



Fact Sheet

The Free Care Safety Net

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I. Improving Access to Free Care in Our Communities

For many people, free hospital services, often in a time of crisis, are the only available form of health care. These services are called free care, indigent care, or charity care. Free care therefore functions as a kind of health care “safety net,” providing health care to those who have no other way of paying for it. Despite its importance, free care is not really a system but a confusing patchwork of non-specific laws and voluntary hospital efforts. While states are moving forward in standardizing free care policies, community vigilance is essential to improving access to free care.

What Is Free Care?

Free care is care provided by a hospital for which it does not expect to be paid. Hospitals may provide free care to people who show they cannot afford to pay for their care. Some hospitals also provide services at a discount to patients who are able to pay some, but not all, of the cost of their care. These discounted services are also considered free care. Most hospitals require that in order to be eligible for free care, a patient’s income must be under a certain defined level.

A thirty-year-old uninsured single woman earning \$8,000/year needs chemotherapy. She applies to a hospital for free care. Because her income is below the defined level, her application is approved. She is treated at the hospital but is not billed for the medical services.

Are Hospitals Obligated to Provide Free Services?

There are laws and legal obligations that require hospitals to provide free services to those in need. However, these laws are often vague and limited. Although they do provide a base for valuable community care, they often lack specific requirements as to how or how much free care hospitals must provide.

For example, nonprofit hospitals are classified as charities and receive tax exemptions, and therefore have some obligation to provide services and other benefits to the community. Often this obligation is met in part by providing some amount of free or reduced-cost care. Additionally, some state laws require hospitals, nonprofit or for-profit, to provide services to those who can’t afford to pay. And hospitals with emergency rooms are obligated under federal law to provide at least emergency services to those in crisis regardless of their ability to pay.

Despite the critical importance of free care to the more than 41 million uninsured people in this country, there are no standard federal free care requirements and few clear state standards. Since there are so few standards, each hospital creates its own free care policy. Because the laws do not require hospitals to provide certain levels of care, free care differs from hospital to hospital and access to health care for the uninsured varies from community to community.

Is It Easy to Get Free Care?

Despite the fact that free care is an important foundation of our health care safety net, it can sometimes be difficult to obtain. Since individual hospitals create their own free care policies, problems can arise. For example:

- There may not be a standard process within a hospital. The hospital may give free care on a discretionary basis and make decisions on a case-by-case basis.
- Those in need of services may not even know that the hospital provides free care. Information about free care may not be given at the time of service. The hospital may not post signs or provide pamphlets explaining its free care policy. If there are signs or pamphlets, they may be written in a language the patient does not understand or may explain the policy in a complicated or intimidating way.
- The application itself may be difficult to read, complicated to complete, or written in a language the patient does not understand.
- The application process may be disrespectful, long and complicated, and patients may receive bills in the meantime.
- Only certain services may be provided free. Patients could still be left with large bills even after receiving free care. For example, room and board may be covered, but laboratory and doctor services often are not.
- Eligibility levels may be set excessively low. People who own a home or a car may be disqualified from receiving free care.
- Free care patients may get different treatment or receive different priority than insured patients.

How Do These Problems Affect the Uninsured?

For people who are already in ill health, the effect can be devastating.

- Uninsured people may be intimidated or confused by the application process and therefore decide not to get the care they need, or delay getting it, making them sicker.
- Uninsured patients may try to pay hospital bills instead of using the money for medications, rent, or food.
- Patients unable to pay may be subject to stressful harassment from bill collectors.
- Because of unclear eligibility requirements, people who are actually eligible for free care may be denied free services.

What Should a Good Free Care Policy Include?

1. A written, board-approved policy that sets a clear and consistent standard for free care eligibility.
2. Notice to the community that free care is available, including appropriate notice during the admitting process, notices throughout the hospital, and outreach to free care-eligible populations in the community.
3. A simple and language-appropriate application including an explanation of the timeframe and process for approval, the hospital and patient responsibility, if any, and all options available to the patient including reduced-cost care. The application should clearly state what the patient can expect and it should guarantee that the patient will not be billed until a free care determination has been made.
4. A respectful and quick approval process including open communication between patient and institution.
5. Comprehensive health services including prescription drugs, laboratory services, doctor and specialist services, and X-rays.

How Can Community Organizations Take First Steps Toward Improving Free Care?

Community groups should learn about the free care policies at their local hospitals and in their county and state. Community leaders should find out whether there are free care laws or regulations in their state and what these laws require. An important first step would be to request the policy and an application directly from the hospital. The hospital response and the materials you receive will reveal a great deal about the fairness and effectiveness of the policy. Interviewing uninsured patients is also important in understanding how the free care process might be improved. Clinic providers and other primary care providers in the community can also give valuable information and a slightly different perspective about unmet health care needs and the relationship of local hospitals to the community. The task is to identify what works as well as what does not.

What Are the Opportunities Community Leaders Can Use to Raise These Issues?

The first step is to approach the hospital. Some institutions will be willing to discuss free care with community leaders and advocates and make changes to improve free care policy. There are also many changes that are occurring today in the health care marketplace, such as mergers and nonprofit to for-profit conversions, new laws and regulations addressing hospital community benefit obligations, and the development of Medicaid managed care networks. Many of these changes present opportunities for community groups to negotiate for more free care and better free care policies.

II. Holding Hospitals Accountable for Free Care in Your Community

In addition to looking at a hospital's free care policy (that is, how that hospital decides what free care to provide), there is also the question of how much free care the hospital provides, and whether that is sufficient.

Determining how much free care hospitals actually provide can be complicated but is important to understand in order to ensure that the community is being fully served. There are certain key concepts to understand when determining how much free care a hospital is providing and how much it should be providing.

Free Care, Bad Debt, and Uncompensated Care

KEY DEFINITIONS:

Free Care: Free services hospitals provide to patients who show that they cannot afford to pay for their care. Hospitals do not expect to be paid for these services.

Bad Debt: Services hospitals provide for which they expect payment, but never receive it. Bad debt usually arises out of insurance companies' or individual patients' not paying bills.

Uncompensated Care: Services hospitals provide but for which they do not receive full payment. The term often includes free care and many categories of "unpaid care" including bills that insurance companies and individuals don't pay. "Uncompensated care" may also include the difference between what the hospital receives for treating Medicare and Medicaid patients and what it usually receives for privately insured patients. Hospitals may lump all these categories together and call them uncompensated care.

What is the Difference Between Bad Debt and Free Care?

In reality, it may be difficult to see the difference between free care and bad debt from these very general definitions. The following two examples should help illustrate the difference.

- **BAD DEBT:** An insured woman takes her baby to the emergency room with a high fever. The baby is treated and released. Because she didn't get prior approval before going to the ER, her insurance company denies coverage and will not pay the hospital for the services. The hospital sends her the bill, but she does not pay it. The hospital assumes the loss.
- **FREE CARE:** An uninsured single 25-year-old woman goes to the hospital with a broken arm. She applies for and receives free care because her income of \$6,000/year is below the eligibility level defined by the hospital or state.

Why are These Differences Important to the Community?

In order to hold a hospital accountable for providing free care, it is important to get an accurate assessment of the free services it provides. Hospitals may talk about free care and uncompensated care as if they were the same. Since uncompensated care includes free care, bad debt, and often the Medicare and Medicaid "shortfall," it is not an accurate assessment of how much free care the hospital is really providing to the community.

Why Is It Important to Exclude Bad Debt When Calculating Free Care?

Not all services classified as bad debt are provided to those who are unable to pay. For example, when insurance companies refuse to pay the hospital bills of policyholders, it increases a hospital's bad debt and benefits only the insurance companies. In these cases the patient is not receiving free care, because they (or their employers) are paying insurance premiums. All industries have bad debt—it is simply a cost of doing business.

Costs and Charges

KEY DEFINITIONS:

Cost: The actual amount of money a hospital spends to provide each service.

Charge: The full list price of a given hospital service. Many HMOs and insurance companies negotiate price discounts and do not actually pay full charges.

Why Is It Important to Understand the Difference Between Costs and Charges?

When citing the amount of free care they provide to the community, hospitals will often base calculations on the price that they charge instead of the actual cost of providing the service. In such instances, it can appear that the hospital is providing more free care than it actually does. Communities should ask hospitals to provide free care calculations based on cost, not charges. If no cost-based information is available, using one-half of charges is a good approximation.

Even for uninsured and underinsured individuals who are not eligible for free care, the distinction between cost and charge is very important. Often, the uninsured and underinsured patient will pay the full retail price for a service while an insurance company can negotiate a discount. Thus, people with middle incomes who are uninsured or underinsured but are not eligible for free care end up paying the most for their health care.

Strong free care policies together with appropriate accounting from your local hospital will ensure that eligible free care recipients are not denied free care and that all available resources are dedicated to caring for those most vulnerable in our communities.

Key Questions to Ask About a Hospital's Free Care Policy

1. Is there a written policy available that sets clear standards for free care eligibility?
2. Are the hospital's policies regarding free care widely available and easy to understand?
3. What are the exact free care eligibility requirements? What is included in income calculations? For example, must a person mortgage their home before they are eligible for free care?
4. What services are covered under the free care policy: doctors' services, lab work, prescription drugs? Is every available effort made to provide comprehensive services as free care, and not just emergency care? Does the hospital have an on-site pharmacy and staff physicians who could provide free services?
5. Does the free care application process put patients at ease? Is it a daunting or intimidating process? Are applicants treated with respect?
6. When is free care eligibility determined—before or after services are provided? Are patients billed while they wait for an eligibility decision?
7. Is the measurement of “overall free care provided” based on the actual cost of goods and services provided, or is it based on the much higher price normally charged to an insured patient? Is the hospital counting bad debt as free care?

Sample State Free Care Policies

No state has completely addressed every issue that would make up a sound free care policy, but several have taken the initial steps. Although not comprehensive, below are examples of what some states have done through legislation and regulation:

Washington ¹	<ul style="list-style-type: none"> ▪ Free care distinguished from bad debt. ▪ Persons whose income is equal to or below 100 percent of the federal poverty standard are eligible for free care. ▪ Hospitals must notify applicants of their decision to award free care within 14 days of receiving an application. ▪ If free care is denied, the applicant may appeal the decision within 30 days of learning of the denial. ▪ Hospitals must submit their free care and bad debt policies to the Department of Health at least 30 days before they are adopted. ▪ Every hospital must also report to the Department of Health the amount of free care that it is provided.
New Jersey ²	<ul style="list-style-type: none"> ▪ Free care distinguished from bad debt. ▪ Persons whose income is less than or equal to 200 percent of the federal poverty guidelines are eligible for free care. ▪ Standard signs informing patients of free care policies must be posted in waiting areas and outpatient clinics. These signs are available in ten languages, the most common being English and Spanish. ▪ Hospitals must provide each patient with individual written notice of the availability of free care. ▪ Hospitals must make a determination of whether to provide free care within ten days of receiving an application.
Maine ³	<ul style="list-style-type: none"> ▪ Free care distinguished from bad debt. ▪ Persons whose income is equal to or below 100 percent of the federal poverty standard are eligible for free care. ▪ Hospitals must post notices stating that free care is available. These notices must be posted in general areas such as admitting areas, waiting rooms, business offices, and outpatient reception areas. ▪ Persons who are denied free care may request a hearing. The request must be made within 60 days of receiving the denial. ▪ Each hospital must file a copy of its free care policy and a copy of its notice of free care with the Department of Human Services. ▪ Each hospital must report the amount of free care it has provided in each year to the Department of Human Services.
Rhode Island ⁴	<ul style="list-style-type: none"> ▪ Each hospital must provide free care at a level that meets “the statewide community standard.” For most hospitals, the standard equals the average amount of free care all hospitals in the state have provided over the past three years. For hospitals that are under new ownership, the standard equals the average amount of free care the hospital, under its previous ownership, provided over the past three years.
Massachusetts ⁵	<ul style="list-style-type: none"> ▪ Standardized free care application for all hospitals. ▪ Persons whose income is less than 200 percent of the federal poverty line (FPL) are eligible for free care at both hospitals and health centers. Care on a sliding scale is available to 400 percent FPL. ▪ Signs are required to be posted and information provided to uninsured patients. ▪ Free care determinations are valid for one year (subject to change in income or insurance status). ▪ Free care distinguished from bad debt. ▪ Free care is valued at actual cost, not “charges.”

¹ Wash. Admin. Code § 246-453 (1997).

² 27 N.J.R. 1995 (1995)

³ Code Me. R. § 10 144 150 (1997).

⁴ 52 R.I. Gov't Reg. 49, 51 (December 1996)

⁵ Code of Mass Regulations 114.6CMR 10 et seq (October 1998)

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