 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.

WHO ARE THE UNINSURED?

In 2022, two in 10 uninsured adults went without needed medical care because of the cost.

The percentage of Americans without health insurance at any point during a calendar year has fluctuated slightly in recent years, generally remaining between 7.9% and 9.2%,[10] affected by the temporary expansion of public insurance coverage during the COVID-19 public health emergency.[11] The uninsured have difficulty accessing care and the medical treatment they need. In 2022, two in 10 uninsured adults went without needed medical care because of the cost.[12] The uninsured are less likely to seek preventative care and services for significant health issues and chronic conditions: 59% of uninsured people did not go to a doctor or clinic despite a medical problem in the past year.[13] Uninsured adults are more than 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, blood sugar, and colon cancer.[14] 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.[15] 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, compared to six visits per year for those with insurance.[16]

Young adults, Hispanic/Latino adults, and low-income, working-age adults are all disproportionately likely to lack health insurance. Young adults ages 19-34 make up 44% of the uninsured population. Hispanic/Latino adults represent 35% of all uninsured people, but only 18% of the working-age adult population.[17] In general, people of color are at higher risk of being uninsured, and may be more likely to live in a state that has not expanded its Medicaid coverage.[18] While people of color make up 43.1% of the non-elderly population in the United States, they account for over half of the total non-elderly uninsured population.[19]

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

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 Commonwealth Fund's Biennial Health Insurance Survey, those who were considered underinsured were:

- individuals with income greater than 200% of the Federal Poverty Level (FPL) who had out-of-pocket costs, excluding premiums, of 10% or more of their household income over the prior 12 months;
- individuals with income less than 200% of FPL who had out-of-pocket costs, excluding premiums, of 5% or more of their household income over the prior 12 months; or
- individuals who were responsible for deductibles totaling 5% or more of their household income.[20]

For a summary of the Federal Poverty Level and incomes, please see Appendix I.

Today, 43% of U.S. adults ages 19 to 64 are inadequately insured.[21] People who purchased health coverage on their own through the individual market or the marketplaces are the most likely to be underinsured, with 44% reporting a lack of adequate coverage in 2022.[22] However, even employer-based healthcare is often insufficient, with 29% of people with employer-sponsored healthcare similarly underinsured.[23]

43% of U.S. adults ages 19 to 64 are inadequately insured.

The underinsured are more likely to struggle to pay hospital bills or to forgo care, such as seeing a doctor or filling prescriptions, because of the cost. Despite having health coverage, 44% of insured adults worry about affording their deductible.[24] 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.[25] 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.[26]

The federal No Surprises Act, which took effect in January 2022, protects consumers from some forms of surprise billing. For example, it prevents most surprise billing in emergency

situations, and when an out-of-network provider works at an in-network hospital. But it doesn't cover ground ambulances, and patients can waive their rights in some circumstances.[27] States such as **Georgia**[28] and **Maryland**[29] have enacted statutes bringing state law into alignment with the No Surprises Act. Several states, including **New Mexico**,[30] **Washington**,[31] **Colorado**,[32] and **Texas**,[33] have 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.[34]

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.

As health care costs have increased, employers have turned to high deductible and cost-sharing plans to keep premiums down, thereby passing more of the costs of health care onto their employees.[35] Deductibles for employer-sponsored health plans in the United States have risen in recent years, and over four out of 10 workers do not have enough savings to cover the deductible.[36] Deductibles for an individual job-based health insurance plan have risen from an average of $379 in 2006 to $1,763 in 2022.[37] Because of this increase in health insurance and health care expenses, one in six covered workers has made significant sacrifices, such as taking on extra work or cutting back on food, clothing, or other essentials.[38]

THE AFFORDABLE CARE ACT AND ITS GAPS

The ACA was enacted on March 23, 2010. The law contains a multitude of provisions that affect a wide range of health insurance matters and increase 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.[39] To date, 41 states including the District of Columbia have adopted the Medicaid expansion, while 10 states[40] have not.[41] Medicaid expansion has improved access to care, utilization of services, the affordability of care, and financial security among the low-income population.[42]

Hospital FAPs may be onerous to apply for and may exclude outside providers the hospital assigns to treat patients.

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;[43] 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.[44] 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.[45]

While the overall number of uninsured has decreased since the enactment of the ACA, the number of underinsured people has increased.[46] Of the U.S. adults who have health insurance through their employer, 29% were underinsured in 2022, up from 17% in 2010.[47]

Under the ACA, both publicly and privately owned hospitals with 501(c)(3) nonprofit status[48] must fulfill the requirements of section 501(r) of the Internal Revenue Code,[49] in addition to the general requirements for tax exemption under section 501(c)(3).[50] About 56% of American community hospitals are nonprofit, which means they are exempt from paying taxes and allowed to float tax-exempt bonds.[51] 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

Nonprofit Healthcare Providers Continued to Pursue Patients During Pandemic

In June 2020, Tyler Boll-Flaig was hospitalized at Froedtert Health System in Wisconsin, after he was seriously injured and his younger brother was killed when an illegal drag racer collided with their car. Froedtert Hospital discharged Tyler 24 hours later with a shattered jaw, broken ribs, and crushed vertebrae.

Tyler was uninsured while working as a food delivery driver, and his family was unable to pay the hospital when contacted days after the crash. By the end of July, Froedtert filed a lien against him for $67,225.

SOURCE: Jenny Deam, "Some Hospitals Kept Suing Patients Over Medical Debt Through the Pandemic," *ProPublica*, June 14, 2021.

hospitals, and the ACA and its implementing regulations do not specify 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's 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. Even where applicable, hospital FAPs may be onerous to apply for and may exclude outside providers the hospital assigns to patients without their knowledge.[52] The requirements also do not apply to for-profit hospitals and other types of large health care provider organizations[53] even though for-profit hospitals and hospital chains are widespread and, in some states, outnumber nonprofit hospitals.[54] There is no federal requirement for profit-driven hospitals to provide similar financial assistance for low- or no-income patients.[55]

CONSEQUENCES OF OVERWHELMING MEDICAL DEBT

While some states have mandates or financial incentives for hospitals to provide financial assistance to residents who are at or below a certain percentage of the FPL, others have no such mandates or 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 2022, more than 30% of uninsured or underinsured patients were targeted by a collection agency about their unpaid medical bills. But a quarter of these patients had not even incurred the debt: they were targeted because of a billing mistake.[56]

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

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.[57] Hospitals file lawsuits to collect both large and small amounts of debt.[58] 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 one court reserved a morning every month for just its 300 or more cases to be heard.[59] In 2017, 36% of Virginia hospitals sued to garnish the wages of patients who owed medical debt.[60] 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.[61] 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

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.

and bank accounts, putting liens on property and homes and forcing families into bankruptcy."[62] 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.[63] Methodist owns a licensed debt collection agency that aggressively pursued unpaid debt through lawsuits and wage garnishments.[64] Because 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 low incomes.[65]

Recently, however, through the efforts of the communities, advocates, local elected officials, and the media, 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.[66] Methodist Le Bonheur Healthcare announced that it would forgive the debts owed by more than 6,500 patients and would stop filing new debt collection lawsuits or garnishment attempts.[67] The hospitals' change of practices demonstrates that improvements toward comprehensive financial assistance plans are feasible.

In addition to aggressive debt collection practices, some hospitals withhold nonemergency care from patients with unpaid medical bills—even if those patients would have qualified for free care. Allina Health System, which "temporarily paused" this practice just days after *The New York Times* reported on it, canceled patients' appointments and refused to reinstate the appointments until any debt was paid in full. Some patients had tens of thousands of dollars in debt after sudden illness and were effectively blocked from any future care or had appointments canceled after they had been waiting for months.[68] Though Allina was the focus of this article, about 20% of hospitals have a similar practice.[69]

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.[70] Even in the state of

Washington, which has a comprehensive financial assistance mandate, the state's attorney general sued St. Joseph Hospital to stop practices such as failing to offer low-income patients applications for assistance and asking how much the patient could pay that day.[71] 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.

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 in the Appendices add detail about 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 (5th ed. 2020), and the 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 reimbursements for discount care provided. As described further, several states have enacted financial assistance laws to mandate free or discounted 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).

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 free and discounted care.

Using certain mechanisms may be more or less feasible or appropriate in each state. Regardless of the mechanism used, however, the strongest consumer protections, and tools to reduce medical debt, 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" for the lowest income patients, with specific, minimum eligibility requirements based on income levels that meet or exceed those outlined in the NCLC Model Medical Debt Protection Act.[72]

Fair and equitable implementation of the law is necessary as well so that assistance reaches eligible patients, including low-income immigrants and people of color. Patient information and application materials must be widely accessible, and the application process should meet the needs of patients with different cultural or language backgrounds. For instance, New Mexico has taken steps to protect access to financial assistance for patients who are immigrants, prohibiting discrimination based on immigration status.[73] A 2021 Illinois statute requires hospitals to "proactively" offer information about financial assistance to all patients regardless of immigration status or residency.[74]

1. Broad 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 broad 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:

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

COLORADO recently passed a state law that strengthens medical debt protections and requires all hospitals to provide financial assistance. Colorado also caps medical debt interest at 3% yearly.

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 whose income is at or below 250% FPL.

ILLINOIS mandates that hospitals provide a discount to uninsured patients whose income is up to 600% FPL, after the patient pays the first $150 of charges for any one inpatient admission or outpatient encounter, a reduction from the $300 required prior to 2021.[75] (Even this reduced amount could be challenging for many low-income households, considering that about 40% of Americans would struggle to pay a $400 unexpected expense.[76]) Free care is available for uninsured patients whose income is at or below 200% FPL, after the patient pays the first $150. The hospital must offer these patients screening for other public insurance programs. If there are multiple admissions or treatments, the hospital cannot collect an amount that is over 20% of the family's income over a 12-month period. Hospitals must notify all uninsured patients of the availability of financial assistance, regardless of immigration status or residency.[77]

MAINE requires hospitals to provide free care to Maine residents whose income is 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.

MARYLAND mandates that hospitals provide free care for patients whose income is at or below 200% FPL, reduced cost care for patients whose income is above 200% FPL, and payment plans for uninsured patients whose income is between 200% and 500% FPL. State agencies and the Maryland Hospital Association are developing a process for identifying and reimbursing patients who paid for medical care but qualified for free care at the time of service, from 2017 through 2021.

NEVADA requires hospitals with at least 100 beds to provide a minimum amount of free care of 0.6% of their net revenue for the preceding year for patients who are indigent (uninsured, are ineligible for public assistance, or have an income of no more than $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 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.

NEW YORK hospitals must provide charity care and, in order to be reimbursed, hospitals may charge no more than a nominal fee to patients with incomes at or below 100% FPL and must 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.

VERMONT requires hospitals, starting in July 2024, to provide cost-free care for uninsured patients below 250% FPL, and at least a 40% discount for uninsured patients between 250% and 400% FPL. These tiered discounts also apply to out-of-pocket costs for insured patients. Further, if a patient is below 600% FPL and a medical bill exceeds 20% of their yearly income, the cost must be reduced to no more than that 20%. Vermont also prohibits hospitals from selling medical debt.

WASHINGTON mandates that large hospitals provide free care for uninsured patients at or below 300% FPL, discounts of 75% for patients between 301% and 350% of FPL, and discounts of 50% for patients between 351% and 400% of FPL. All other hospitals must provide free care for uninsured patients at or below 200% FPL, discounts of 75% for patients between 201% and 250% of FPL, and discounts of 50% for patients between 251% and 300% of FPL. Hospitals may reduce the discount if patients own assets of a certain value, but may not consider things like equity in a patient's primary home or up to two necessary cars that a patient owns.

See Appendix A for additional detail about these states and citations to statutes.

2. Limited State 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.

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 2021, 27% of hospitals in Louisiana were reported to be state-owned hospitals.[78]

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, most hospitals in Oregon are nonprofit entities, so this financial assistance would be accessible for a high proportion of Oregon patients.

Implementation and Enforcement of Policies are Essential

Even the most comprehensive financial assistance policies 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 to 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. When they can't pay, they are the subject of aggressive collection tactics.

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.

See Appendix B for additional information on states that mandate financial assistance for nonprofit and publicly funded hospitals.

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 other programs. For example, **MASSACHUSETTS** does not mandate that hospitals provide financial assistance, but it does pay the cost of care for some low-income 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 whose income is between 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.

See Appendix A for more information on Colorado's Indigent Care Program.

SOUTH CAROLINA's Medically Indigent Assistance Program covers inpatient hospital treatment and pays for the same services that Medicaid would cover 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.

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

In some states, hospitals applying for a Certificate of Need to expand 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.[79] 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 a certificate of need.

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.[80] These payments are made to qualifying hospitals that serve large numbers of individuals who are insured through Medicaid or are uninsured.[81] 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. In New York, hospitals cannot charge uninsured patients whose income is under 300% of the federal poverty level more than what the hospitals receive from Medicare, Medicaid, or the highest volume payer for that hospital.[82]

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 these states.

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 **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, though there is no private right of action included in the law.

See Appendix F for additional information on these states.

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 about these states.

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 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 enacted more detailed and 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. Advocates seeking to reduce medical debt for low-income consumers have advocated for comprehensive programs in many states to shield patients from burdensome medical debt.

Strong financial assistance policies are an important consumer protection to mitigate medical debt for vulnerable families, but the problem of medical debt cannot be solved with financial assistance alone. NCLC's Model Medical Debt Protection Act also provides recommendations for consumer protections from aggressive collection practices, and, in its introduction, outlines a broader range of possible solutions to medical debt and health care affordability. In the short term, financial assistance and protection from aggressive collection actions can help protect consumers from devastating medical debt, without significant impacts on hospital budgets.[83] In the long term, broad solutions to reduce health care costs, address health care disparities resulting from a long history of racism, and provide universal, adequate coverage will be needed to eliminate medical debt in the United States.

Many resources are available for advocates, community members, and legislators who seek to strengthen financial assistance requirements and other consumer protections in their states. NCLC's Model Medical Debt Protection Act[84] offers model language that states can build on.

At a minimum, states should create a comprehensive policy addressing free and discount care[85] that covers all hospitals and includes:

- A written financial assistance policy that applies to all hospitals licensed in the state, as a condition of licensing, and requires that eligible low-income patients receive financial assistance for emergency care and other medically necessary health care services;

- A plain-language summary of the financial assistance policy, no more than two pages long;
- Translation requirements for informational material and applications;
- 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 (for example, the types listed in the NCLC Model Medical Debt Protection Act);
- The obligation of hospitals to screen patients for financial assistance eligibility and insurance eligibility as early as possible and before starting collection actions;
- The method and application process that patients are to use to apply for financial assistance;
- The information and documentation (and reasonable substitutes) that a hospital may ask an individual to provide as part of the application;
- The reasonable steps that the provider will take to determine whether a patient is eligible for financial assistance;
- The billing and collections policy, including the actions that may be taken in the event of nonpayment;
- Non-discrimination requirements;
- An accessible complaint process for patients who are denied assistance; and
- Enforcement by the attorney general or state agency, as well as a private right of action.[86]

States can also turn to examples, such as **CALIFORNIA**, **CONNECTICUT**, **ILLINOIS** and **MARYLAND**, which have already adopted strong financial assistance policies and continue to improve their health care consumer protections. State initiatives and policies like these are essential in providing low-income patients with the comprehensive, meaningful financial assistance they need to help avoid burgeoning medical debt.

APPENDIX A: STATES WITH BROAD FINANCIAL ASSISTANCE RULES 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 (with the ability to allow charity care for those with higher incomes) or underinsured patients with high medical costs (which include annual out-of-pocket costs at the hospital that exceed the lesser of 10% of the patient's current family income or family income in the prior 12 months) 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; AB 1020
Colorado	Colorado Indigent Care Program (CICP) – All hospitals (hospitals decide whether to participate) Hospital discounts (current) – All hospitals Hospital discounts (beginning on July 1, 2022) – All public and private hospitals, free standing emergency rooms, and providers that provide care in the above settings	CICP – people at or below 250 % FPL who can establish lawful presence and are not eligible for Medicaid or CHIP; qualified patients pay an income-based co-pay for selected hospital services (participating hospitals must provide CICP discounts for emergency and urgent services; other services may be discounted depending on the hospital) Hospital discounts (until June 30, 2022) – Uninsured people at or below 250% of the federal poverty level receiving a service not covered by CICP; qualified patients are entitled to receive the hospital's "lowest negotiated rate"	CICP – State funds and federal matching funds (from Colorado's DSH allotment) Hospital discounts (current) – no public funding allocated; counts as community benefit investment for tax-exempt hospitals Hospital discounts (beginning July 1, 2022) – no public funding allocated; counts as community benefit investment for tax-exempt hospitals	CICP – 25.5-3-101, C.R.S. Hospital discounts (current) – 25-3-112, C.R.S. Hospital discounts (beginning July 1, 2022) – 25.5-3-501, C.R.S. et seq. Bill # HB21-1198

State	Who is affected?	Who is eligible?	How is it funded?	Statutes
Colorado (continued)		Hospital discounts (beginning on July 1, 2022) – All people at or below 250% of the federal poverty level receiving hospital services not covered by CICP; hospitals and FSEDs limited to charging 4% of qualified patient's income a month and must consider patient's bill paid in full after 36 payments; providers billing separately from the hospital limited to charging 2% of qualified patient's income a month and must consider bill paid in full after 36 months; if qualified patient is uninsured, the rate is capped by Colorado's Medicaid agency at an amount that approximates the rate paid by public payers.		
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

State	Who is affected?	Who is eligible?	How is it funded?	Statutes
Illinois	All hospitals	Hospital Uninsured Patient Discount Act: Effective January 1, 2022, free care will be available for uninsured patients with income at or below 200% FPL, after paying the first $150. Discount to uninsured patients with income of up to 600% FPL, after paying the first $150 of charges for any one inpatient admission or outpatient encounter.	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; IL LEGIS 102-581 (2021), 2021 Ill. Legis. Serv. P.A. 102-581 (S.B. 1840)
Maine	All hospitals	Free care for patients with income up to 150% of FPL.	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	Free care for households with family income up to 200% of FPL; reduced cost care with family income above 200% FPL; payment plans for uninsured with income at 200-500% 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

State	Who is affected?	Who is eligible?	How is it funded?	Statutes
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 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	General hospital assessments	N.Y. Pub. Health Law §§ 2803-l, 2805-a, 2807-c, 2807-k
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.260 to 439B.340

State	Who is affected?	Who is eligible?	How is it funded?	Statutes
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
Vermont	Large healthcare facilities	Free care for patients with incomes of up to 250% FPL; discounted care for patients of between 250% and 400% FPL	Hospitals	18 V.S.A. §§ 9481 to 9487
Washington	All hospitals	Large hospitals: free care for families at or below 300% FPL; discounted care for families at or below 400% FPL. All other hospitals: free care for families at or below 200% FPL; discounted care for families at or below 300% FPL.	Hospitals	Wash. Rev. Code § 70.170.060(5). Wash. Admin. Code §§ 246-453-001 to 246-453-090

APPENDIX B: STATES THAT MANDATE FINANCIAL ASSISTANCE FOR NONPROFIT AND PUBLICLY FUNDED HOSPITALS

State	Who is affected?	Who is eligible?	How is it funded?	Statutes
Louisiana	Designated state-sponsored hospitals	Individual 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

State	Who is affected?	Who is eligible?	How is it funded?	Statutes
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

APPENDIX C: STATES THAT HAVE THEIR OWN PROGRAMS FOR ASSISTANCE

State	Who is affected?	Who is eligible?	How is it funded?	Statutes
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 services that Medicaid covers	State/Counties	South Carolina Code of Regulations Annotated 126-500 to 126-570

APPENDIX D: STATES THAT REQUIRE FINANCIAL ASSISTANCE FOR CERTIFICATE OF NEED

State	Who is affected?	Who is eligible?	How is it 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 underserved groups" to get a Certificate of Need required to offer a" new institutional health service."	Counties oversee the care of indigent persons within their borders	N.C. Gen. Stat. §§131E-183(13); 153A-255

State	Who is affected?	Who is eligible?	How is it funded?	Statutes
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, and are required to screen uninsured patients for hospital or state assistance programs.	Hospitals	Va. Code Ann. §§ 32.1-102.2(C) and 32.1-137.09; 12 Va. Admin. Code 5-220-270(A)(i)

APPENDIX E: STATES THAT REQUIRE SPECIFIC FAP FOR REIMBURSEMENTS

State	Who is affected?	Who is eligible?	How is it 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

State	Who is affected?	Who is eligible?	How is it funded?	Statutes
Kentucky	No mandated free care	Certain hospitals participating in Medicaid and a disproportionate share program may have up to 100% of uncompensated costs reimbursed (where patients could not pay). No direct assistance to patients.	State Medical Assistance Revolving Trust Fund with revenue from taxes.	Kentucky Statutes § 205.640
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
New Mexico	All hospitals	Hospitals can apply for reimbursement of charity care for indigent patients: 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. Financial assistance shall be provided to qualifying patients regardless of immigration status.	Counties through Health Care Assistance Funds: hospitals can apply to be reimbursed for hospital care rendered to indigent patients.	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.	General hospital assessments	N.Y. Pub. Health §§ 2807-c and 2807-k; N.Y. Pub. Health Law §§ 2803-l and 2805-a

State	Who is affected?	Who is eligible?	How is it funded?	Statutes
New York (continued)		For incomes between 100 and 300% FPL, must provide sliding scale		
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
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 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 (Note: no private right of action, Fowler v. Morristown-Hamblen Hosp. Ass'n, 2019 WL 2571081 (Tenn. Ct. App. June 24, 2019)).	Disproportionate share hospitals may get reimbursed through the Indigent Health Care Fund	Tennessee Code Annotated §§ 68-11-262; 68-11-1101—68-11-1104

APPENDIX F: NO MANDATE BUT FINANCIAL ASSISTANCE IN PRACTICE

State	Who is affected?	Who is eligible?	How is it 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, In the Matter of Kittson Mem'l Hosp. Ass'n, No. C1-05-10586 (Minn. Dist. Ct. 2017)

APPENDIX G: STATES THAT PROVIDE SOME UNSPECIFIED ASSISTANCE

State	Who is eligible?	How is it 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 must 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
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

State	Who is eligible?	How is it funded?	Statutes
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

APPENDIX H: STATES THAT PROVIDE NO REQUIREMENTS FOR FREE CARE

State	Who is affected?	Who is eligible?	How is it funded?	Statutes
Hawaii	No free care mandated except for Hawaii State Hospital (psychiatric services only)	Patients in need of psychiatric care only through Hawaii State Hospital	State	Hawaii Admin. Rules §§ 11-174-1 to 11-174-8
Montana	No mandated free care	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	No mandated free care	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

State	Who is affected?	Who is eligible?	How is it funded?	Statutes
Wisconsin	No mandated free care	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	No mandated free care	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

APPENDIX I: FEDERAL POVERTY GUIDELINES (COVERAGE YEAR 2023)

# in Household	100% FPL	138% FPL	150% FPL	200% FPL	250% FPL	300% FPL	400% FPL
1	$14,580	$20,120	$21,870	$29,160	$36,450	$43,740	$58,320
2	$19,720	$27,214	$29,580	$39,440	$49,300	$59,160	$78,880
3	$24,860	$34,307	$37,290	$49,720	$62,150	$74,580	$99,440
4	$30,000	$41,400	$45,000	$60,000	$75,000	$90,000	$120,000
5	$35,140	$48,493	$52,710	$70,280	$87,850	$105,420	$140,560
6	$40,280	$55,586	$60,420	$80,560	$100,700	$120,840	$161,120
7	$45,420	$62,680	$68,130	$90,840	$113,550	$136,260	$181,680
8	$50,560	$69,773	$75,840	$101,120	$126,400	$151,680	$202,240

SOURCE: HHS Poverty Guidelines for 2023. Office of the Assistant Secretary for Planning and Evaluation.

*For households with more than 8, add $5,140 for each additional person.

ENDNOTES

1 Katherine Keisler-Starkey and Lisa N. Bunch, Health Insurance Coverage in the United States: 2021, U.S. Census Bureau, September 2022.

2 Daniel McDermott, Cynthia Cox, Robin Rudowitz, and Rachel Garfield, How Has the Pandemic Affected Health Coverage in the U.S.?, Kaiser Family Foundation, December 9, 2020.

3 Daniel McDermott, Cynthia Cox, Robin Rudowitz, and Rachel Garfield, How Has the Pandemic Affected Health Coverage in the U.S.?, Kaiser Family Foundation, December 9, 2020.

4 Raymond Kluender, Ph.D., et al., Medical Debt in the US, 2009-2020, Journal of the American Medical Assoc., Vol. 326, No. 3, pp. 250-256 (July 20, 2021).

5 Alex Montero, Audrey Kearney, Liz Hamel, and Mollyann Brodie, *Americans' Challenges with Health Care Costs*, Kaiser Family Foundation, July 14, 2022.

6 Raymond Kluender, Ph.D., et al., Medical Debt in the US, 2009-2020, Journal of the American Medical Assoc., Vol. 326, No. 3, pp. 250-256 (July 20, 2021). *See also* Consumer Financial Protection Bureau, *Medical Debt Burden in the United States*, February 2022.

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