UNDUE Medical Debt

Improving FAP Presumptive Eligibility in the Age of Un(der)insurance:

Five Domains for Strong Programs

WE ARE LIVING IN UNPRECEDENTED TIMES.

The recent passage of the federal budget bill (H.R. 1) will upend Medicaid and Affordable Care Act (ACA) coverage for at least 14 million low-income and working class people while simultaneously slashing hospital funding. It casts a long shadow over any discussion about medical debt. The uncertainties of what lies ahead are vast, placing enormous pressure on policymakers and providers to find revenue in new places—all while stanching the loss of affordable coverage and access for as many people in their communities as possible. **With cuts to Medicaid and the ACA looming, does having a robust, patient-friendly financial assistance program that incorporates presumptive eligibility (PE) remain a priority? We think the answer is yes.**

When we first launched our inquiry into presumptive eligibility (PE) for hospital financial assistance last year, underinsurance was already trending upward[I]. Policymakers had renewed focus on hospital financial assistance as a way to stave off medical debt, with heightened interest in expanding the use of **predictive analytics software** to *proactively*, or "presumptively," screen patients who need financial help earlier in the billing process. Many hospitals reported using these predictive analytics tools on unpaid patient balances as a final screen for financial assistance before consigning them to bad debt or collectors. Some state policymakers have legislated approaches that go further, requiring hospitals to screen for financial assistance prior to sending bills.[II] Critically, hospitals themselves have begun to explore how to reimagine their use of PE as bad debt and charity care accounts have grown.[III] The current environment makes PE innovations even more necessary.

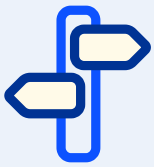
Hospitals will need every tool at their disposal to balance the books while limiting harm to patients. Using predictive analytics software is not a cure for what is coming. But integrating these tools into a robust, patient-friendly billing process can help hospitals meet the moment. While there are costs and limitations associated with the use of predictive analytic tools, they also allow hospitals to offset costs by reducing administrative overhead, decreasing the amount of paperwork and collections activities staff handle and outsource. This can improve workflow for revenue cycle staff while giving patients greater clarity about their financial responsibility and available relief. Having clear policies in place—and communicating them effectively—can mitigate the harms to uninsured and underinsured patients, giving hospitals an invaluable chance to show their commitment to their communities in a time of crisis.

OUR APPROACH

As the sole nonprofit organization relieving patient medical debt in bulk, Undue Medical Debt is uniquely positioned to understand the complex issues that face key stakeholders including hospitals and other providers. Our goal is to help foster solutions that remove the patient from plight of medical debt. In our work with provider partners, we appreciate the challenges of maintaining financial solvency and meeting mission. The current system and incentives do not set up providers or patients for success. It is not working for anyone. This paper and work are an effort to identify better practices – not one-off solutions – that hold potential to improve both patient and provider experiences.

Undue Medical Debt asked stakeholders and consultants from hospital, fintech and patient advocacy organizations to share what opportunities and challenges they have encountered in using predictive analytics software for financial assistance determinations. Our conversations with hospitals and health systems included community benefit, finance and revenue cycle leaders from academic medical centers, large national health systems, and small regional systems.

We organized their feedback into five key domains:



Workflow

Technology

Evaluation

Communication

Leadership

HOSPITAL FINANCIAL ASSISTANCE: A REFRESHER

Hospital financial assistance—sometimes called **charity care**—refers to hospital programs that provide free or discounted care to patients who cannot afford to pay all of their bill, and who qualify under the hospital's eligibility criteria.[IV] Nonprofit hospitals with 501(c)(3) tax-exempt status are required by federal law to **have financial assistance policies, or FAPs,** and to inform patients about these programs.[V] Some states have expanded these requirements to for-profit hospitals and, in the case of California, to emergency room physicians.[VI] While hospitals have latitude under federal law in setting their eligibility criteria, most use the patient's income and household size to determine eligibility.[VII] On average, most hospital financial assistance policies are set at 200-300 percent of the Federal Poverty Level[VIII], or about $65,000 – 95,000 for a family of four.[IX]

Why is financial assistance critical for patients and for hospitals?

In 2023, the Federal Reserve reported that 28 percent of American adults went without some form of care due to cost—including 26 percent of insured adults and 45 percent of uninsured adults.[X] Nationally, healthcare costs have continued to grow faster than inflation.[XI] Significant increases in patient out-of-pocket cost-sharing, the rise of high-deductible health plans (HDHPs) and rising prices have all contributed to an affordability crisis with no immediate end in sight.[XII] For an increasing number of patients, seeking care can mean facing financial fallout as bills rack up, and delaying care or not following up on treatment plans until relatively manageable problems become full-blown health crises.[XIII]

Having patients miss out on financial assistance or other relief programs holds risks for providers, too. Studies show that fear of the financial fallout of a cancer diagnosis or unexpected emergency can impact patient outcomes. For example, patients may have concerns about the high cost of care, uncertainty over the pricing and collection tactics a provider will use, or timelines for repaying balances. These very real fears—and the decisions that flow from them as patients consider their options—contribute to "financial toxicity" of certain medical conditions, like cancer.[XIV] This vicious cycle can lead to lower utilization of healthcare services, and higher bad debt numbers for hospitals as more patients use costlier emergency room services after deferring care. Patients may even avoid preventive care or proactive screenings.[XV]

For many people—including, increasingly, people with insurance—hospital financial assistance is the last line of defense to avoiding medical debt. A recent study showed that hospital financial assistance programs can serve as a protective factor to increase patient utilization and more timely connection to appropriate care for chronic conditions, even for insured patients—a win-win for hospitals and their patients.[XVI] Yet, by many accounts, patients who need financial help from hospitals are not always getting it. In an effort to remove barriers for patients, several health systems, state regulators[XVII], patient advocates and revenue cycle experts[XVIII] have begun revisiting presumptive eligibility as a way to help hospitals streamline patient qualification for financial assistance.

What is presumptive eligibility for financial assistance?

Presumptive eligibility (PE) for financial assistance is the process of accessing estimated or verified information about a patient's income, relative to their household size, in order to determine whether a patient qualifies for financial help through the provider's financial assistance program without requiring a paper application and documentation. PE can be a valuable approach to remove barriers for patients who may overlook FAP notices, assume they are not eligible for support, or be daunted by more traditional paper-based applications that may require extensive documentation. PE approaches may include:

- **Gathering patient registration information** that helps hospitals estimate eligibility, including simple questionnaires about household size, family income, and extenuating circumstances that could indicate the family is under duress
- **Accepting proof of enrollment in other programs that already verify patient income**, such as Medicaid, SNAP, WIC, LIHEAP and other means-tested local or state programs
- **Honoring referrals from community-based providers of sliding scale or free care**, including charitable clinics or Federally Qualified Health Centers (FQHCs)
- **Integrating predictive analytics software that use available credit and community data to estimate patient income**, relative to household size
- **Allowing patients to provide self- or employer-attestations** about income or need when documents cannot reasonably be procured, which can be particularly necessary for people facing housing instability, homelessness, language barriers or literacy issues

One important distinction: PE for hospital financial assistance is not the same as PE for Medicaid. PE for Medicaid is a state policy option that allows states to authorize certain providers—including hospitals—to presumptively enroll people in the Medicaid or Children's Health Insurance Program (CHIP) and assist families in gathering documentation for a final eligibility determination.[1]

Hospital financial assistance is not a panacea for medical debt. Nor are PE tools for financial assistance perfect. Still, hospitals and health system leaders should immediately pursue strategies that adopt or expand PE as a tool for connecting patients to financial assistance and enrollment support for Medicaid and other programs.[XIX] Despite the costs of starting up or expanding these tools, they are an important part of reducing administrative burden, alleviating medical debt, and connecting more patients to care.[XX]

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1 See the "Presumptive Eligibility" page on the Medicaid website for a list of states that currently allow presumptive eligibility for Medicaid (though this list, and PE requirements, will likely change in response to the passage of H.R. 1). Hospitals in states that choose this option must use a common application form. Historically, PE for Medicaid has been governed by a set of strict state and federal rules. By contrast, state and federal requirements for PE screening for financial assistance have been much more lax.

There are also lower-cost entry points to PE, such as accepting proof of enrollment in income-verified programs. Another option is sharing data with local community partners providing social services that support clinical interventions, such as food security or housing assistance programs.[xxi] These partners may already be working with other hospital departments like community health, population health, or community benefit teams. These can be particularly important tactics for rural hospitals, where resources to build out IT infrastructure are more limited. They can serve as building blocks to a more sophisticated use of predictive analytics.

The following principles illustrate potential uses and guardrails for PE initiatives.

WORKFLOW

Bolster existing financial assistance policies and procedures to include a robust presumptive eligibility screening and determination approach.

1. Make sure financial assistance policies (FAP) adequately meet the community's current needs.

It is critical that hospitals and health systems routinely revisit their financial assistance policies (FAP) and procedures to ensure they are a) meeting local community needs and b) staying current with recommended practice. Rather than having low- and moderate-income patients stuck in limbo over unpaid balances they know they cannot afford, hospitals with solid FAPs are better positioned to move patient balances from "bad debt" to "charity care." This approach benefits hospitals, which are increasingly facing questions about the levels of community benefit they provide, their FAPs and collection practices. And it offers relief and financial certainty to patients, who can rest and recover with the assurance that they will not face crushing hospital bills as a result of seeking care for their illness or injury.

- **Evaluate current FAP eligibility thresholds.** Look at the health system's current bad debt and charity care data and talk with the community benefit team, which is tasked with conducting routine community health needs assessments (CHNA) that can pinpoint access problems. Compare data and discuss: Is the current FAP policy adequate to meet the need?
- **Expand FAPs to include low- and moderate-income insured patients.** While the Affordable Care Act expanded health insurance coverage, out-of-pocket costs for patients have continued to grow.[xxii] Increasingly, insured patients are struggling to afford deductibles, coinsurance and copayments. Many hospitals have expanded their financial assistance policies to cover low- and moderate-income insured patients.[xxiii]
- **Use patient income—not assets—to determine eligibility for financial assistance.** Most patients under 400 percent of the Federal Poverty Level—the average ceiling for financial assistance—have few, if any assets. Evidence suggests that requiring asset testing as part of eligibility determinations for low-income people disincentivizes savings, causes harm, and increases administrative burden.[xxxvi]

As an added boon, having robust FAP screening policies in place can help hospitals identify self-pay patients who should be enrolled in Medicaid, CHIP or other lower-cost insurance options that may be more affordable and offer better coverage. **Converting these patients from uninsured to insured status is a win-win for the hospital**, which can now get paid for care, and for the patient, who can access care beyond the hospital setting.

2. Expand PE screening to include insured patients, not just self-pay patients, and run screens for insured patients earlier in the billing cycle.

Currently, many organizations that deploy presumptive eligibility screening tools for insured patients do so late in the billing cycle, once an account is past-due and has been flagged as bad debt. Multiple bills may have been sent; multiple calls may have been made and the account may have been referred to a third-party vendor for collections. The problem with this approach in the age of underinsurance is that insured patients may not be aware of financial assistance or think it applies to them. Waiting for these patients to affirmatively apply for FAP means some of them fall through the cracks. Rather than waste resources pursuing collections on patients who cannot afford to pay, redirect resources to presumptively screening insured patients earlier in the billing process. Adopting a proactive approach can help hospitals avoid spending resources on collection efforts that will ultimately fail, and support the patient's return to care.

3. Align front-end and back-end revenue cycle teams on financial assistance goals and PE approaches.

One challenge flagged by several stakeholders was the need to align "front-end" teams performing patient registration, insurance claims and financial counseling functions with "back-end" teams that focus more on collections. To get the most out of any PE approach, hospitals will likely need to invest in strengthening communication channels and data-sharing between "front-end" and "back-end" staff. This includes patient registration, financial counseling staff, and revenue cycle teams, including third party vendors.

It is particularly important to build a culture of financial assistance first, making patients aware of this pathway before introducing payment plan options. As part of a PE integration, provide registration and patient billing staff with scripts and training that highlight financial assistance policies first, especially if those policies have expanded recently to include new populations like the underinsured. Many low- and moderate-income patients with insurance, including Medicare beneficiaries, may not realize they qualify for financial help and will not think to ask. Taking proactive steps to share information and ask questions could help increase the accuracy of any PE determination, and make sure patients are getting upfront information about financial assistance.

4. Use multiple PE pathways to FAP eligibility.

Predictive analytics software is not the only pathway to presumptive eligibility. For some hospitals, it may not be feasible. Even if a hospital is using predictive analytics software, using a combination of the approaches suggested below may improve accuracy.

- **Integrate presumptive screening for financial assistance into patient registration for scheduled visits**. Hospitals have already made huge investments into meeting price transparency laws and No Surprises Act requirements, including upfront scheduling encounters. Look for opportunities to build key screening questions about income and household size—and awareness about financial assistance, more generally—into patient registration questionnaires or social determinants of health (SDOH) screenings.
- **Accept proof of enrollment in means-tested programs as sufficient documentation for FAP eligibility. Many local and state-based programs rely on means-testing for eligibility.** Participants in these programs have already been vetted and their incomes verified. Rather than making patients jump through hoops twice, look for opportunities to view eligibility data from community partners and public agencies that run means-tested programs, or accept proof of participation in one of these programs in lieu of requiring

a full application or additional documentation from low- and moderate-income patients. Examples include SNAP, the Children's Health Insurance Program, low-income housing assistance, Medicaid, SSI and more. This is also a great opportunity to build synergy with the community benefit team, which knows the landscape of community programs.

- **Use electronic health records (EHRs) to streamline PE for patients.** There are several ways hospitals can use EHRs to streamline financial assistance processes. First, hospitals can use EHRs to document prior FAP eligibility findings and to flag individual life circumstances, such as homelessness, that negate the need for a formal application. Second, they can use EHRs to streamline care for patients from federally qualified health centers (FQHCs) and charitable clinics, which also use sliding scales based on patient incomes. Hospitals can align with these care partners so that patients who qualify for care in the clinic setting can qualify for hospital or specialty care, too, without having to complete a separate FAP application. Third, several EHRs already include modules or allow integration with third-party tools that screen patients for social services or Medicaid eligibility, help with referrals, or enable closed-loop communications with care partners.
- **Maintain active lists of addresses that tend to correspond with low- to no-income patients such as churches[2], shelters, and short-stay hotels.** If these addresses are flagged within the system as known resources for low-income people, the hospital can create a flag that indicates a patient with that address may have had a significant income change warranting further outreach.

5. Communicate PE practices and outcomes directly to patients.

Disclosure and notification requirements for hospitals using PE have been fairly lax.[xxiv] At a minimum, hospitals and health systems should describe the PE approaches and tools they use in their FAPs.[xxv] The FAP should describe the tools that will be used, identify at what points in the revenue cycle and support that use by citing regulatory requirements if applicable. Hospitals should also proactively educate patients about what PE means for them. For example, many patients do not know that a "soft hit" on patient credit, a common data point for PE tools (not to mention many marketing firms), does not impact their credit score. Sharing this information may allay patients' concerns. Patients should also be informed when they are found eligible for financial assistance through PE screening. **Notification is an important part of closing the loop with the patient and building trust.**

TECHNOLOGY

When using predictive analytic tools, understand their limits and develop strategies that adjust for inaccuracies while holding patients harmless.

Many revenue cycle management (RCM) companies offer suites of predictive tools that purport to do a bit of everything, from pre-registration to bad debt collection. It is imperative that staff understand what types of data are being collected, the limitations of each tool, and how they are designed to be used so they employ the right tool at the right time.

2 Some churches will act as a mailstop for homeless populations in their community.

1. Don't allow "propensity to pay" scores to trump estimated FPL information.

Many of the predictive analytic tools on the market today pull various credit and community data to estimate a patient's income, or ability to pay. Others use this data to estimate how likely the patient is to pay, often called **propensity to pay**. Both presumptive income estimates (sometimes called "presumptive charity scoring") and propensity-to-pay scoring tools have their place. Both attempt to gather a clearer picture of a patient's financial situation by looking at an individual patient's payment histories, household size and other credit or community data. But they have different aims. Presumptive charity scoring tools use these data to estimate income as a proxy for the patient's **ability to pay**, for the limited purpose of determining whether a patient is eligible for financial assistance. They are essentially trying to answer the question, "Can this patient afford this bill right now?" By contrast, propensity-to-pay scoring tools are asking, "How likely is the patient to pay this bill right now?" They use these data to predict the *likelihood* that a patient will pay if they are sent a bill—not their ability to pay it in the first place—with the goal of helping staff determine their approach to collections.

Patient-Friendly Guardrails for Using Propensity to Pay

High Ability to Pay

↑ Ability to pay ↓ Propensity to pay

Patient can afford to pay but will likely not pay, based on credit history and other historical data.

Action: Hospitals may send a FAP application or bill first. If a bill, hospitals may do a second sweep for P2P for unpaid bills and/or a FAP application prior to the bill being sent to collections.

↑ Ability to pay ↑ Propensity to pay

Patient can afford to pay and will pay.

Action: Send bill.

Low Propensity to Pay ← → **High Propensity to Pay**

↓ Ability to pay ↓ Propensity to pay

Patient cannot afford to pay and likely won't.

Action: Screen for eligibility in Medicaid/other coverage and FAP.

↓ Ability to pay ↑ Propensity to pay

Patient cannot afford to pay but likely will pay something based on historical data (credit history, past payment history)

Action: Screen for eligibility in Medicaid/other coverage and for FAP; send FAP application.

Low Ability to Pay

One common issue arises when hospitals or third-party vendors conflate these tools. Uniformly using propensity-to-pay scoring in lieu of, or before, presumptive charity screens may result in hospitals receiving payment from some

low- or middle-income patients. But there are several risks to this approach. First, it can lead to inaccuracies for low-income patients who have a high propensity-to-pay score prior to an unexpected health event. Second, hospitals run the risk of having low-income patients who should have qualified for financial assistance or Medicaid—patients deemed "unable/limited ability to pay" but who are likely to pay—receiving and paying bills they actually cannot afford. This can result in these patients possibly delaying follow-up or future care, and runs the risk of running afoul of state law or public opinion.

2. **Establish routine quality controls to ensure consistent results and effective support for all patients who are eligible for Medicaid or financial assistance.**

Systems that use propensity-to-pay scoring should put guardrails in place to ensure that low- and moderate-income patients are always vetted for financial assistance. Consider using propensity-to-pay scoring at the end of the billing cycle solely to inform collections strategies for patients whose income estimates make them ineligible for financial assistance. This may help avoid instances of patients being billed who should have qualified for help. It ensures staff are investing efforts and energy on accounts where payment is likely, keeping financially vulnerable patients connected to care, and avoids scenarios that draw negative publicity and invite regulatory scrutiny.

Some stakeholders reported that propensity-to-pay scoring can be attractive because it increases accuracy of presumptive charity scoring, weeding out higher-income patients who might erroneously receive FAP.[XXVI] Others raised the issue that cost of living varies tremendously across communities, and that people living between 200 and 400 percent of the Federal Poverty Level in low-cost areas might be fair game for a payment plan while those in high-cost areas would need FAP. Given the current environment, this desire to wisely steward hospital resources is understandable. But there are better, more patient-friendly ways to reconcile differences between presumptive charity scores and patient records. These include:

- Increasing communication with patients (for example, asking for confirmation of PE results, or asking patients to voluntarily provide income and household size information at registration or check-in)
- Reviewing potential FAP awards over a certain dollar amount
- Conducting routine spot-checks of PE awards and comparing them to patient-provided data
- Requiring additional documentation for patients to qualify for financial assistance for an extended period of time (up to 12 months), or for patients in higher income thresholds (over 200 percent of the Federal Poverty Level)
- Referencing ALICE data, which uses additional metrics to quantify which households are struggling financially, to ensure FAP eligibility guidelines reflect the true cost of living in the hospital's service area [XXVII]

EVALUATION

Conduct routine data and landscape scans to understand how best to target financial assistance policies and PE initiatives.

Understand the baseline: where are patients who qualify for Medicaid, financial assistance or other state or local programs falling through the cracks? Collaborate with revenue cycle, patient access and community benefit teams to collect data on key indicators related to bad debt and charity care, such as current bad debt figures and

application rates for financial assistance. Map existing workflows for screening patients for coverage and assistance. With this baseline data in hand, providers can better identify opportunities to improve screening, connect more patients to coverage and convert bad debt to charity care by using PE and other strategies—and make a stronger case for return on investment.

Review FAP materials and procedures and simplify processes for patients. Yes, PE technology can streamline the paper-based FAP application process. However, no technology is 100 percent accurate. Further, some patients who do not appear to qualify after a PE screen may be able to demonstrate eligibility after providing additional documentation. (This may be particularly true if a system relies on propensity-to-pay scoring.) By creating multiple access points for applications and regularly communicating these options to patients, clinical staff and the community, providers can improve the chances of connecting patients to financial assistance or coverage. Because some patients will slip through the cracks, it is important to identify where documentation requests or application processes may create barriers. Data analysis and stakeholder discussions may also reveal the need to adjust FAP eligibility based on community needs.

Don't let "perfect" be the enemy of "good." None of the current PE tools currently on the market are perfectly able to estimate patient income. That should not stop providers from taking steps towards PE. Providers should stay current: work with staff and vendors to understand the strengths and weak points of the analytical tools and data they rely on to develop their scores. They can use this knowledge to create safeguards in the rest of the revenue cycle workflow to ensure that collection resources are really focused on people who can afford to pay.

COMMUNICATION

Proactively share data and trends with patients, partners and policymakers.

Keep community partners in the loop. Providers should share what their systems are doing to actively monitor and respond to community trends in affordability and medical debt with their community partners. Many hospitals partner with government and community organizations in a wide variety of ways. These partners can include local business associations and employers; clinical and public health partners, such as charitable clinics, rehab facilities, FQHCs and public health departments; social and human services organizations working on issues ranging from food access to homelessness; schools; and neighborhood, volunteer and faith-based organizations or groups with deep connections to particular pockets of a given community.[XXVIII]

The list is potentially endless. Billing teams can work with community benefit and clinical staff to identify existing relationships and plug into existing community meetings. Asking for third-party feedback on what is working well, and what can be improved, from organizations who know and understand the community allows hospitals to avoid delays in patient care, streamline patient eligibility in coverage and financial assistance programs and build alliances with local stakeholders to develop additional solutions to support families. Alternatively, billing teams can present to PFACs (patient-family advisory councils, comprised of hospital patients and their caregivers) or hold their own community meetings. Holding regular meetings to ask for feedback on financial assistance policies and billing procedures, and sharing improvements as they are made, makes it more likely that patients get the right outcome.

LEADERSHIP

Develop champions among senior leaders and board members who will invest in the technology, workforce and infrastructure to upgrade financial assistance policies and procedures as an integral part of delivering quality care.

A well-integrated PE initiative requires buy-in from senior leaders who are willing to invest proactively in financial assistance strategies and tools, including PE, that keep patients out of debt and connected to care. Here are ways hospitals can cultivate a culture that prioritizes robust financial assistance as a core function of revenue cycle management and quality patient care.

1. **Build internal partnerships between revenue cycle, population health, and community benefit leaders.**

Community benefit and population health leaders have crucial relationships with community-based organizations and public health leaders. They often have their fingers on the pulse of larger community trends around medical debt and access to care. However, even though financial assistance is a core component of community benefit, these leaders are usually isolated from revenue cycle management workflows and larger decisions about financial assistance policies. By forming an interdisciplinary team that includes them, health systems can develop financial assistance processes that are culturally competent and responsive to community needs and preferences.

2. **Share expertise and data to inform policymaking.**

Almost all stakeholders we spoke with raised the problems posed by high-deductible health plans (HDHPs) in their markets and the accompanying increase in insured patients who need financial assistance. Others mentioned various policy and practice issues that impede their ability to offer FAP as effectively as they would like, including data gaps. Providers should track and share data about the trends, progress and challenges their system and patients are facing around financial assistance with policymakers, employers and insurers in their markets. Collaborating with state and national professional organizations to propose changes to the out-of-pocket costs for insured patients can also be helpful. Healthcare providers' insights are an invaluable part of making the case for more systemic changes.

CONCLUSION

While it will take policy and political will to solve the nation's affordability crisis, patients and providers need strategies to create certainty and give peace of mind about financial expectations today. Revenue cycle staff are essential for keeping healthcare providers operational. Their roles are fast-paced and complex, with high caseloads and a constantly changing regulatory landscape. Even as the health care safety net has been weakened, one thing is startingly clear: hospital leaders will continue to face scrutiny, fairly or unfairly, as more patients struggle to pay rising out-of-pocket costs. And hounding low-income patients for payments they cannot afford will not make hospitals whole. Hospital financial assistance is not a panacea for medical debt. Nor are the predictive analytics tools available on the market today perfect. Still, with the right guardrails in place, they can be a critical strategy for reducing administrative burden, alleviating medical debt and connecting more patients to care.

Endnotes

I Hagland, Mark. "Underinsurance Is Undermining Americans' Health."

II Williams, Jeni. "Soaring Charity Care Grabs Hospital Leaders' Attention." Healthcare Financial Management Association, July 31, 2025. Accessed August 11, 2025.

III Ibid.

IV Levinson, Zachary, et al. "Hospital Charity Care and Why It Matters." KFF, November 3, 2022. Accessed August 11, 2025.

V Ibid.

VI Kona, Maanasa; and Raimugia, Vrudhi. "State Protections against Medical Debt: A Look at Policies across the U.S." Commonwealth Fund, September 7, 2023. Accessed June 3, 2025.

VII Other frequently used eligibility criteria, besides income and household size, include a patient's insurance status, assets and expenses, and residence. Messac, Luke, et al. "US Nonprofit Hospitals Have Widely Varying Criteria To Decide Who Qualifies For Free And Discounted Charity Care." Health Affairs, Vol. 43, No. 11, November 2024. Accessed June 3, 2025.

VIII Ibid.

IX "Federal Poverty Level." Healthcare.gov. Accessed August 11, 2025.

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XI Cox, Cynthia, et al. "Health Care Costs and Affordability." KFF, May 28, 2024. Accessed August 11, 2025.

XII Ibid.

XIII Pisu, Maria, and Martin, Michelle Y. "Financial Toxicity: A Common Problem Affecting Patient Care and Health." Nature Reviews Disease Primers, Vol. 8, Article 7, February 10, 2022. Accessed August 11, 2025.

XIV Ibid.

XV Bad debt refers to services for which the hospital expected to receive payment—either from patients or insurers—but did not do so. By contrast, charity care refers to services where the hospital did not expect to receive payment due to a patient's inability to pay. Bad debt and charity care numbers are combined to make up a hospital's total amount of uncompensated care. See "Fact Sheet: Uncompensated Hospital Care Cost." American Hospital Association, February 2022. Accessed August 11, 2025.

XVI Adams, Alyce, et al. "The Impact of Financial Assistance Programs on Health Care Utilization: Evidence from Kaiser Permanente." Am Econ Review Insights, November 4, 2022. Accessed August 11, 2025.

XVII Kona, Manaasa. "State Options for Making Hospital Financial Assistance Programs More Accessible." Commonwealth Fund Blog, January 11, 2024. Accessed August 11, 2025.

XVIII "Principles and Practices Board's Sample 501(c)(3) Hospital Charity Care and Financial Assistance Policy and Procedures." Healthcare Financial Management Association. Accessed August 11, 2025.

XIX Kona, Maanasa. "Making Financial Assistance Programs Equitable and Accessible." JAMA Internal Medicine, Vol. 84, No. 10, September 3, 2024. Accessed August 11, 2025.

XX See Williams, Jeni.

XXI For example, the state of Illinois has implemented presumptive eligibility through community partnerships and referrals. "Presumptive Eligibility Criteria." Illinois Hospital Association. Accessed August 11, 2025.

XXII Schmidt, Theresa, et al. "Expanding the Catalog of Patient and Caregiver Out-of-Pocket Costs: A Systematic Literature Review." Population Health Management, vol. 27 no. 1, February 6, 2024. Accessed August 11, 2025. Notably, the authors found that data likely underrepresent the total costs to patients of accessing health care, including transportation and other costs.

XXIII See Bai, Ge, et al. "Comparison of Trends in Nonprofit Hospitals' Charity Care Eligibility Policies between Medicaid Expansion States and Medicaid Nonexpansion States." Sage Journals, August 2021. Accessed June 3, 2025.

XXIV The IRS requires tax-exempt hospitals to disclose when they use PE tools and inform patients who do not qualify for full financial assistance after a PE screening. This gives the patient another opportunity to "correct the record" and apply for more help. Treas. Reg. § 1.501(r)-6(c)(2).

XXV Ibid.

XXVI Stakeholder interviews.

XXVII "Research Center: Methodology." United for Alice. Accessed September 25, 2025.

XXVIII For detailed examples of hospital-community partnerships, see "Hospital-Community Partnerships to Build a Culture of Health: A Compendium of Case Studies." American Hospital Association. Accessed August 11, 2025.