Implementation of Act 119: Moving to a Statewide Minimum Standard for Hospital Free Care Policies

The Office of the Health Care Advocate

Emma Zavez, Consumer Research & Health Policy Analyst
Eric Schultheis, Staff Attorney

February 21, 2024

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Agenda

- Background & Legislative History
- Detailed Requirements
- HCA Resources & Support for Hospitals
- Measuring Success
- Questions

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Background & Legislative History

- H.287 (Act 119) - *An act relating to patient financial assistance policies and medical debt protection*
  - Signed by Governor Scott: May 19, 2022
  - Effective Date: July 1, 2024
- Major Problems Act 119 Solved
  - Wide discretion in contents and application
  - Variance in income-eligibility
  - Mismatch of behavior and spatial eligibility standard
  - Income calculation
  - Liquid asset definition

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Detailed Requirements of Act 119

Vermont Statutes Annotated

Title 18: Health

Chapter 221: Health Care Administration

Subchapter 10: Patient Financial Assistance

- § 9481. Definitions
- § 9482. Financial assistance policies for large health care facilities
- § 9483. Implementation of financial assistance policy
- § 9484. Public education and information
- § 9485. Prohibition on sale of medical debt
- § 9486. Prohibition of waiver of rights
- § 9487. Enforcement

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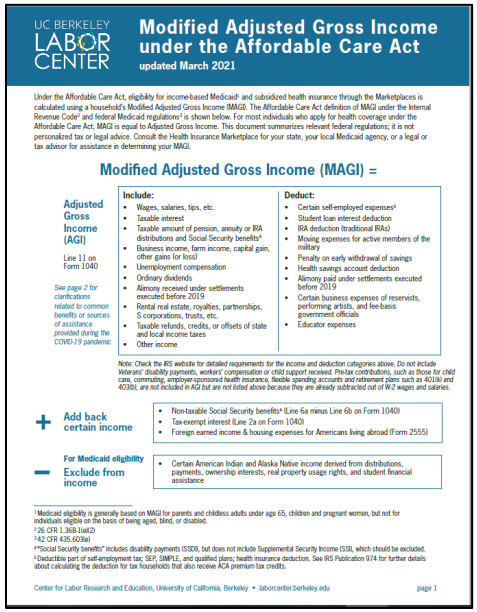
Household Income & Size

- **"Household income"** means income calculated in accordance with **the financial methodologies for determining financial eligibility for advance premium tax credits** under 26 C.F.R. § 1.36B-2, including the method used to calculate household size, with the following modifications…" 18 V.S.A. § 9481(5)
- **Modified adjusted gross income or "MAGI"** 26 CFR §1.36B-1(e)(1) - (2)

"Modified adjusted gross income is the adjusted gross income on your federal income tax return plus any excluded foreign income, nontaxable Social Security benefits (including tier 1 railroad retirement benefits), and tax-exempt interest received or accrued during the taxable year. It does not include Supplemental Security Income (SSI)."

IRS Fact Sheet: Questions and Answers on the Premium Tax Credit



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Modified Adjusted Gross Income under the Affordable Care Act

updated March 2021

Under the Affordable Care Act, eligibility for income-based Medicaid[1] and subsidized health insurance through the Marketplaces is calculated using a household's Modified Adjusted Gross Income (MAGI). The Affordable Care Act definition of MAGI under the Internal Revenue Code[2] and federal Medicaid regulations[3] is shown below. For most individuals who apply for health coverage under the Affordable Care Act, MAGI is equal to Adjusted Gross Income. This document summarizes relevant federal regulations; it is not personalized tax or legal advice. Consult the Health Insurance Marketplace for your state, your local Medicaid agency, or a legal or tax advisor for assistance in determining your MAGI.

Modified Adjusted Gross Income (MAGI) =

Adjusted Gross Income (AGI)

Line 11 on Form 1040

See page 2 for clarifications related to common benefits or sources of assistance provided during the COVID-19 pandemic

Include:

- Wages, salaries, tips, etc.
- Taxable interest
- Taxable amount of pension, annuity or IRA distributions and Social Security benefits[4]
- Business income, farm income, capital gain, other gains (or loss)
- Unemployment compensation
- Ordinary dividends
- Alimony received under settlements executed before 2019
- Rental real estate, royalties, partnerships, S corporations, trusts, etc.
- Taxable refunds, credits, or offsets of state and local income taxes
- Other income

Deduct:

- Certain self-employed expenses[5]
- Student loan interest deduction
- IRA deduction (traditional IRAs)
- Moving expenses for active members of the military
- Penalty on early withdrawal of savings
- Health savings account deduction
- Alimony paid under settlements executed before 2019
- Certain business expenses of reservists, performing artists, and fee-basis government officials
- Educator expenses

Note: Check the IRS website for detailed requirements for the income and deduction categories above. *Do not include Veterans' disability payments, workers' compensation or child support received. Pre-tax contributions, such as those for child care, commuting, employer-sponsored health insurance, flexible spending accounts and retirement plans such as 401(k) and 403(b), are not included in AGI but are not listed above because they are already subtracted out of W-2 wages and salaries.*

+ Add back certain income

- Non-taxable Social Security benefits[4] (Line 6a minus Line 6b on Form 1040)
- Tax-exempt interest (Line 2a on Form 1040)
- Foreign earned income & housing expenses for Americans living abroad (Form 2555)

– For Medicaid eligibility Exclude from income

- Certain American Indian and Alaska Native income derived from distributions, payments, ownership interests, real property usage rights, and student financial assistance

[1] Medicaid eligibility is generally based on MAGI for parents and childless adults under age 65, children and pregnant women, but not for individuals eligible on the basis of being aged, blind, or disabled.
[2] 26 CFR 1.36B-1(e)(2)
[3] 42 CFR 435.603(e)
[4] "Social Security benefits" includes disability payments (SSDI), but does not include Supplemental Security Income (SSI), which should be excluded.
[5] Deductible part of self-employment tax; SEP, SIMPLE, and qualified plans; health insurance deduction. See IRS Publication 974 for further details about calculating the deduction for tax households that also receive ACA premium tax credits.

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"with the following modifications"

(A) domestic partners, and any individual who is considered a dependent of either partner for federal income tax purposes, shall be treated as members of the same household;

(B) married individuals who file federal income tax returns separately but could file jointly, and any individual who is considered a dependent of one or both spouses for federal income tax purposes, shall be treated as members of the same household;

(C) married individuals who are living separately while their divorce is pending shall not be treated as members of the same household, regardless of whether they are filing federal income tax returns jointly or separately; and

(D) household income for individuals who are not required to file a federal income tax return, and for undocumented immigrants who have not filed a federal income tax return, shall be calculated as if they had filed a federal income tax return.

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Income Eligibility

- **Free Care:** Income at or below **250% FPL = 100% discount**
- **Low-Cost Care:** Income from **251% to 400% FPL = minimum of 40% discount**

Household Size	250% FPL	400% FPL
1	$37,650	$60,240
2	$51,100	$81,760
3	$64,550	$103,280
4	$78,000	$124,800

Current Landscape

- 5 out of 15 hospitals meet the free care requirement
- 7 out of 15 hospitals meet or exceed the low-cost care requirement

Note: For uninsured patients, the discount is taken off the amount generally billed. For insured patients, the amount is taken off their out-of-pocket costs. 18 V.S.A. § 9482 (b)(2)(A-D)

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Catastrophic Assistance

Catastrophic Assistance: Income at or below 600% FPL and total medical bills exceed 20% of household income = Reduce the bill to 20% of household income. 18 V.S.A. § 9482 (b)(2)(E)

Example

Household size: 3 (Shelly, spouse, and child)
Household income: $129,100 (500% FPL)
Total owed: $37,000
Percent of household income owed: 28.7%

Shelly is over-income for free or low-cost care, but she qualifies for catastrophic assistance because her household income is less than 600% FPL and she owes the hospital more than 20% of her income. The total owed should be **reduced to $25,820 which is 20% of her annual income.**

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Resource Eligibility

- Resource test is optional
- Applies to liquid assets only
  - Liquid assets shall **not** include: primary home, 401(k) or other retirement accounts, pension plans.
- The hospital cannot consider liquid assets **less than the dollar amount equal to 400% FPL** for the applicant's household size in the year services were delivered. 18 V.S.A. § 9483 (b)(4)(A-B)

Example

Household size: 4
Liquid asset limit: $124,800 (400% FPL for household size)

Juan and his spouse have $50,000 in combined checking and savings accounts. His liquid assets are less than 400% FPL for his household size so the hospital **cannot** deny financial assistance on this basis.

Residency Test

- Hospitals **can require** an applicant to be a Vermont resident.

- "Vermont resident" includes students, people who are employed in Vermont, undocumented immigrants, people living in Vermont but who lack stable housing, etc. 18 V.S.A. § 9481 (12)

- Hospitals **cannot** impose requirements regarding the duration of a patient's status as a Vermont resident. 18 V.S.A. § 9482 (d)

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Non-Discrimination

A large health care facility shall not discriminate on the basis of **race, color, sex, sexual orientation, gender identity, marital status, religion, ancestry, national origin, citizenship, immigration status, primary language, disability, medical condition, or genetic information** in its provision of financial assistance or in the implementation of its financial assistance policy.

18 V.S.A. § 9483 (e)

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Documentation

Income:

- Hospitals can **ask** patients to submit a recent federal or state income tax return.
- Hospitals **must** give patients the option to submit paystubs, proof of public assistance, or any documentation accepted by the Dept. of Vermont Health Access (DVHA) instead of or in addition to a tax return.
- Undocumented immigrants can submit other documentation, like a profit and loss statement. Hospitals cannot require any other type of income documentation.
- Defined at: 18 V.S.A. § 9483 (b)(1-3)

Residency: Act 119 is silent on proof of residency.

- HCA recommends that hospitals follow the example set by Vermont Health Connect on the 205ALLMED application. **The applicant's signature is considered sufficient attestation** that they meet the residency requirement.

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Covered Services

Financial assistance must apply, at a minimum, to all emergency and medically necessary care. 18 V.S.A. § 9482 (b)(1)

"Medically necessary health care services" means health care services, including diagnostic testing, preventive services, and after care, that are appropriate to the patient's diagnosis or condition in terms of type, amount, frequency, level, setting, and duration. Medically necessary care must:

(A) be informed by generally accepted medical or scientific evidence and be consistent with generally accepted practice parameters as recognized by health care professions in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition;

(B) be informed by the unique needs of each individual patient and each presenting situation; and

(C) meet one or more of the following criteria:

(i) help restore or maintain the patient's health;

(ii) prevent deterioration of or palliate the patient's condition; or

(iii) prevent the reasonably likely onset of a health problem or detect an incipient problem.
18 V.S.A. § 9481(10)

"Health Care Services" means services for the diagnosis, prevention, treatment, cure, or relief of a physical, dental, behavioral, or mental health condition or substance use disorder, including procedures, products, devices, and medications.
18 V.S.A. § 9481(4)

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Policy Elements

Must be written and include:

- eligibility criteria
- basis for calculating amounts charged
- method / process for applying for assistance
- steps hospital will take to determine eligibility
- the billing and collections policy (including actions they may take in event of non-payment)
- appeals process
- a plain language summary of the policy

Defined at: 18 V.S.A. § 9482 (b)(3)(A-G)

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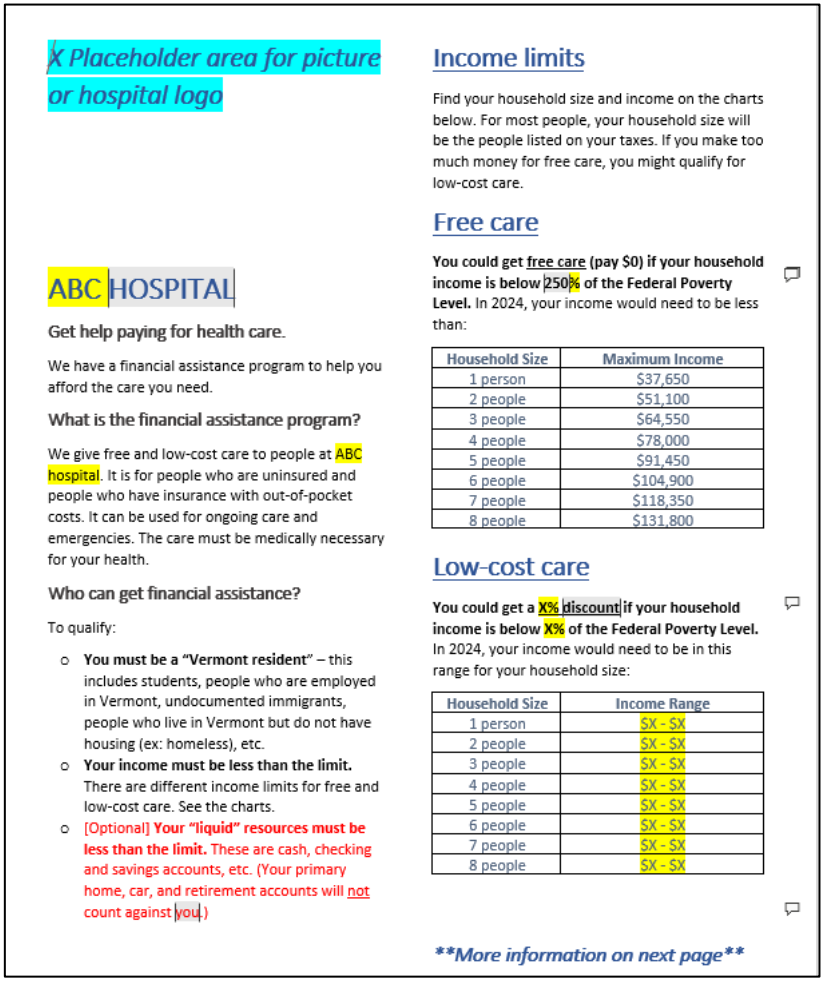
Plain Language Summary

- Section 501(r)(4) of the Internal Revenue Code – requirement for tax exempt hospitals
- 18 V.S.A. § 9482(b)(3)(G) – requirement for all large health care facilities
- Act 119, Sec. 2 (enacted May 19, 2022) – requirement to submit plain language summary to the **Green Mountain Care Board** as part of the fiscal year 2025 hospital budget review process.



X Placeholder area for picture or hospital logo

ABC HOSPITAL

Get help paying for health care.

We have a financial assistance program to help you afford the care you need.

What is the financial assistance program?

We give free and low-cost care to people at ABC hospital. It is for people who are uninsured and people who have insurance with out-of-pocket costs. It can be used for ongoing care and emergencies. The care must be medically necessary for your health.

Who can get financial assistance?

To qualify:

- **You must be a "Vermont resident"** – this includes students, people who are employed in Vermont, undocumented immigrants, people who live in Vermont but do not have housing (ex: homeless), etc.
- **Your income must be less than the limit.** There are different income limits for free and low-cost care. See the charts.
- [Optional] **Your "liquid" resources must be less than the limit.** These are cash, checking and savings accounts, etc. (Your primary home, car, and retirement accounts will not count against you.)

Income limits

Find your household size and income on the charts below. For most people, your household size will be the people listed on your taxes. If you make too much money for free care, you might qualify for low-cost care.

Free care

You could get free care (pay $0) if your household income is below 250% of the Federal Poverty Level. In 2024, your income would need to be less than:

Household Size	Maximum Income
1 person	$37,650
2 people	$51,100
3 people	$64,550
4 people	$78,000
5 people	$91,450
6 people	$104,900
7 people	$118,350
8 people	$131,800

Low-cost care

You could get a X% discount if your household income is below X% of the Federal Poverty Level. In 2024, your income would need to be in this range for your household size:

Household Size	Income Range
1 person	$X - $X
2 people	$X - $X
3 people	$X - $X
4 people	$X - $X
5 people	$X - $X
6 people	$X - $X
7 people	$X - $X
8 people	$X - $X

More information on next page

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Public Education & Information

- **Easily accessible** online through **website and patient portal**
- Paper copies upon request **free of charge by mail and in-person:**
  - Patient reception and admissions areas
  - Patient billing locations
  - Financial assistance / services locations
- **Oral and written translations** upon request
- **Conspicuous display** (notice of and information about FAP):
  - Patient reception and admissions areas
  - Patient billing locations
  - Financial assistance / services locations
- Defined at: 18 V.S.A. § 9484

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Public Education & Information (cont'd)

- **Community notification / outreach:**
  - Hospitals must notify "the community served by the facility about the financial assistance policy in a manner reasonably calculated to **reach the members of the community who are most likely to need financial assistance, including members who are non-native English speakers,** provided that these efforts shall be commensurate with the facility's size and income. 18 V.S.A. § 9484 (a)(4)
- **Direct notification of patients:**
  - Paper copy during "**patient's first visit or, in the case of a hospital, during the intake and discharge processes"**
  - Include **"conspicuous written notice on billing statements"**
  - All written and oral attempts to collect a debt by a medical creditor or medical det collector must include information about FAP

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Procedural Requirements

Hospitals must…

- Review and approve the policy at minimum, every **3 years.**
- Respond to an application in writing within **30 days** of receipt with approval, denial, or information about what is missing.
- Allow patients to appeal a financial assistance decision within **60 days** of receipt of the facility's decision.
- Respond to an appeal with a written decision within **60 days.**

Defined at: 18 V.S.A. § 9482 (c), 18 V.S.A. § 9483 (c)(1-3)

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Before Seeking Payment

Hospitals must…

- Determine if patient has insurance or other coverage;
- Offer to **help patients apply** for public programs, health insurance, or private programs that could lower their costs;
- Use information the hospital already has to see if patient qualifies for financial assistance;
- **Offer information about hospital financial assistance and help applying.**

Defined at: 18 V.S.A. § 9483(a)(1)-(5)

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Medical Debt

Hospitals **cannot** sell medical debt.
18 V.S.A. § 9485

If a patient qualifies for financial assistance…

- Must offer a payment plan;
- **Cannot require payments in excess of 5%** of the household's gross monthly income;
- No prepayment or early payment penalties or fees;
- No interest on debt owed.
  18 V.S.A. § 9483 (d)(1-2)

Must include information about financial assistance with **all** oral and written attempts to collect a debt. 18 V.S.A. § 9484 (c)

Example

Household size: 1
Household income: $41,415/year or $3,451/month (275% FPL)
Max payment: $172.55/month (5% of monthly income)

Abby does not qualify for free care but is granted a 60% discount based on her FPL. After the discount, she still owes $1,500.00 to the hospital. The hospital or medical debt collector must offer her a payment plan and **payments cannot be more than $172.55/month.**

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Complaints

Patients may file complaints about the hospital's patient financial assistance program with the Vermont Attorney General's Office.

18 V.S.A. § 9487

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HCA Resources & Support for Hospitals

Introduction (July 2023)

- Overview of the law, forthcoming resources

Part 1: Review and update your financial assistance policy (Oct. 2023)

- Act 119 requirements checklist, model FAP template that complies with Act 119

Part 2: Update your public education plan & plain language summary (Jan. 2024)

- Public education requirements & ideas for implementation, Plain Language Summary template

Part 3: Implementation (April 2024)

- Letter templates (approved, denied, need more information), poster & social media templates, guides for staff who process applications

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Measuring Success

- FAP Application & Outcome Data
  - Normalized approved count
  - Normalized denial count
  - Ratio of approved to denied and approved to abandoned / incomplete
  - Percent patients granted 100% discount
  - Percent patient granted less than 100% discount
  - Normalized net free care (cost) (most recent 990)
  - Denials by standardized reason category
  - Ratio of free care to bad debt

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Discussion