Financial Assistance and Collections Policies at Missouri Hospitals

How improved regulation and transparency can protect patients from medical debt

AUGUST 2025

LOWN INSTITUTE

Missouri Foundation for Health

Acknowledgments

This project is supported by Missouri Foundation for Health.

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About Missouri Foundation for Health

Missouri Foundation for Health (MFH) is building a more equitable future through collaboration, convening, knowledge sharing, and strategic investment. Working in partnership with communities and nonprofits, MFH is transforming systems to eliminate inequities within all aspects of health and addressing the social and economic factors that shape health outcomes. The Foundation takes a multifaceted approach to health issues, understanding that strategic initiatives, policy, communications, and research all play a role in creating lasting impact.

An independent philanthropic foundation, MFH was created in the year 2000, following Blue Cross Blue Shield of Missouri's conversion from nonprofit to for-profit status. It is the largest organization of its kind in the state and among the largest in the country. Visit www.mffh.org for more information.

About the Lown Institute

The Lown Institute is an independent think tank advocating bold ideas for a just and caring system for health. We envision a healthcare system focused on what's best for people, like hospitals caring for those most in need, patients living without fear of financial distress, and health professionals finding joy in their roles. The Lown Hospitals Index, a signature project of the Institute, is the first ranking to assess the social responsibility of U.S. hospitals by applying measures never used before like community investment, medical overuse, and CEO pay. For more, go to www.LownInstitute.org.

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Executive summary

Medical debt impacts about half of Missouri adults, leading to unnecessary financial and health harms. Financial assistance (FA)—discounts that hospitals give to low- and middle-income patients—can help prevent medical debt before it starts. Gaps in regulation have given hospitals flexibility in setting their own eligibility levels for these programs, leading to inconsistencies in how these policies are written and implemented.

Our analysis of FA policies at 112 general hospitals and 51 specialty hospitals in Missouri shows gaps in transparency and accessibility when it comes to billing and collections.

View data scorecards for all Missouri hospitals through our interactive map!

Awareness gap: Most Missouri hospitals offer financial assistance, but patients don't know about these programs

Despite most Missouri general hospitals (96%) offering financial assistance of some kind, only 24% of Missouri adults report receiving information about FA from a provider.

Implementation gap: Hospitals set thresholds for free and discounted care that are accessible to many Missouri families, but few patients actually receive assistance

At most Missouri hospitals, a family of three making the state median income ($68,920) could access discounted care. However, only 16% of Missouri adults have actually received financial aid through these programs, indicating significant barriers to access. Additional obstacles to FA such as residency requirements, restrictions based on insurance status, asset tests, and fees exacerbate these barriers.

Consistency gap: Hospital free and discounted care thresholds do not always align with community income, and can vary within the same city

Financial assistance eligibility levels were largely unrelated to the county median income and in some cases, even hospitals within the same cities had different income thresholds for free care. Most hospitals in high-debt areas had less generous FA policies or did not have their policy available online.

| **Transparency gap:** Lack of information on allowed collection activities exposes patients to harm

Nearly half of Missouri residents with medical debt report facing a negative outcome from an aggressive collection activity, such as being contacted by a collection agency or seeing their credit score go down. However, many Missouri hospitals do not make any information available online about whether or not they conduct these activities, creating a large transparency gap for patients trying to avoid financial harm due to medical debt.

| **Driving disparities:** Differences in hospital policies may increase medical debt for rural residents and non-English speakers

Most general hospitals in Missouri (88%) make their FA policy available online, but for-profit, public, and rural hospitals have lower rates of transparency. Fewer than 40% of public hospitals and rural hospitals make their policies available in multiple languages. Rural and public hospitals had less generous policies overall.

| **Policy solutions:** Missouri can follow the lead of many other states to protect patients from medical debt

Policy solutions to address these transparency and accessibility gaps include: Better notifications of financial assistance, reporting requirements, minimum eligibility thresholds, patient screening requirements, and limits on allowed extraordinary collection actions.

Introduction

[Medical debt is] something that I will have to pay for the rest of my life...[It's] stuck to my social security number, my birthday, my name. So that's stuck with me for the rest of my life. "

— Respondent from Missouri Foundation for Health Focus Group Report.[1]

Half of Missouri adults, an estimated 2.4 million people, currently have or have had medical debt in the past five years. Three in ten Missourians have medical debt of $1,000 or more, an amount that most Americans could not afford to cover with savings.[2] Those with medical debt face considerable financial and health consequences: having to cut their spending on food, clothing, and other basic household items; avoiding or delaying medical care due to cost; weathering stress and anxiety about their debt; drawing down on their savings; seeing damage to their credit score; and getting contacted by collection agencies.[3]

Medical debt and hospital financial assistance

Hospitals are essential care providers, offering complex, emergency, and preventive medical services that save lives. However, hospital care is also a significant source of medical debt. An estimated 73% of Americans with debt owe some or all of it to hospitals.[4] In Missouri, lab fees and diagnostic tests, emergency care, hospitalization, and outpatient surgery are some of the biggest drivers of medical debt, each contributing to past-due medical bills in more than 30% of cases.[5]

Hospitals' billing and collection practices can have a big impact on patients' financial outcomes. Hospitals try to mitigate the impact of unexpected medical bills by offering free or discounted care to those who can't afford to pay, also known as financial assistance (FA). Alternatively, hospitals can put up barriers to accessing FA and even undertake aggressive collection actions to collect medical debt from low-income patients, such as reporting their debt to credit agencies or taking legal action.

[1] Steiger & Lowe, 2024
[2] Lee, 2023
[3] Sutton & Ben-Porath, 2024
[4] Karpman, 2023
[5] Sutton & Ben-Porath, 2024. Respondents could choose multiple options, totaling up to more than 100%.

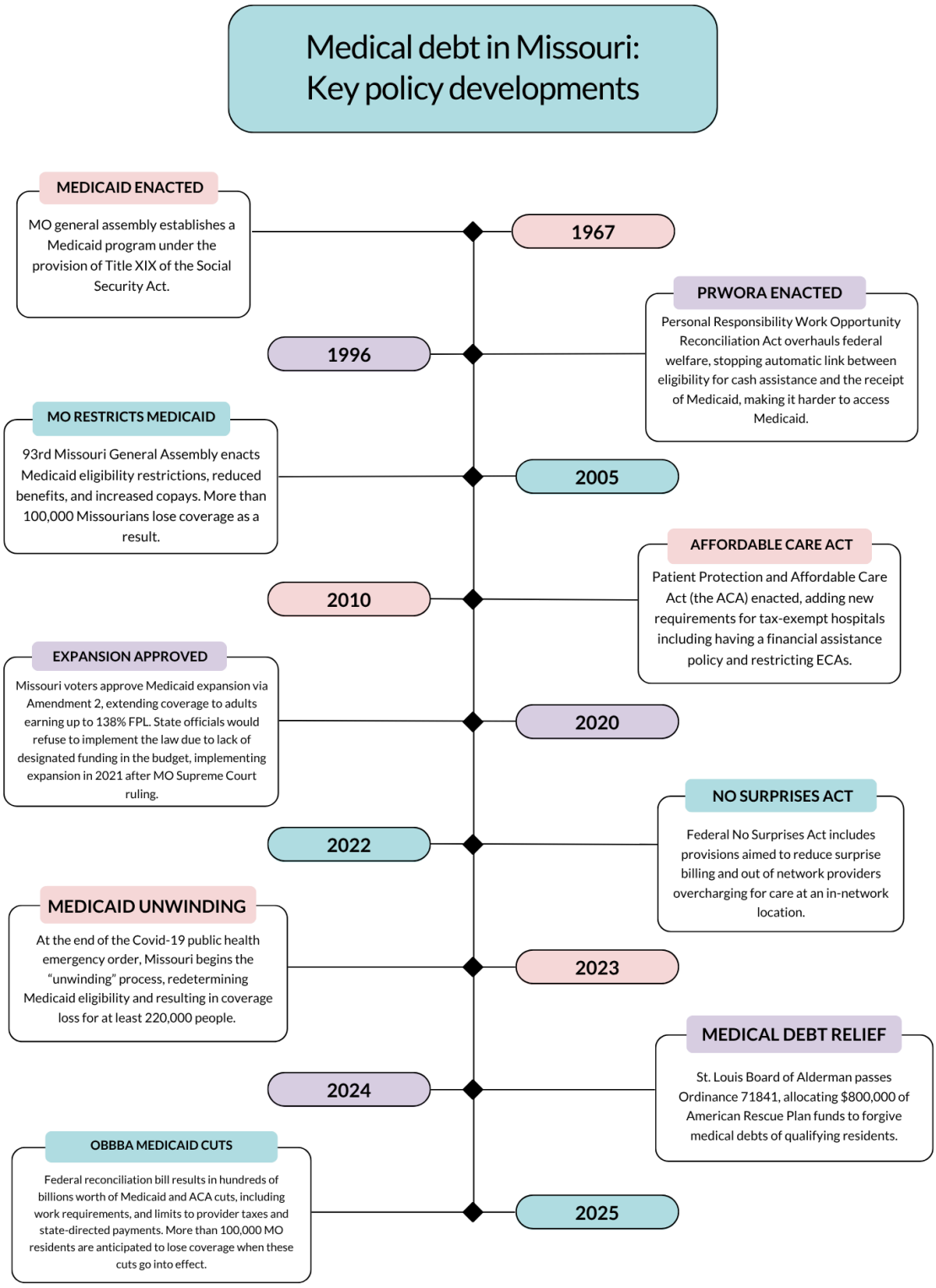
Missouri policy landscape

In Missouri, there are very limited regulations around hospital billing and collections practices. Under federal law, private nonprofit hospitals must have a written FA policy and make the policy widely available to maintain their tax-exempt status. However, there are no federal or Missouri state standards for whom hospitals must make eligible for FA or how much they must spend on free or discounted care. Missouri law limits the amount that hospitals may take in wage garnishments or property liens, but the state does not prohibit any extraordinary collection actions outright.[6]

The absence of standards means that hospitals in Missouri have considerable leeway to decide which patients and medical services are eligible for FA, and the actions they may take to collect medical debt.

Additionally, restrictions on Medicaid eligibility in the late 1990s/2000s and delayed enactment of Medicaid expansion in 2020 limited coverage and made more Missouri residents vulnerable to medical debt. Recent developments on the federal level have reduced Medicaid enrollment further. The Medicaid "unwinding" process from 2023-24 (redetermining eligibility for enrollees who were automatically re-enrolled during the COVID-19 pandemic) resulted in more than 200,000 people losing coverage in Missouri.[7] Proposed cuts to Medicaid through the 2025 budget reconciliation bill would result in at least 130,000 more enrollees losing coverage.[8] (See infographic on page 9 for more on developments in state Medicaid policy over time).

[6] Kona & Raimugia, 2025
[7] Theriault, 2024
[8] Manatt Health, 2025

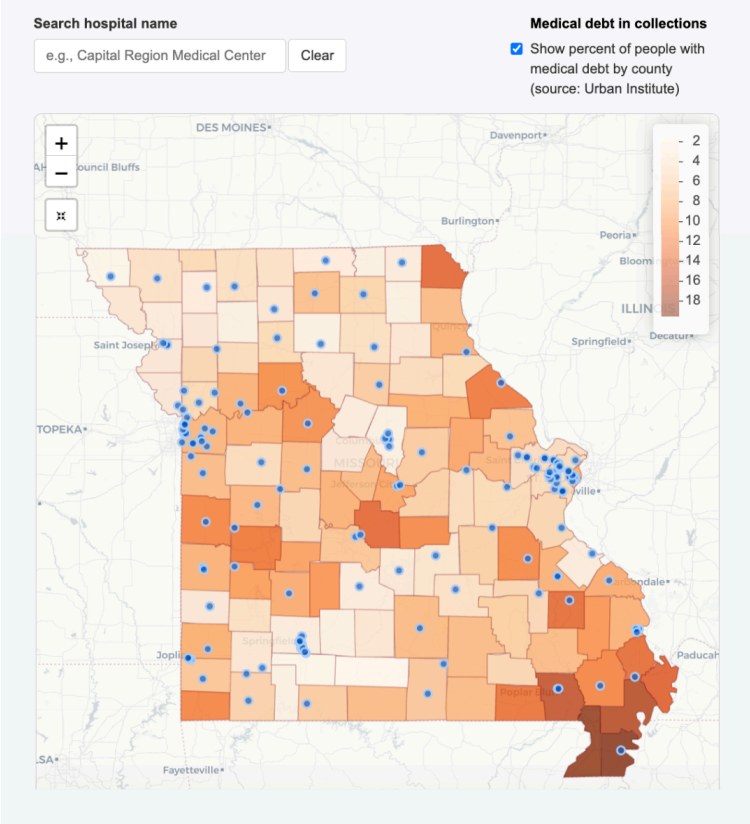

Medical debt in Missouri:
Key policy developments
MEDICAID ENACTED
MO general assembly establishes a Medicaid program under the provision of Title XIX of the Social Security Act.
1967
PRWORA ENACTED
Personal Responsibility Work Opportunity Reconciliation Act overhauls federal welfare, stopping automatic link between eligibility for cash assistance and the receipt of Medicaid, making it harder to access Medicaid.
1996
MO RESTRICTS MEDICAID
93rd Missouri General Assembly enacts Medicaid eligibility restrictions, reduced benefits, and increased copays. More than 100,000 Missourians lose coverage as a result.
2005
AFFORDABLE CARE ACT
Patient Protection and Affordable Care Act (the ACA) enacted, adding new requirements for tax-exempt hospitals including having a financial assistance policy and restricting ECAs.
2010
EXPANSION APPROVED
Missouri voters approve Medicaid expansion via Amendment 2, extending coverage to adults earning up to 138% FPL. State officials would refuse to implement the law due to lack of designated funding in the budget, implementing expansion in 2021 after MO Supreme Court ruling.
2020
NO SURPRISES ACT
Federal No Surprises Act includes provisions aimed to reduce surprise billing and out of network providers overcharging for care at an in-network location.
2022
MEDICAID UNWINDING
At the end of the Covid-19 public health emergency order, Missouri begins the "unwinding" process, redetermining Medicaid eligibility and resulting in coverage loss for at least 220,000 people.
2023
MEDICAL DEBT RELIEF
St. Louis Board of Alderman passes Ordinance 71841, allocating $800,000 of American Rescue Plan funds to forgive medical debts of qualifying residents.
2024
OBBBA MEDICAID CUTS
Federal reconciliation bill results in hundreds of billions worth of Medicaid and ACA cuts, including work requirements, and limits to provider taxes and state-directed payments. More than 100,000 MO residents are anticipated to lose coverage when these cuts go into effect.
2025

About this study

The Lown Institute examined the financial assistance (FA) policies of 163 Missouri hospitals to better understand how hospital policies may be contributing to medical debt. Our research seeks to answer the following questions:

- How do hospitals provide FA to patients? How do these eligibility requirements differ among hospitals in the state, and how do Missouri hospitals compare to other states in their eligibility requirements?
- Which extraordinary collection activities (ECAs) are allowed by Missouri hospitals? How does this compare to other states?
- Are there differences among Missouri hospital policies that could disproportionately impact people based on race, ethnicity, disability, income, or other similar identifying characteristics?
- Do trends in hospital policies correspond to previous research on patients' experiences with medical debt in Missouri? Do these trends point to any potential policy solutions?

All collected data from hospitals is available to view in an [interactive map](#).



Methods and results

We reviewed the available online financial assistance (FA) policies and collections policies of 163 hospitals in Missouri that were open as of June 2025. Among these, 133 had policy data available for analysis, either in a written policy or elsewhere on their website.

Hospital policies were reviewed from November 2024 to March 2025. Hospitals were contacted via email to verify the information in their policies from January 2025 to April 2025. Hospitals were considered not to have responded after three outreach attempts. Comparisons to the U.S. average are based on the Lown Institute's national sample of 2,500 general hospitals.

Additionally, the Lown Institute reached out to all Missouri hospitals asking them to fill out a survey with additional questions about their practices to notify patients about FA and additional collection actions. Despite multiple attempts through various modes of outreach, only two hospitals responded to the survey, so trends across the state's hospitals cannot be ascertained.

Table 1: Data set by hospital type

Hospital type	Number of hospitals in state (% of all hospitals)	Hospitals with available policy information online (% of hospital type)
Acute care*	78 (48%)	77 (99%)
Critical access*	34 (21%)	33 (97%)
Children's	4 (2.5%)	4 (100%)
Psychiatric	17 (10%)	3 (18%)
Children's psychiatric	9 (5.5%)	3 (33%)
Long-term acute care	9 (5.5%)	1 (11%)
Rehabilitation hospital	11 (6.7%)	11 (100%)
Rural emergency hospital	1 (0.6%)	1 (100%)
Total	163 (100%)	133 (82%)

*Included in analyses of "general hospitals" below

We collected the following variables related to hospitals' financial assistance (FA) and collection policies, based on publicly available information.

1. Is the hospital's FA policy available online?
2. Is the FA policy available in multiple languages?
3. Is free care available for patients who cannot afford to pay? If so, what is the income threshold at which patients are eligible?
4. Is discounted care available for patients not eligible for free care? If so, what is the income threshold at which patients are eligible?
5. Is aid for large bills available? If so, what are the income or bill amount requirements to qualify?
6. If a patient is approved for FA, how long does the approval last?
7. Does the hospital limit access to FA based on patient insurance status, location, type of service received, or assets?
8. Does the hospital allow any of the following "extraordinary collection actions"?
    a. Legal action, including wage garnishment, property lien, or lawsuit
    b. Reporting debt to a credit agency
    c. Selling debt to a third party
    d. Denying non-emergency care for patients with outstanding debt

For most of these questions, we focus on general hospitals (short-term acute care hospitals and critical access hospitals only), as these are the majority of hospitals in the state and can be compared to the larger U.S. sample collected by the Lown Institute. See the "Specialty Hospitals" section on page 25 for more information about children's, psychiatric, and long-term acute care hospitals.

Most Missouri general hospitals make financial assistance policies available

Out of 112 general hospitals in Missouri, most (88%) had their full FA policy available online. Missouri hospitals have a slightly higher rate of FA policy availability compared to general hospitals in the U.S. overall (84%). Private nonprofit hospitals were much more likely than public or for-profit hospitals to have a policy available online, which shows that these hospitals are complying with the federal requirement to widely publicize their FA policy within their communities.

Language accessibility lower for Missouri hospitals than U.S. average

Among Missouri general hospitals with policies available, most make their policy available in multiple languages (63%), a lower rate than the U.S. average (70%). **In particular, public hospitals and hospitals in rural areas had low rates of policies available in multiple languages, under 40%**.[9] These disparities could create barriers to accessing FA for those residents (about 6%) with limited English proficiency.

We note there is substantial overlap between the set of rural general hospitals in Missouri and public hospitals. Of the 47 rural general hospitals in Missouri, 21 (45%) are public; only 12% of the 65 urban hospitals in Missouri are public. Most of the public hospitals in the state (72%) are in rural areas.

Table 2: Financial assistance policy availability

Hospital type	FA policy available online	FA policy available in multiple languages*
Private nonprofit	70 (99%)	52 (74%)
Public	22 (76%)	5 (23%)
For-profit	6 (50%)	5 (83%)
Urban/suburban location	61 (94%)	48 (79%)
Rural location	37 (79%)	14 (38%)
Total general hospital	98 (88%)	62 (63%)
U.S. comparison	*2,111 (84%)*	*1,488 (70%)*

*Percentage based on total number of hospitals with policies available online (n=98)

Families making up to 200% federal poverty level can access free care at most MO hospitals

Most general hospitals in Missouri (86%) have some free care available for eligible patients, a rate similar to U.S. hospitals on average (87%). All private nonprofit hospitals

[9] Unlike private nonprofit hospitals, public hospitals are not required to make their FAPs available in non-English languages spoken by people in their service area. Rural nonprofit hospitals may not be subject to the requirement if they have few people in the area with limited English proficiency.

have free care available, while for-profit hospitals (75%) and public hospitals (55%) have lower rates of free care availability.

Rural hospitals had lower rates of free care availability (77%) compared to urban hospitals (91%), which may be attributed to the higher proportion of public and for-profit hospitals in rural areas, which are not subject to the same requirements as private nonprofits.

For hospitals with free care available, the most common income threshold to qualify is up to 200% of the federal poverty level (FPL) (about $50,000 for a family of three), with about half of Missouri hospitals using this threshold. An additional 21% of hospitals make free care available up to 200% of the federal poverty guidelines (FPG) (about $53,000 for a family of three). The 200% FPL/FPG threshold is also the most common in the U.S. overall.[10]

Free care thresholds for family of three

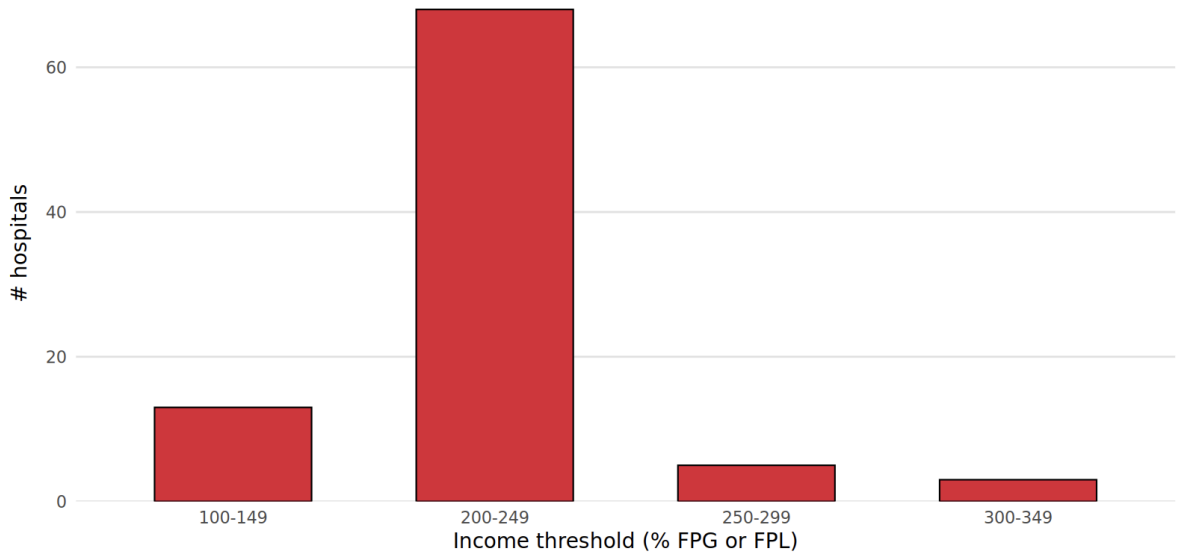
	Federal poverty level (FPL)	Federal poverty guideline (FPG)	
100%	$25,249	$26,650	
150%	$37,874	$39,975	
200%	$50,498	$53,300	← Most common threshold for free care
250%	$63,123	$66,625	
300%	$75,747	$79,950	← Most common threshold for discounted care
350%	$88,372	$93,275	
400%	$100,996	$106,600	
450%	$113,621	$119,925	
500%	$126,245	$133,250	
550%	$138,870	$146,575	
600%	$151,494	$159,900	

While most hospitals use the 200% FPL/FPG threshold, there is some variation. Eleven hospitals restrict free care to only patients making up to 100% FPL/FPG ($25-$27k for a family of three). Three hospitals make free care available to patients making up to 300% FPL/FPG ($76-$80k for a family of three). Six hospitals indicate they offer free care but do not provide information on the income threshold for eligibility.

Rural hospitals overall had lower income requirements for FA eligibility than urban hospitals, with 22% restricting free care only to those 125% FPL or less (compared to 7% of urban hospitals).

[10] Lown Institute, 2025

Chart 1: Free care eligibility thresholds at Missouri general hospitals



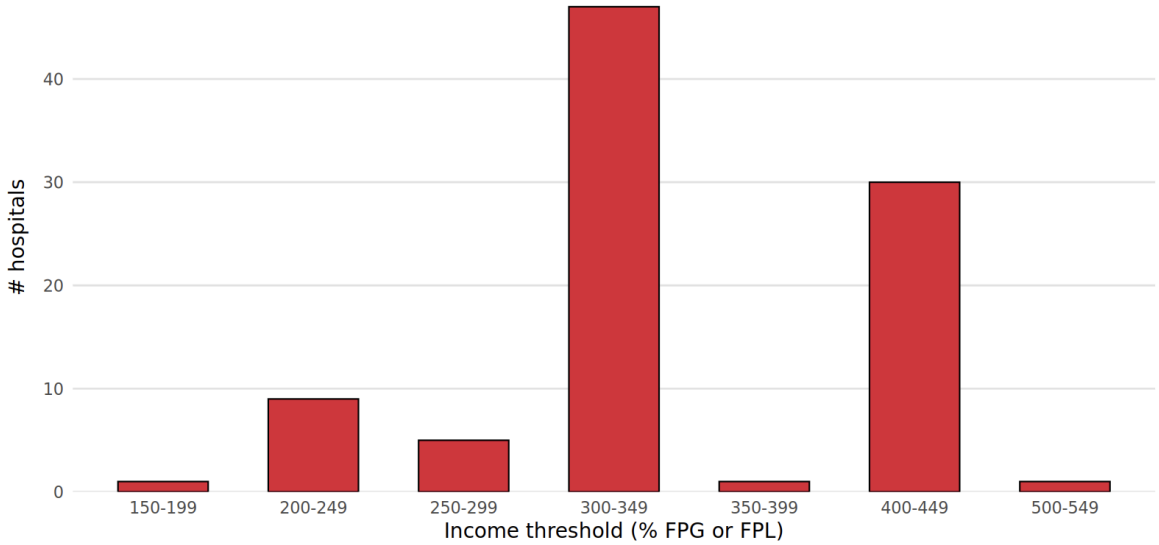
Families making up to 300% federal poverty level can access discounted care at most MO hospitals

The majority of Missouri hospitals (96%) have discounted care available. For-profit hospitals were less likely to offer discounted care (83%) compared to private nonprofits (100%) or public hospitals (93%).

The most common threshold for discounted care is up to 300% FPL/FPG ($76-$80k for a family of three), with 44% of hospitals using this threshold. Another 30% of hospitals make discounted care available to patients making up to 400% FPL/FPG ($101-$107k for a family of three).

Rural hospitals had less generous income thresholds for discounted care compared to urban hospitals. Twenty percent of rural hospitals with discounted care available had thresholds below 300% FPL, compared to 9% of urban hospitals. More than 40% of urban hospitals had thresholds above 300% FPL, compared to 14% of rural hospitals.

Chart 2: Discounted care eligibility thresholds at Missouri general hospitals



Families with large medical bills can access discounts at most hospitals, but eligibility requirements vary

Most general hospitals in Missouri (54%) offer discounts for patients with especially large medical bills who would not otherwise qualify for FA. This is helpful because middle-income or even higher-income households may not have enough savings to pay thousands in medical bills. However, among hospitals that offer discounts, about **one third do not specify how large a bill must be for patients to qualify**, presenting transparency issues for families seeking aid.

The most common threshold for a large bill is 20% of patient income or greater, with about one-third of hospitals using this threshold (for a family of three at 400% FPL, this would be a $20,000 bill). However, six hospitals have more generous thresholds, offering a discount on a bill worth 4% of patient income or greater ($4,000 bill for the same family). Three hospitals only provide aid if the bill is worth 200% of patient income ($200,000 bill for the same family).

Table 3: Thresholds for large bill discounts at Missouri general hospitals

Threshold for bill size to qualify for aid (as % of patient income)	Number of general hospitals (%)*
Under 20% of income	6 (10%)

20% of income or greater	19 (32%)
25%-30% of income or greater	13 (22%)
200% of income or greater	3 (5%)
Amount of bill not specified	19 (31%)

*Percentage based on number of hospitals that offer large bill discounts (n=61)

Rural hospitals were less likely to offer aid for large medical bills (40%) compared to urban hospitals (65%) and had slightly higher thresholds for aid. All six for-profit hospitals with available data offer discounts for medical bills over 4% of patient income.

Hospital financial assistance thresholds do not always align with community need

Hospitals have the freedom to adjust their eligibility criteria for free or discounted care to better align with their community's needs. To better understand this relationship, we compared hospital eligibility thresholds for free and discounted care to the median family income in their county (see **Charts 3a-b**).

Free care and county income

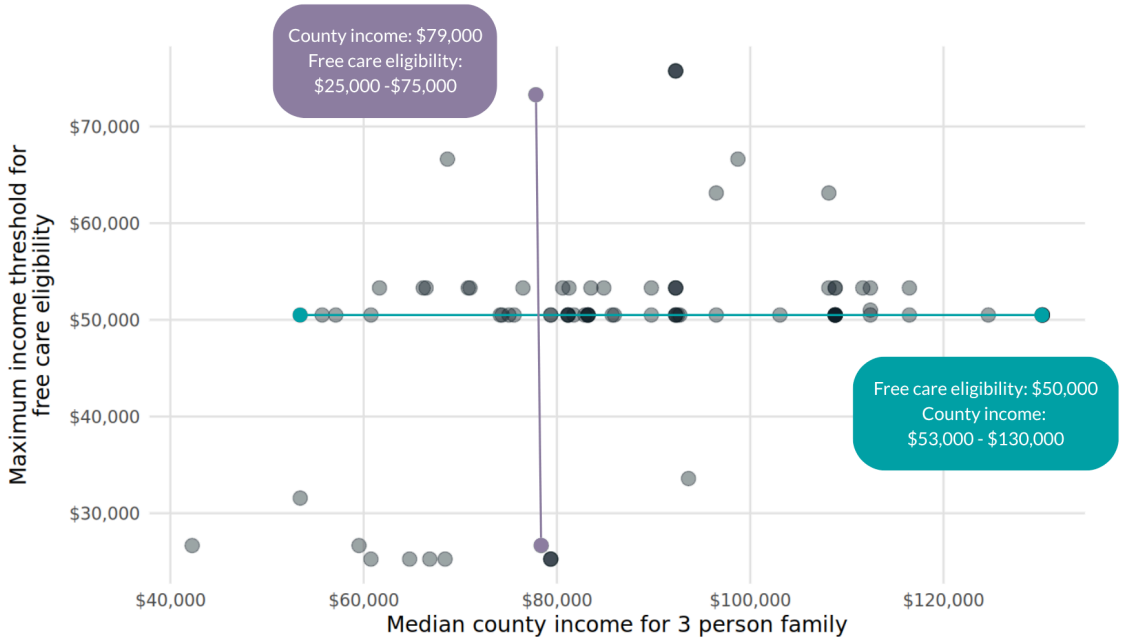
We found a very weak relationship between hospitals' FA thresholds and their county income.[11] The median county income ranged from $53,429 to $130,230 for the 67 hospitals that offer free care up to 200% FPL/FPG (see green dots, **Chart 3a**). This indicates that many hospitals in higher-income areas could increase their free care thresholds to better serve their community needs.

Among hospitals in counties with a median income of $80,000, at least one provided free care to those making up to $75,000 while others limited free care to those making under $30,000 (see purple dots, **Chart 3a**). This indicates that some hospitals may be taking into account community needs when creating their FA policies while others are not.

[11] The r-squared value for free care and county income was 0.086, meaning that 8.6% of the variation in free care thresholds is explained by differences in county income. The r-squared value for discounted care and county income was 0.064, meaning that 6.4% of the variation in discounted care thresholds is explained by differences in county income.

Chart 3a: Hospital free care thresholds and median county income

Each dot represents one hospital. The vertical axis shows hospitals' free care thresholds and the horizontal axis shows the median county income for each hospital. The green dots are an example of variation in county income among hospitals offering free care to the same patient income level. The purple dots are an example of variation in free care thresholds among hospitals with the same county income.

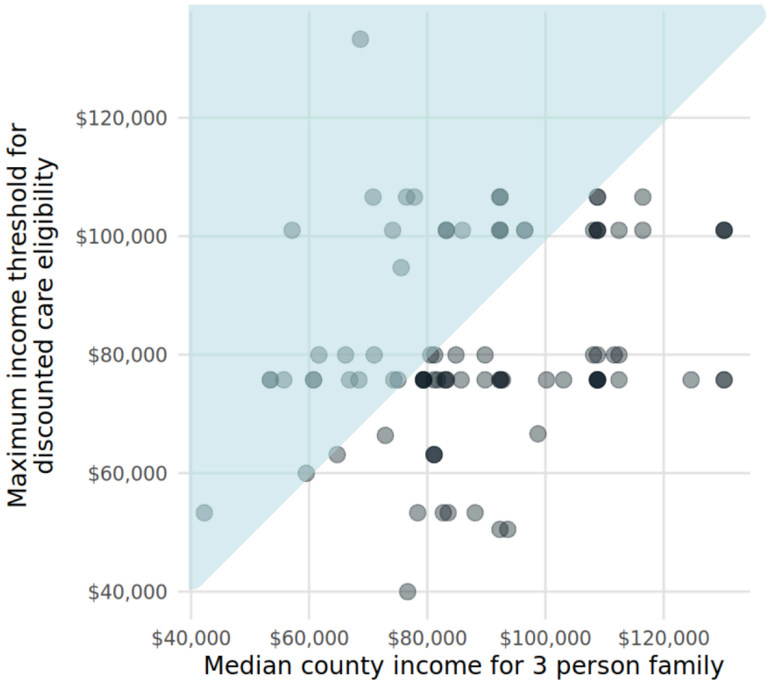


Discounted care and county income

Discounted care thresholds were also not strongly related to county median income (see **Chart 3b)**. Among the 47 hospitals that offer discounted care up to 300% FPL/FPG (the most common discounted care threshold range), county income ranged from $53,429 to $130,230. The county median income range for hospitals offering discounted care up to 400% FPL/FPG was $57,109 to $130,230—overlapping almost completely with hospitals that offer discounted care up to 300% FPL/FPG.

Chart 3b: Discounted care thresholds and community income

Each dot represents one hospital. The vertical axis shows hospitals' discounted care thresholds and the horizontal axis shows the median county income for each hospital. The shaded area represents hospitals that set their thresholds for discounted care at or above the median community income.



The typical Missouri family would be able to access discounted care at nearly half of hospitals. About 36% of hospitals set their discounted care thresholds above their median family income, and an additional 13% set their threshold within $5,000 of their county's median family income. The shaded area in **Chart 3b** indicates hospitals that set their thresholds for discounted care at or above the median community income.

Same city, different free care threshold

In some cases, hospitals in the same city have different eligibility thresholds for free care. This means that whether a patient can access free care or not may depend on which hospital they happen to go to.

For example, St. Luke's Hospital in Kansas City provides free care to families making up to 200% FPL (about $50,000 for a family of three), while University Health Truman Medical Center offers free care to those making up to 300% FPL (about $76,000 for a family of three). See below for more inter-city comparisons.

Table 4: Hospitals in the same cities with different free care thresholds

Kansas City	Free care threshold
Saint Luke's Hospital of Kansas City	200% FPL ($50k for family of three)
University Health Truman Medical Center	300% FPL ($76k for family of three)

Springfield	Free care threshold
Cox Medical Center South	100% FPL ($25k for family of three)
Mercy Hospital Springfield	200% FPL ($50k for family of three)

Jefferson City	Free care threshold
SSM Health St. Mary's Hospital	200% FPL ($50k for family of three)
Capital Region Medical Center	250% FPL ($63k for family of three)

Columbia	Free care threshold
Boone Hospital Center	200% FPG ($53k for family of three)
University of Missouri Health Care	250% FPL ($63k for family of three)

Medical debt rates and financial assistance policies

How may hospital policies contribute to medical debt? Medical debt rates throughout Missouri vary, from 2% in some counties to 19% in others. Using the Urban Institute's interactive map of medical debt in collections, we compiled information on hospitals in Missouri counties with medical debt rates above 10% (the state average rate is 7%).[12] (See **Table 5**.)

Several counties with high rates of medical debt did not have hospitals in the county, suggesting that access issues (e.g., having to travel far for hospital care) or sources of debt aside from hospitals are common. Of the 12 hospitals in high-debt counties, only two offer both free and discounted care with eligibility thresholds at or above the state median rate. Five hospitals do not make free care available to low-income patients. Seven

[12] Data include medical debt in collections from August 2023. Medical debt in collections only covers a portion of medical debt that patients may hold. Source: Urban Institute, 2024.

hospitals do not have available information on the income levels for patients to be eligible for FA. Only one hospital disallows extraordinary collection activities (ECAs) and eight hospitals do not have information on ECAs.

Medical debt in collections is only one measure of medical debt prevalence, and more research is needed to investigate the relationship between hospital FA policies and medical debt rates in Missouri. This small sample indicates that hospitals in high-debt areas have room for improvement on FA transparency and accessibility. Given that most of these hospitals are public hospitals (which are not subject to similar FA requirements as private nonprofits), stronger regulations for hospitals of all types may be needed to ensure that hospitals are serving their community's needs.

Table 5: Financial assistance policies at hospitals in high-debt areas

Name	County	County medical debt rate	FA policy information	Collections information
Pemiscot County Memorial Hospital	Pemiscot	19%	Free and discounted care thresholds below state median level (100% FPG for free care, 200% FPG for discounted care)	No information online
Missouri Delta Medical Center	New Madrid	17%	Free and discounted care available, threshold not specified. Full FAP not available online. Limited to uninsured only.	Legal actions and reporting debt to credit agencies allowed
Poplar Bluff Regional	Butler	16%	Free and discounted care available, threshold not specified. Full FAP not available online.	No information online
Madison Medical Center	Madison	14%	Only discounted care available, threshold not specified. Limited to uninsured only.	No information online
Ellett Memorial Hospital	St Clair	13%	Only discounted care available, threshold not specified. Limited to uninsured only.	No information online
Pike County Memorial Hospital	Pike	13%	Only discounted care available, threshold below state median (200% FPG). Not limited to uninsured.	Reporting to credit agencies, legal actions allowed
Mercy Hospital Stoddard	Stoddard	12%	Free and discounted care thresholds at state median level (200% FPG for free care, 300% FPG for discounted care). Full FAP is available. Not limited to uninsured.	Denying non-emergency care to patients with medical debt is allowed
Bates County Memorial Hospital	Bates	12%	Only discounted care available, threshold not specified. Full FAP not available online.	No extraordinary collection practices allowed.
Washington County Memorial Hospital	Washington	12%	Only discounted care available, threshold not specified.	No information online

Carroll County Memorial Hospital	Carroll	12%	Free care threshold at state median (200% FPL). Discounted care threshold above state median (400% FPL). Full FAP is available. Not limited to uninsured.	No information online
Fitzgibbon Hospital	Saline	11%	Free and discounted care thresholds below state median level (100% FPG for free care, 200% FPG for discounted care). Not limited to uninsured.	No information online
Cedar County Memorial Hospital	Cedar	10%	Free care available at state median level (200% FPG). Discounted care available, threshold not specified.	No information online

Many hospitals have put up additional barriers to financial assistance

A substantial number of hospitals in Missouri include restrictions on FA aside from income, such as residency requirements, restrictions based on insurance status, asset tests, and additional fees. Some restrictions are concentrated within a few specific health systems or hospital types (see **Table 6**).

The most common restrictions on FA are application deadlines, asset tests, and residency requirements. Forty percent of hospitals indicate that they take patient assets into account when determining FA eligibility and 38% of hospitals restrict FA to those in the state or local area. The majority of hospitals in Missouri (52%) do not extend their deadline beyond the federally mandated 240 days.

Less common restrictions on FA are citizenship or legal resident requirements (15%), additional fees or co-pays (12%), limits for those with insurance (6.5%), requirements that FA only apply to emergency care (5.3%), and disallowing refunds for patients later deemed eligible for FA (2.6%). Many hospitals appear to exclude elective care from FA, although definitions of what constitute "elective" within these policies was often unclear (see sidebar, page 24).

Some hospitals have very unique qualifiers; for example, Samaritan Memorial Hospital in Macon only gives free care to patients who are "homeless, those indigent in a nursing home, and those deceased with no estate."

Table 6: Restrictions on financial assistance at Missouri hospitals

FA restriction or qualifier	Number of Missouri hospitals with restriction (%)*	Types of hospitals or systems represented	Data source
Patients may have a fee	13 (12%)	Freeman, Cox, and University health systems. Mostly urban and private nonprofit.	Lown Institute
FA limited to patients in state or local area	17 (15%) limited to MO or IL 25 (22%) limited to local area	Public and private nonprofit hospitals, mostly in urban areas	Lown Institute
Limited to emergency or non-elective care	6 (5.3%) hospitals limit FA to emergency care only	HCA Midwest (urban, for-profit system) limit FA to emergency care	Lown Institute
Limited to uninsured patients	7 (6.5%)	Mostly public rural hospitals	Lown Institute
Limited to citizens or legal residents	17 (15%)	University of Missouri Healthcare, Freeman Health System, SSM health system (mostly urban nonprofit)	Dollar For^
Patients must have assets below a certain amount to qualify for FA	45 (40%)	Mostly private nonprofit and public hospitals.	Dollar For
Patients cannot get a refund if they pay for care and are later determined to qualify for FA	3 (2.6%)	Public hospitals	Dollar For
Deadline to apply for FA restricted to federal minimum (240 days)	58 (52%)	Mostly private nonprofit hospitals	Dollar For

*Percentage based on 112 general hospitals with financial assistance information available

^ Data made available from Dollar For on February 3, 2025

Exclusion of elective care from financial assistance

Several Missouri hospitals appear to restrict FA to emergency and urgent services, excluding any "elective" care. For example, Poplar Bluff Regional Medical Center's website reads, "Financial relief may be available to patients who receive non-elective care." This could exclude scheduled services that are not urgently needed but could still create serious health problems if delayed too long, like cancer biopsy or hernia repair. Other policies are unclear about what "elective" means, defining it as purely cosmetic or not medically necessary surgery.

In a recent perspective piece in *NEJM**, researchers found that 15% of large private nonprofit hospitals from a national sample either excluded elective care outright or were not clear in what types of care were covered. These rates may be higher among public hospitals and smaller hospitals, as these hospitals in Missouri were more likely to indicate that they exclude elective care. Additional research is needed to understand how many hospitals exclude elective care, how these policies are being implemented, and the impact on patients.

*Source: Hall and Garber, 2025

Approval periods for financial assistance

Hospitals can remove administrative barriers to FA by extending the approval period for patients who qualify for assistance. This means that rather than applying for assistance for every episode of care, patients may be able to apply once every six months or a year, reducing the hassle to patients and making it easier to access assistance.

Approval periods varied across hospital types. Most public and for-profit hospitals did not have available data on their approval period, while most private nonprofits did have this information. Private nonprofit hospitals were much more likely to extend the approval period to six months or a year compared to other types of hospitals. Among hospitals that require patients to reapply for assistance for every single episode of care, most were for-profit hospitals.

Table 7: Financial assistance approval periods at Missouri hospitals

FA approval period	Number of Missouri hospitals (%)*
Current balance only	10 (9%)
1-3 months	18 (16%)
4-6 months	30 (27%)

7-12 months	27 (24%)
Not specified	27 (24%)

*Percentage based on 112 general hospitals with FA information available

A look at specialty hospitals in Missouri

In general, specialty hospitals did not make their FA policy available online, making it difficult to evaluate their FA and collections practices. Specialty hospitals in the data set include psychiatric, children's, long-term care, rehabilitation, and rural emergency hospitals. Of 51 specialty hospitals in Missouri, only 23 (45%) had FA policies available online.

For those with information available, the FA policies at specialty hospitals mirror those at general hospitals, likely because many specialty hospitals are affiliated with hospital systems that operate both types of hospitals. Here are key takeaways from specialty hospitals with information available online:

- All specialty hospitals with policies online had their FA policy available in multiple languages and had free care available. All but one hospital with FA policy available offer discounted care.
- The vast majority of specialty hospitals with free care available (83%) offer free care to patients making 200% FPL/FPG or less. About half of hospitals offered discounted care to patients making 300% FPL/FPG, and the other half offered discounted care at 400% FPL/FPG.
- For six hospitals, discounted care was offered at a level at or above the county median income.
- The most common threshold for large bill size at which aid was available was 20% of family income, although most specialty hospitals did not specify the size of a bill that would be eligible for a discount.
- The most common approval period for FA was 12 months.
- About 40% of specialty hospitals require patients to be state or local residents to access FA, but almost all offer assistance to those with insurance.
- The vast majority of specialty hospitals do not include information on their allowed extraordinary collection actions (ECAs). Over 75% of all specialty hospitals did not have data on their ECAs. Among the 23 specialty hospitals with FA information online, 43-70% of hospitals did not have information available on their ECAs, depending on the ECA studied. Legal actions were the most commonly allowed ECA, with 30% of hospitals with data indicating these were allowed in their policy.

Most Missouri hospitals don't disclose information on all of their allowed collection actions

Nonprofit hospitals are allowed to conduct so-called "extraordinary collection actions" (ECAs) to pursue outstanding medical debt, as long as they make reasonable efforts to determine whether patients qualify for FA first. These actions include reporting debt to a credit agency or credit bureau, selling debt to a third party, denying non-emergency care for patients with outstanding debt, and legal actions such as lawsuits, garnishing wages, or putting a lien on property.

Overall, relatively few Missouri hospitals had information on the collection actions they take to pursue medical debt. Depending on the collection action, **between 40% and 86% of general hospitals do not have available information online** on whether they conduct these actions, a lower transparency rate than the U.S. average (see **Table 8a**).

More than half of Missouri general hospitals (57%) allow one or more ECAs according to their policy. The most commonly allowed collection actions were legal actions (45%) and reporting debt to a credit agency (40%).

Table 8a: Extraordinary collection actions allowed by Missouri general hospitals*

	Legal actions	Reporting debt to credit agency	Selling debt to third party	Denying non-emergency care
Allowed according to policy	50 (45%)	45 (40%)	3 (2.7%)	2 (1.8%)
Not allowed according to policy	1 (0.9%)	12 (11%)	2 (1.8%)	1 (0.9%)
Not done in practice, according to hospital representative	9 (8.0%)	1 (0.9%)	11 (9.8%)	14 (13%)
No information	52 (46%)	54 (48%)	96 (86%)	95 (85%)
US national rate	*979 (39%)*	*1,074 (43%)*	*1,721 (69%)*	*1,843 (74%)*

*Percentage based on 112 general hospitals in data set

Even removing hospitals without FA policies available online, 33%–89% of hospitals still did not have information available about ECAs depending on the action, a bit higher than the national rate (28%–69%). Excluding hospitals without FA policies online, 64% of Missouri hospitals allow at least one ECA.

During our outreach to hospitals, representatives for nine hospitals indicated that they did not conduct certain ECAs in practice, although their policy allows them. For 11 hospitals with no information on certain ECAs, a representative said they did not conduct these actions. These answers indicate that hospital policies could be more transparent about the ECAs that are allowed.

Table 8b: Legal actions to collect medical debt allowed by Missouri general hospitals*

	Lawsuit	Wage garnishment	Property lien
Allowed according to policy	31 (28%)	23 (21%)	32 (29%)
Not allowed according to policy	7 (6.3%)	3 (2.7%)	7 (6.3%)
Not done in practice, according to hospital representative	3 (2.7%)	9 (8.0%)	8 (7.2%)
No information	71 (63%)	77 (69%)	65 (58%)
US national rate	*1,317 (53%)*	*1,401 (56%)*	*1,179 (47%)*

*Percentage based on 112 general hospitals in data set

Assignments and prepayments: Additional actions that can drive medical debt

Hospitals may use collection actions aside from the "Extraordinary Collection Actions" listed in this section. For example, hospitals may decide not to sell their medical debt but instead "assign" the debt to a third party while maintaining ownership over the debt. This can mask hospitals' involvement in legal actions if the third party sues patients or takes other legal action. The results of our survey of hospital executives in Missouri found that some hospitals do assign medical debt to third parties.

Additionally, hospitals may require upfront payments from patient before providing care. This can dissuade low-income patients from scheduling needed care, potentially leading to worse health. The results of our survey of hospital executives in Missouri found that some hospitals require upfront payment of a co-pay or percentage of the full payment before an appointment is scheduled or care is provided.

Extraordinary collection actions at tax-exempt hospitals

Private nonprofit hospitals in Missouri were less transparent about their ECAs compared to other nonprofit hospitals nationwide (see **Table 8c**).

Table 8c: Private nonprofit hospitals with no information on allowed ECAs

	% hospitals with no information on…			
	Legal actions	Reporting debt to credit agency	Selling debt to third party	Denying non-emergency care
Missouri private nonprofit hospitals (n=71)	32%	37%	89%	87%
U.S. private nonprofit hospitals (n=1,709)	26%	30%	59%	65%

Nationally, between 14-17% of private nonprofit hospitals specify that they do not allow certain ECAs. In Missouri, no private nonprofit hospitals disallow lawsuits, liens, denial of care, or debt sales according to their written policy. According to responses from Missouri hospitals, between 4-11% of private nonprofit hospitals do not conduct ECAs in practice (depending on the ECA).

Private nonprofit hospitals were much more likely to have information on reporting debt to credit agencies and allowed legal actions, compared to public and for-profit hospitals in the state. However, few private nonprofit hospitals included information on whether they allow selling debt to third parties or denial of non-emergency care.

Extraordinary collection actions at rural hospitals

Rural hospitals were less likely than urban hospitals to have information about allowed ECAs available (see **Table 8d**). This pattern held when accounting for hospitals without FA policies online. Only one rural hospital indicated in its policy that it did not conduct an ECA (in this case, reporting debt to a credit agency). The most commonly allowed ECA among rural hospitals were legal actions (28%).

Table 8d: Rural general hospitals with no information on allowed ECAs

	% hospitals with no information on…			
	Legal actions	Reporting debt to credit agency	Selling debt to third party	Denying non-emergency care
Rural hospitals (n=47)	70%	68%	98%	94%
Urban hospitals (n=65)	29%	34%	77%	78%

Analysis and policy implications

When patients cannot afford to pay for medical care, hospital financial assistance (FA) can be a safety net. If Medicaid cuts are implemented and rates of coverage decline, there will likely be a greater need for FA, making it even more important that hospital policies are clear, generous, and well-implemented.

Our analysis of 163 Missouri hospitals shows significant gaps in the availability of FA and collections information, consistency of eligibility requirements, and implementation of these policies. Policymakers can help close these gaps by following the lead of other states taking action on this issue.

For examples of various policy solutions and supporting evidence, see Table 9 on page 34.

Most Missouri hospitals offer financial assistance, but relatively few patients know about these programs

Despite most Missouri general hospitals (96%) offering free or discounted care, relatively few patients are aware of these programs.

According to the 2024 Missouri Foundation for Health (MFH) survey on medical debt, only 24% of respondents had received information about financial aid from a medical provider in the past five years. In comparison, a national survey of people struggling to pay medical bills found that 48% of patients were informed about FA.[13]

While information on financial assistance is low across the country, it appears that **Missouri residents have an especially low rate of receiving financial assistance information from providers**. In particular, middle-income residents (who may be eligible for discounted care) are less likely to receive information on FA compared to lower-income Missourians.[14]

[13] Goldstein et al., 2024
[14] Sutton & Ben-Porath, 2024

Awareness gap: Policy solutions

Require hospitals to **improve patient notification** on FA, with measures such as:

- requiring hospital staff to inform patients about financial assistance at intake and/or discharge;
- providing assistance to patients in completing applications when they receive it in the hospital
- making FA policies available on hospital websites in three clicks or less from home page
- specifying requirements for posted notifications in hospital waiting rooms

State and local public health departments may also consider conducting an **awareness campaign** targeting middle-income families (making 300%-400% FPL) to let them know they are likely eligible for discounted care at hospitals.

Many eligible Missouri families aren't receiving financial assistance

Nearly 80% of hospitals offer discounted care above the state median family income and about half offer discounted care at or above the median family income in their county.[15] This means at least 25% and as many as 50% of Missouri families should be able to access FA.

However, a 2024 MFH survey found that only 16% of Missouri adults have actually received financial aid through provider programs in the past five years. To the extent to which debt is owed to hospitals, this gap indicates significant barriers to access for Missouri residents.

Implementation gap: Policy solutions

Require hospitals to **screen patients for eligibility** for financial assistance and apply discounts automatically to patients who qualify. Some states require screening for all uninsured patients, patients with Medicaid coverage, patients who owe a certain amount to the hospital after insurance, or any patient upon request.

Require hospitals to accept a **universal application** for FA to simplify the application process.

While lack of awareness of FA is a key obstacle to access, we found that 20% of hospitals put up additional barriers such as residency requirements, restrictions based on

[15] Most Missouri hospitals offer free or discounted care for patients making at or below 300% FPL/FPG. Given that the per capita median income in the state is 250% of the federal poverty level (about $38,500), this threshold should cover most Missouri residents. However, county median income is higher than the state median income for most hospitals, suggesting that hospitals are located in higher-income areas, leaving access gaps for the state's poorer residents.

insurance status, asset tests, and fees. In particular, public and rural hospitals were more likely to restrict care to patients without insurance, which is concerning given that insured Missourians are just as likely to have medical debt as those who are uninsured.

Filling these gaps could have a significant impact on the health and well-being of Missouri residents. According to the 2024 MFH survey, 61% of those who received FA said that aid "made a major difference in their ability to pay their medical bills."[16]

Free and discounted care thresholds do not always align with community income, and can vary within the same city

Consistency gap: Policy solutions

Set **minimum thresholds for eligibility** for hospital free and discounted care.

- These could be set at the current state median rate (200% FPL for free care, 300% for discounted care), to bring all hospitals up to the most common level.
- For discounted care, the amount of the discount should be specified on a sliding scale (i.e. patients at 250% FPL get 50% discount).
- Restrictions on eligibility for FA based on local residency, insurance status, or assets owned should be limited.
- Hospitals in higher-income areas should be encouraged to set thresholds above the state minimum.
- All types of hospitals should be included, to address low FA thresholds at public hospitals and FA restrictions at for-profit hospitals.

The thresholds hospitals set for free and discounted care were not related to the income in their community.

We found many examples of hospitals with the same eligibility requirements located in areas with very different incomes, and hospitals in the same cities with very different free care thresholds, which could lead to confusion for patients.

In the areas with the highest rates of medical debt, few hospitals had FA thresholds at the state median level. Restrictions on FA based on assets owned, insurance status, type of care needed, and other factors were common, making the application process more burdensome and confusing for patients.

[16] Sutton & Ben-Porath, 2024

Lack of information on allowed collection activities exposes patients to harm

Transparency gap: Policy solutions

Policies to improve transparency on extraordinary collection actions (ECAs):

- Require all hospitals (including public and for-profit hospitals) to **make their collections policies easily available online** and provide physical copies in the hospital if requested.
- Require hospitals to **report the number of each ECA undertaken** each year to the state.

Policies to limit ECAs:

- Require **patient screening before any ECAs** to ensure patients eligible for financial assistance do not go to collections
- Restrict ECAs for hospitals that do not make their **insurer-negotiated prices** available
- **Prohibit** certain ECAs entirely, either for patients below a certain income level or for all patients

A substantial proportion of Missouri residents with medical debt report harm from extraordinary collection actions (ECA). According to the 2024 MFH survey, 45% of adults with debt were contacted by a collection agency, 31% said that medical debt has negatively impacted their credit score, 11% were denied a future appointment because of outstanding debt, and 9% were sued by a provider or collection agency.

However, a relatively small number of Missouri hospitals admit to allowing these actions, leaving a large gap in transparency for patients attempting to avoid ECAs. Most hospitals do not have available information on four commonly conducted ECAs. While nearly half of Missouri residents with debt say they have been contacted by a collection agency for medical or dental bills, only 3% of hospitals indicate in their policy that they may sell debt to a third party. The vast majority of hospitals (86%) do not have any information on this ECA.

Financial assistance and medical debt disparities

Differences in FA information and policies among different types of hospitals may drive disparities in medical debt rates. For example, Missouri hospitals are less likely than other U.S. hospitals to make their FA policies available in multiple languages, particularly among hospitals in rural areas.

This creates another barrier to access for residents with limited English proficiency in the state, and may exacerbate **disparities in medical debt for Hispanic Missourians**, who have a 14% higher rate of medical debt than white non-Hispanics.[17]

Aside from language gaps, rural and public hospitals are lagging behind their peers in FA accessibility. Rural and public hospitals have lower thresholds for free and discounted care compared to urban hospitals. They are more likely to restrict care to uninsured patients, although insured Missouri residents face medical debt at similar rates. Rural and public hospitals also have low rates of transparency around ECAs compared to private nonprofit and urban hospitals.

Medical debt disparities: Policy solutions

- Any new regulations or requirements for hospital FA policies should **apply to public and for-profit hospitals** as well as private nonprofit hospitals.
- Require hospitals to track their number of financial assistance applications, approvals, and rejections, **including demographic information** such as race, gender, zip code, primary language spoken, and ethnicity.
- The state should consider **convening board members of public hospitals and community members** to discuss ways to address transparency for FA policies and collection policies and improve uptake of FA while maintaining financial stability.

These policy differences are born out in variable spending on FA. An analysis of data from Centers for Medicare & Medicaid Services (CMS) hospital cost reports from 2022 found that most public hospitals dedicated 1.4% of their expenses to FA on average, far less than the statewide average (2.7%). Rural hospitals spent 2% of expenses on FA compared to 3.1% of urban hospitals. Public hospitals in rural areas had the lowest levels of average FA spending as a share of expenses (1%) compared to hospitals of other ownership types and hospitals in urban locations.[18] Rural, private nonprofit hospitals had similar rates of FA spending as urban nonprofits, indicating that low charity care spending in rural areas may be due to a higher concentration of public hospitals.

Missourians living in rural areas are more likely to have medical debt than those in urban or suburban areas (44% vs 37%) and less likely to be able to afford an unexpected medical bill (48% vs 61%).[19] **Lack of access to financial assistance and lower eligibility levels may drive higher rates of medical debt for rural Missourians**.

[17] Sutton & Ben-Porath, 2024
[18] Authors' analysis of CMS hospital cost report data, 2022
[19] Sutton & Ben-Porath, 2024

As previously noted, most public hospitals in Missouri are in rural areas and a greater proportion of rural hospitals are public compared to urban hospitals. Public hospitals are not subject to federal 501(c)(3) regulations, but given that they are government-run institutions, they should be more transparent and accountable to communities.

Table 9: Policy recommendations to fill gaps in financial assistance

For even more policy solutions, see "Additional Resources" in Appendix

Gap to fix	Policy recommendations	State examples[20]	Supporting evidence
Awareness gap: Low awareness of FA programs	Require hospitals to **improve patient notification** on FA, with measures such as: • requiring hospital staff to inform patients about financial assistance at intake and/or discharge; • providing clinicians with resources to help them have conversations about cost and FA • providing assistance to patients in completing applications when they receive it in the hospital • making FA policies available on hospital websites in three clicks or less from home page • specifying requirements for posted notifications in hospital waiting rooms (size of notification, information on poster) Expand existing requirements for private nonprofit hospitals to **public and for-profits**, such as including	Maryland requires hospitals to provide all patients with a "patient information sheet" that includes FA information.	Having more interactions with hospital staff related to FA increases the likelihood of applying for assistance.[21] According to a MFH survey, 94% of respondents support requiring medical providers and hospitals to provide information about available discounts and charity care with all medical bills.[22] Among people who were eligible but did not apply for financial assistance, 25% said it was because they did not think they would qualify.[23] Focus groups with patients support removing barriers to FA, offering assistance with completing applications, and taking minimal clicks to see application.[24] A large hospital specialty organization includes in their best practices making financial assistance policies

[20] Source for this column unless otherwise specified is Kona & Raimugia, 2025
[21] Goldstein et al., 2024
[22] Sutton & Ben-Porath, 2024
[23] Goldstein et al., 2024
[24] Undue Medical Debt, 2024

	the FA plain language summary and application at intake or discharge, and in billing statements. Conduct an **awareness campaign** targeting middle-income families (making 300%-400% FPL) to let them know they are likely eligible for discounted care at hospitals.		available on the website within three clicks of the home page.[25]
Implementation gap: Low uptake of FA programs	Require hospitals to accept a **universal application** for FA to simplify the application process (similar to the "common app" for college applications) Require hospitals to **screen patients for eligibility** for financial assistance and apply discounts automatically to patients who qualify.	New York, Maryland, Colorado, and Rhode Island are among the many states that require hospitals to use a universal application form. New Jersey and Illinois do not require use of a universal application but do set minimum standards. Oregon, Illinois, North Carolina, Colorado require hospitals to screen patients for financial assistance and apply discounts automatically. Regulations vary by state in terms of which patients are required to be screened. States have taken different approaches to screening, with some using public benefit eligibility others using income information from third party tools.	85% of respondents support requiring all medical providers to use the same applications for financial assistance programs, according to an MFH survey. One year after Oregon required patient screening, one academic medical center reported that 64% of patients were being identified as eligible for FA, compared to 12% prior to this program.[26] Screening programs may still require additional enforcement to ensure that hospitals are adequately screening patients. In Colorado, about 41% of patients were not screened in the first year after the program was implemented.[27]
Consistency gap: Not all hospitals set FA levels that serve community needs.	Set **minimum thresholds** for free and discounted care • These could be set at the current state median rate (200% FPL for free care, 300% for discounted care), to bring all hospitals up to the most common level. • For discounted care, the amount of the discount should be specified on a sliding scale (i.e. patients at	About 20 states, including California, North Carolina, Oregon, Washington, and New York set eligibility thresholds for financial assistance. Some states, such as Washington, specify the discounts that hospitals must make available at each income level. Washington state also has separate thresholds for larger urban hospitals and	85% of respondents support requiring all medical providers to use consistent criteria for financial assistance programs, according to an MFH survey. In Oregon, financial assistance spending at hospitals increased by $423,000 on average after minimum thresholds were imposed, compared to hospitals not subject to thresholds.[28]

[25] Healthcare Financial Management Association, 2022
[26] Reilly et al., 2025
[27] Colorado Department of Health Care Policy & Financing, 2024
[28] Santos et al., 2025

	250% FPL get 50% discount). • Restrictions on eligibility for FA based on local residency, insurance status, or assets owned should be limited. • All types of hospitals should be included, to address low FA thresholds at public hospitals and FA restrictions at for-profit hospitals.	smaller hospitals. Oregon specifies that hospitals may not take assets into account when determining eligibility for FA.	
Transparency gap: Most hospitals do not provide information about ECAs	Policies to improve transparency on ECAs: • Require all hospitals (including public and for-profit hospitals) to **make their collections policies easily available online** and physical copies in the hospital if requested. • Require hospitals to **report the number of each ECA undertaken** each year to the state. Policies to limit ECAs: • Require **patient screening before any ECAs** to ensure patients eligible for financial assistance do not go to collections • Restrict ECAs for hospitals that do not make their **insurer-negotiated prices** available • **Prohibit** certain ECAs entirely, either for patients below a certain income level or for all patients	California, Colorado, New York, Massachusetts, North Carolina, and Maryland are among the many states that restrict ECAs. Some states restrict ECAs for patients at certain income levels, others restrict ECAs for all patients. New Mexico, Minnesota, and California require screening for financial assistance before ECAs are undertaken.	Over 75% of Missourians support prohibiting selling debt to collection agencies, denying care, and putting liens on houses, according to a MFH survey. Nearly all (94%) of respondents support price transparency for hospitals, lending support to ECA restrictions on hospitals that do not make prices transparent.[29] Early evidence from consumer advocates in New Mexico noted fewer aggressive collections after protective measures were passed in 2021 that required patient screening before ECAs.[30]
Medical debt disparities	Any new regulations or requirements for hospital FA policies should **apply to public and for-profit hospitals** as well as	Washington, Colorado, Illinois, Maryland, and New Jersey require hospitals to report financial assistance program	Hispanic and rural Missourians have higher rates of medical debt.[31]

[29] Sutton & Ben-Porath, 2024
[30] Karpman et al., 2024
[31] Sutton & Ben-Porath, 2024

	private nonprofit hospitals. Require all hospitals to track their number of financial assistance applications, approvals, and rejections, **including demographic information** such as race, gender, zip code, primary language spoken, and ethnicity. The state should consider **convening board members of public rural hospitals and community members** to discuss ways to address transparency for FA policies and improve uptake while maintaining financial stability.	participation stratified by demographic factors. Oklahoma, California, Colorado, Florida, Texas, and other states apply their financial assistance requirements to both nonprofit and for-profit hospitals.	Financial assistance policy data shows that rural and public hospitals have less generous FA thresholds and give less in assistance compared to urban hospitals.

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Appendix

Federal poverty level/guidelines by family size

Table A1: Federal poverty level thresholds for 2024 by size of family and number of related children under 18 years

Size of family unit	Related children under 18 years			
	None	One	Two	Three
One person (unrelated individual):				
Under 65 years	$16,320			
65 years and over	$15,045			
Two people:				
Householder under 65 years.	$21,006	$21,621		
Householder 65 years and over.	$18,961	$21,540		
Three people	$24,537	$25,249	$25,273	
Four people	$32,355	$32,884	$31,812	$31,922
Five people	$39,019	$39,586	$38,374	$37,436
Six people	$44,879	$45,057	$44,128	$43,238

Source: U.S. Census Bureau, 2025.

Table A2: 2025 Federal poverty guidelines for the 48 contiguous states and DC

Persons in family/household	Poverty guideline
1	$15,650
2	$21,150
3	$26,650
4	$32,150
5	$37,650
6	$43,150
7	$48,650
8	$54,150
For families/households with more than 8 persons, add $5,500 for each additional person.	

Source: HHS, January 2025

Additional resources

Interactive map with Missouri hospital FA policy information, Lown Institute, 2025

Hospital financial assistance and collections policies, Lown Institute, 2025

- Insights from a national sample of 2,500 hospitals

Past Due: How medical debt is harming Americans and the solutions we need now, Lown Institute, 2025

- A white paper on the scope, harms, and solutions for medical debt, written in collaboration with a working group of researchers and advocates

State Protections Against Medical Debt, The Commonwealth Fund, 2025