AN OUNCE OF PREVENTION

Reforming the Hospital Financial Assistance Law Could Save Pounds of Patient Debt

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CSS Community Service Society

The Community Service Society of New York (CSS) is an informed, independent, and unwavering voice for positive action representing low-income New Yorkers. CSS addresses the root causes of economic disparity through research, advocacy, litigation, and innovative program models that strengthen and benefit all New Yorkers. **www.cssny.org**

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EXECUTIVE SUMMARY

All hospitals operating in New York State are charitable entities under state law and are bound by Internal Revenue Service regulations requiring the establishment of financial assistance.[1] The New York State Hospital Financial Assistance Law (HFAL) likewise requires any hospital that receives funding—and nearly all do—from the State's $1.1 billion Indigent Care Pool (ICP) to have a financial assistance application and policy.[2] Ideally, the combination of financial support and requirements to have a financial assistance policy would remove the need for nonprofit hospitals to engage in extraordinary collection practices, such as suing patients. However, research indicates that New York's nonprofit hospitals have sued over 53,000 patients in just five years—many of whom should have been eligible for financial assistance.[3]

This report describes how New York's HFAL permits every hospital to develop its own unique financial assistance application and policy that should comply with the HFAL, but often does not. The uneven implementation and enforcement of New York's HFAL leaves uninsured low-income patients with medical debts that they cannot pay. Moreover, medical debt data indicates that this poor implementation of HFAL has exacerbated New York's existing racial and ethnic medical debt disparities.[4]

Policymakers have recognized that the existing HFAL is not protecting patients as it should and have called for streamlining the application and eligibility processes. This report outlines actionable steps to address New York's medical debt crisis by modernizing the state's Hospital Financial Assistance Law, including:

- Implement a common financial assistance policy and application process to be used by all hospitals in the state;
- Align hospital financial assistance eligibility with other health care programs offered in New York state;
- Increase and clarify patient discounts;
- Eliminate the obsolete asset test that is only applied to poor patients;
- Extend the time to apply for hospital financial assistance law from 90 days to any time during the collection process; and
- Require all providers who practice in a hospital to abide by the hospital's financial assistance policy.

Modernizing New York's Hospital Financial Assistance law will build fairness and equity into our state's health care system, benefiting patients and providers alike.

PATIENT STORY

A patient in Syracuse discovered that she was eligible for financial assistance after being sued. In 2019, she signed a settlement agreement for $7,794. She began making payments, but then discovered that she should have received nearly $5,000 in financial assistance. She returned to court and was put on a new payment plan for the $1,560 she still owed. However, this patient was sued six years after receiving care, and had accumulated interest at a rate of 9 percent. This patient could have been saved additional debt and at least two court dates if properly screened for assistance at the outset. Much of the remaining debt was interest that she would not have incurred if she had been offered financial assistance from the outset.

(New York v. V., 5047/2019 (Onondaga))

BACKGROUND

Hospital financial assistance is intended to protect patients from incurring damaging medical debt. A statewide survey from 2022 found that many New Yorkers with medical debt report that their debt causes hardships such as being unable to pay for food or housing.[5] Thirty-one percent of New Yorkers have appealed or questioned a bill and another 20 percent have paid a health care bill they thought was wrong out of fear of being sued or harassed for not paying.[6]

Patients' fears about medical billing and debt are well-founded. Medical debt is the most common type of debt reported by credit reporting agencies.[7] The Consumer Financial Protection Bureau (CFPB) reports that medical debt on credit reports is contested three times as often as other types of debt because it is so frequently erroneous, and that medical debt is not a good predictor of someone's credit worthiness.[8] The CFPB also describes how patients are often "extorted" into paying inaccurate or unfair medical bills through credit threats.[9]

The Hospital Financial Assistance Law (HFAL), also known as Manny's Law, was enacted in 2006 to protect patients from medical debts and to ensure that uninsured patients would be able to secure life-saving hospital care on a sliding fee scale.[10] The law was named for Manny Lanza, who died at the age of 24 after a New York hospital refused to schedule a lifesaving surgery because he was uninsured.

DESCRIPTION OF NEW YORK'S HFAL

From the patient's perspective, there are four important components to the HFAL: (1) application and policy; (2) income eligibility and sliding fee scale charges; (3) assets test; and (4) application time frames. These components are discussed below.

Model Application and Policies

The HFAL requires all hospitals to have a clear, understandable, publicly posted financial assistance policy to receive funding from the ICP.[11] The New York State Department of Health issued two sets of guidance (in 2007 and 2009) to assist hospitals with implementing the HFAL. The 2009 guidance included a template application form that hospitals were encouraged, but not required, to use.[12]

The HFAL requires hospitals to help patients understand the hospital's financial assistance policy. Hospitals are permitted to ask patients for documentation that is not "unduly burdensome or complex." [13] The 2009 guidance clarifies the "unduly burdensome or complex" requirement existing in statute. For example, the guidance prohibits hospitals from requiring patients to submit past tax returns because the eligibility determination should be based on current income, not past income.[14] The guidance similarly prohibits requiring information about patients' monthly expenses because it makes the process overly burdensome.[15] Hospitals are not permitted to require patients to provide social security numbers or other proofs of immigration status.[16]

Income Eligibility and Sliding Fee Scale Charges

The HFAL requires hospitals to offer financial assistance to uninsured people with incomes up to 300 percent of the federal poverty level (FPL). Some hospitals voluntarily offer financial assistance to patients at higher income levels, typically 400-600 percent of FPL, and to patients whose insurance does not fully cover the cost of their care (e.g., co-insurance, deductibles).

The law does not require hospitals to provide free care. Instead, it caps what a hospital may charge an uninsured patient to a schedule of discounted prices and requires them to set up payment plans if needed. The sliding scale discounts are calculated as a percentage of the highest rate paid between Medicaid, Medicare, or the hospital's highest-volume payer—which is typically a major commercial carrier.

The HFAL does not provide much assistance to patients at the higher-income band, between 150-300 percent of FPL. For example, one private insurer paid an average of $45,602 to a New York hospital for C-sections between 2019 and 2021.[17] If that were the rate used to calculate discounted charges for a patient eligible for financial assistance, a family of four earning $75,000 (250% of the FPL) a year would be charged half their annual salary under the current HFAL rules. The same family earning 27,000 a year could be charged $9,120 (20 percent of what the private insurer pays), or a quarter of their gross family income.

Hospital Financial Assistance Discount Schedule

Income as percent of the FPL	Income in $ for a Family of Four (2023)	Maximum Charge
Below 100%	Below $30,000	Nominal fees set by the Department of Health: $150 for inpatient services, ambulatory surgery, and MRIs
101 – 150%	$30,300 - $45,000	20% of the highest rate paid between Medicaid, Medicare, or the hospital's highest volume payer
151 – 250%	$45,300- $75,000	20%-100% of the highest rate paid between Medicaid, Medicare, or the hospital's highest volume payer
251 – 300%	$75,300 - $90,000	100% of the highest rate paid between Medicaid, Medicare, or the hospital's highest volume payer

Assets test

Counterintuitively, the HFAL permits hospitals to evaluate the assets of low-income patients, who earn below 150 percent of FPL ($45,000 for a family of four), but not the assets of higher-income patients.[18] Asset tests can only be imposed with the approval of the DOH.

An asset test for low-income patients was permitted at the time of the enactment of the HFAL (in 2006) because New York had an asset test for patients applying for Medicaid. The HFAL was not simultaneously updated when New York eliminated asset tests just a few years later, in 2010, for most people applying for Medicaid. Importantly, no other community-based insurance programs in New York require asset tests (e.g., the Essential Plan, Marketplace Qualified Health Plans or the Child Health Plus program).

Application time frame

The current law also requires patients to apply for financial assistance within 90 days. Patients do not always know what they really owe a hospital within 90 days. They often receive bills with errors or get caught in the middle of disputes between their insurance and the hospital. Some patients do not know they owe money until they see medical debt reported on their credit reports or find out they are being sued.

HOSPITAL COMPLIANCE WITH HFAL

Since its enactment, patients have complained about the difficulty in accessing hospital financial assistance applications and policies. This section describes issues with its implementation.

THE DEPARTMENT OF HEALTH'S ANNUAL AUDIT RESULTS

In response to reports and patient complaints about inability to access financial aid, the Department of Health began to audit hospital compliance with the HFAL in 2012. To incentivize better practices at the hospital level, the Department withholds 1 percent of a hospital's ICP funding until it passes the audit. The state's audit includes 52 questions about hospital policies and financial assistance applications. Most of the questions are about legal requirements, but some are about patient-friendly practices that hospitals could adopt. Hospitals fill out the audit on their own, and the auditors conduct an additional field audit of a subset of hospitals each year.

In its early years, the audit process appeared to modestly improve compliance with the HFAL.[19] In the first year, 96 percent of hospitals failed at least one question in this open-book test. Nine years later, 59% of hospitals still got at least one question wrong. Thus the auditing regime is having only a modest impact on improving access to hospital financial assistance for patients.

While missing an audit question can sound harmless, the impact on patients can be enormous. For example, the HFAL bans the use of "accelerator" clauses in repayment plans. Accelerator clauses trigger higher interest rates when patients who have a payment plan miss a payment. Having an accelerator clause is the most common failure on the 2021 audit (37 out of 172 hospitals audited). A related, and more common collection practice, known as acceleration clauses, is still allowed. Acceleration clauses require patients to pay the entire debt when a single payment is missed.

Financial Assistance Policy Audit Results, 2012-2021

	Hospitals That Failed At Least One Audit Question	Total Non-Compliant Answers
2012	96%	857
2013	70%	556
2014	69%	497
2015	N/A	N/A
2016-2017	62%	360
2018	61%	447
2019	62%	360
2020	60%	447
2021	59%	379

Difficulty in Locating a Hospital's Financial Aid Application

One threshold issue for patients is finding information about hospitals' financial assistance policies and applications. A 2018 report found that that 77 out 174 hospitals did not post their financial assistance policies or summaries on their websites, as required by the DOH. [20]

Improper Demands for Overly Burdensome Documents

Despite the auditing system, many hospitals still use policies and application forms that create insurmountable barriers for patients seeking financial assistance to defray the cost of their care. According to the 2021 state audit:

- 28 hospitals require patients to provide tax returns;
- 26 require Medicaid denials before processing applications;
- 25 require information about patient bills; and
- 15 require Social Security Numbers.[21]

Hospitals are prohibited from imposing these requirements because they are "overly burdensome or complex."[22] A 2018 analysis of hospitals' financial assistance processes found that these problems are underreported in the state audit.[23]

PATIENT STORY

When Bebhinn Francis from Albany, NY rushed to a hospital-based urgent care facility with a painful tooth, she was asked to pay $600 in fees and copays. Since she was unable to pay, she was denied care and sent to the emergency room where she waited for six hours to be seen – and then was hit with a large bill after receiving the care she needed, with no financial assistance offered. "The stress that I feel, the anxiety, all of these things result from the constant harassment from the debt collectors. I know that there's a certain amount of money allotted to low-income people – I have never been offered any financial relief, I only get threats."

THE HFAL'S INCOME LIMITS, DISCOUNT SCHEDULE, AND ASSET TEST ARE OUTDATED AND CONFUSING

The health care landscape has evolved substantially since 2006, when the HFAL was enacted. As a result, the HFAL is outdated and cumbersome. While the New York HFAL was considered a landmark reform when enacted, many other states have since implemented far more generous financial assistance laws. For example, in New Jersey, patients earning under 500 percent of the federal poverty level cannot be charged more than 15 percent of the Medicare rate (see Appendix A).[24] In Illinois, hospitals must discount care for patients earning up to 600 percent of the federal poverty level.

The HFAL also fails to mesh with New York's own income eligibility policies for health care programs. The income eligibility limit for HFAL is 300 percent of the FPL. By contrast, the New York state of Health Marketplace offers financial assistance to purchase private insurance to people with incomes as high as 600 percent of FPL.

The HFAL's income limits have likewise not kept up with New York's changing public coverage landscape. For example, New Yorkers with incomes up to 200% of FPL ($60,000 for a family of four) qualify for the Essential Plan, which is free with no deductibles and very low co-pays. Those who cannot enroll in the Essential Plan, such as immigrants and religious minorities, must rely on the HFAL to secure health care. But under the HFAL, a patient earning $41,400 (138 percent of FPL for a household of four) could be charged up to 20 percent of what the highest-volume private payer pays (over $9,000 in the C-section example).

Other states ensure that patients in this income group receive larger discounts. In Illinois, uninsured patients earning under 200 percent of the federal poverty level pay just $150. In Maryland and Rhode Island, they pay nothing.[25]

The charge limits in the existing discount schedule are also confusing. Hospitals can choose to charge patients discounts based on what it is paid by one of three payers: (1) Medicare; (2) Medicaid; or (3) its highest-volume private payer. Each hospital is allowed to set the discounts based on very loose guidelines in the statute. For example, hospitals are required to offer discounts of between 20 percent and 100 percent to patients with incomes between 151 percent and 200 percent of the FPL. In the absence of transparent price information, patients have no way to verify if the hospital is accurately following the discount schedule.

Those who earn below 150 percent of FPL ($45,000 for a household of four) face extra screening through an asset test. This provision was included in the original HFAL because New Yorkers applying for Medicaid at that time were subject to an asset test. New York eliminated asset tests just a few years later, in 2010, for most people applying for Medicaid. However, the HFAL was not updated at the same time. Currently, eligibility for Medicaid through the NY state of Health Marketplace, the Essential Plan, and premium subsidies is determined without considering assets.

The counterintuitive low-income-persons-only asset test is confusing for hospitals to implement. In 2018, four hospitals reported that they apply an asset test to people who earn above 150 percent of the FPL, and researchers discovered three more hospitals that did so on reviewing the actual policies.[26] Many other hospitals routinely request information about assets from all patients, not just patients subject to the asset test. This serves as a barrier to patients from applying.

Primary homes, regularly used cars, college savings accounts, and tax deferred retirement accounts are all exempt from asset screening according to the current rules. However, the state's audit shows that hospitals frequently disregard this: 20 consider the value of a patient's home, 17 consider vehicles that are the family's primary mode of transportation, 16 consider retirement accounts, and 15 consider college savings accounts.[27]

Providers not required to participate in HFAL policies

Another barrier to securing financial assistance for patients posed by the HFAL is that only the hospital, and not its providers, are required to offer discounts to eligible patients. But upon discharge, patients are billed by many separate providers operating within the hospital's four walls. A patient who applies for hospital financial assistance in advance of receiving services may receive undiscounted bills from these providers. Hospitals have agreements with the providers who work in their facilities that impose other requirements on them, but many have not chosen to require providers who practice in the hospital to follow the hospital's financial assistance policy. This is a growing problem as private practices increasingly take over critical hospital functions such as emergency rooms.

HFAL AND HEALTH EQUITY

Updating New York's HFAL can have a meaningful impact on health equity. Hospital financial assistance is an important safety net for New Yorkers who don't have insurance and need to go to the hospital. People of color are disproportionately uninsured, compared to White New Yorkers. Only 3 percent of White New Yorkers are uninsured, compared to 10 percent of Hispanic or Latino New Yorkers, 7 percent of Asian New Yorkers, and 6 percent of Black New Yorkers.[28] Hospital compliance with the law can reduce racial and ethnic disparities in health outcomes by ensuring that uninsured New Yorkers have timely access to the health care they need.

Compliance with the HFAL, and the related distribution of ICP funds, is also a health equity issue because it impacts the financial viability of safety net hospitals. In 2020, hospitals provided a range of financial assistance from just $2,017 to $85.3 million. The hospital providing the most financial assistance ($85.3 million) was Elmhurst Hospital in Queens. Just four miles away, NY Presbyterian-Queens, with almost the same number of beds, provided just $6.2 million in discounts.

Safety net hospitals provide a disproportionate share of financial assistance to patients. This disparate burden on essential safety-net hospitals causes additional financial strain on hospitals that serve disproportionately more low-income patients and communities of color.[29]

For the most part, the hospitals providing the most financial assistance tend to be the hospitals in racially diverse, ethnically diverse, and low-income neighborhoods. For example, 5 out of the 10 hospitals that provide the most financial assistance (Elmhurst, Queens Hospital Center, Jacobi, Lincoln and Harlem hospitals) are part of New York City's public hospital system.

Hospitals Providing the Most Financial Assistance to Eligible Patients, 2020

Hospital	Financial Assistance	Indigent Care Pool Distribution	Difference
Elmhurst Hospital Center	$85,264,576	$17,370,195	($67,894,381)
NYU Hospitals Center	$69,211,268	$34,169,893	($35,041,375)
Queens Hospital Center	$56,318,765	$11,587,302	($44,731,463)
New York Presbyterian Hospital	$46,783,210	$20,863,484	($25,919,726)
Jacobi Medical Center	$46,321,980	$9,663,564	($36,658,416)
Lincoln Medical & Mental Health Center	$40,786,325	$7,854,138	($32,932,187)
Bronx-Lebanon Hospital Center	$33,761,614	$62,710,306	$28,948,692
Harlem Hospital Center	$28,385,067	$6,452,012	($21,933,055)
Montefiore Medical Center	$22,961,406	$11,728,368	($11,233,038)
Jamaica Hospital	$22,185,370	$16,549,140	($5,636,230)

Hospitals Providing the Least Financial Assistance to Eligible Patients, 2020

Hospital	Financial Assistance 2020	Indigent Care Pool 2020	Difference
Schuyler Hospital	$27,076	$605,048	$577,972
O'Connor Hospital	$26,986	$286,799	$259,813
Margaretville Hospital	$19,127	$225,742	$206,615
Gouverneur Hospital	$16,465	$204,657	$188,192
River Hospital	$9,958	$351,871	$341,913
Cuba Memorial Hospital	$5,381	$405,228	$399,847
St. Elizabeth Medical Center	$4,147	$5,994,673	$5,990,526
Albany Memorial	$2,684	$1,953,175	$1,950,491
Bertrand Chaffee	$2,082	$235,806	$233,724
Clifton-Fine	$2,017	$138,229	$136,212

All 10 of the hospitals providing the least financial assistance to patients receive more from the indigent care pool than they provide in discounts to patients who are eligible for financial assistance.

CONCLUSION

All of New York's hospitals are nonprofits, required by the IRS to screen patients for financial assistance eligibility before engaging in extraordinary collections actions.[30] Tens of thousands of New Yorkers have been subjected to medical debt "never events" such as being sued, having their wages garnished, or having liens placed on their homes.[31] Many of these actions are taken against patients in low-income communities.

For example, a 2022 analysis of five hospitals that garnish patients' wages found that the communities affected by this practice had median incomes well-below 300 percent of the federal poverty level.[32] A similar analysis of hospital liens in the wake of medical debt lawsuits yielded the same result.[33]

Other location-specific analyses revealed that hospitals are disproportionately suing patients who live in low-income zip codes or zip codes where the residents are disproportionately people of color. The inexorable conclusion from all of these analyses is that patients eligible for financial assistance were either not screened, were unable to complete the application process, or were improperly rejected.

New York can prevent these unnecessary lawsuits and collection activities by updating its HFAL. Governor Hochul has emphasized her administration's commitment to health equity, announcing her Equity Agenda in 2022 and supporting legislation that promotes health equity.[34]

The state can help make this vision a reality by updating and modernizing the HFAL as follows:

- adopting a common financial assistance policy and application process to eliminate the barriers revealed by its audits;
- aligning hospital financial assistance with other health care programs by raising the eligibility level and matching eligibility to other health care programs;
- increasing and clarifying the discounts available to patients at these income levels;
- eliminating the asset test that only exists for people earning under 150 percent of FPL;
- extending the time to apply for hospital financial assistance law from 90 days to any time during the collection process;
- requiring all providers who practice in a hospital to adopt the common financial assistance policy and application; and
- imposing guardrails that protect patients from extraordinary collections practices like lawsuits while they are still being screened for financial assistance.

The New York State Legislature is contemplating a bill that would modernize the HFAL. Dubbed the "Ounce of Prevention Act," it seeks to streamline patient access to financial assistance thus preventing medical debt, ruined credit reports and devastating lawsuits. A uniform application form and policy would reduce unnecessary red tape for hospitals and patients, and make it easier for people to learn the rules and apply. It would allow the Department of Health to easily create trainings for hospitals and certifications for anyone who works with patients on billing problems. Other improvements would ensure people are protected from high hospital prices at appropriate income levels. Enactment of the Ounce of Prevention law would ensure patients can access medical care without lasting financial harm.

ENDNOTES

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APPENDIX

	NCLC Model Medical Debt Legislation	Ounce of Prevention Act	Colorado
Common application	No	Yes	Yes
Discounts	"Free care below 200% FPL At 201% to 400% FPL: Annual maximum of $2,300. 100% discount of amounts over $10,000. Before that: 50% Medicare rates for first $1,000; 10% up to $5,000; 5% up to $10,000. 401% - 600% FPL: Same discounts apply if in the previous year medical expenses were over 10% of household income."	"Nominal fee below 200% FPL 20% of the Medicare rate for people between 201% and 400% FPL 100% of the Medicare rate for people between 401% and 600% FPL"	"For patients earning under 250% FPL (including insured patients), hospitals may not collect more than 4% of monthly income and must waive remaining balance after 36 payments. Providers billing seperately are limited to 2% of patients' monthly income. If the patient is uninsured, Medicaid agency caps rate at a rate similar to that paid by public payers."
Covered providers	All providers in or affiliated with a hospital or large group practice with over $20 million annual revenue.	Hospitals seeking reimbursement from the Indigent Care Pool	Hospitals, freestanding emergency rooms, and all providers working in either; outpatient hospital clinics
Asset test	No	No	No
Timeline to apply		Patients can apply for assistance at any time during the collection process.	All uninsured patients must be screened by the hospital unless they refuse
Collections protections	No extraordinary collections practices until 180 days after the first bill has been sent. Must notify patient 30 days before about the upcoming collections action and the possibility of financial assistance. All extraordinary collections actions must be reversed if patient is later found eligible for financial assistance.	Patients are not responsible for bills until their application has been approved or rejected. No extraordinary collections actions until at least 180 days has passed since the first post-service bill. Must update credit agencies within 30 days of recieving payment. No collections actions may be taken if an insurance appeal or financial assistance application is in process.	
Source		S1366	C.R.S. Title 25.5-3-501

	Illinois	Maryland
Common application	No	Yes
Discounts	"In one year, may not collect more than 20% of family income of uninsured patients earning 600% FPL or less. For any one encounter, maximum charge is $150 for uninsured patients at or below 200% FPL and 1 less than the product of the hospital's cost-to-charge ratio multipplied by 1.35 for uninsured patients up to 600% FPL on charges over $150. For rural and Critical Access hospitals thresholds are 100% FPL and 300% FPL."	"Free care up to 200% of FPL. Discounts up to 500% FPL if patient has medical debt incurred in one year over 25% of family income."
Covered providers	Hospitals	Hospitals
Asset test	Yes; maximum annual charge does not apply if assets are valued over 600% FPL; limit is 300% FPL for rural and critical Access hospitals and hospitals outside metropolitan statistical areas. Primary residence, retirement accounts, and some personal property are exempt.	Yes; excludes first $10,000 in savings, $150,000 of equity in a private residence, retirement accounts, one car, and prepaid higher education accounts (529)
Timeline to apply	90 days from date of service or discharge	Can update with changes in financial circumstances within 240 days.
Collections protections		"Hospitals must have a policy that describes in detail how patients' income and assets will be considered in collections actions, its procedures for collecting a debt, and the circumstances under which it will sue patients. Hospitals must vacate judgments or strike adverse credit information if the patient is found eligible for free care within 240 days of the initial bill."
Source	210 ILCS 89/ Hospital Uninsured Patient Discount Act	Md. Code, Health-Gen. § 19-214..1 and 214.2

	New Jersey	Rhode Island
Common application	No	Yes; modifications must be approved by the Department of Health.
Discounts	"Free care at or below 200% FPL. Uninsured patients earning under 500% FPL can be charged a maximum of 15% of Medicare rate. After this adjustment, people earning between 2010-300% FPL may be charged as follows: 20% of charges at 200-225%, 40% at 225-250%, 60% at 250-275%, and 80% at 275-300%. For patients earning between 201% to 300% FPL, health expenses are capped at 30% of annual gross income."	"Free care up to 200% FPL Discounts for patients with incomes between 200% and 300% FPL determined by individual hospitals."
Covered providers	Hospitals	Hospitals
Asset test	Yes (capped at $7,500 for individuals and $15,000 for families for people earning between 200% to 300% FPL)	Yes
Timeline to apply	One year	
Collections protections	Patients eligible for charity care may not be subjected to collections procedures.	
Source	N.J.A.C, Title 10, Ch. 52, Subchapter 11: Charity Care and N.J.S.A. 26:2H-12.52	216-RICR-40-10-23.14 Provision of Charity Care, Uncompensated Care, and Community Benefits.

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