



# Paying for Health Care When You're Uninsured:

## How Much Support Does the Safety Net Offer?

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## About The Access Project

**The Access Project** is a program of the Center for Community Health Research and Action of the Heller School for Social Policy and Management at Brandeis University. It has served as a resource center for local communities working to improve health and healthcare access since 1998. The project receives its funding from a variety of public and private sources.

The mission of The Access Project is to strengthen community action, promote social change, and improve health, especially for those who are most vulnerable. The Access Project conducts community action research in conjunction with local leaders to improve the quality of relevant information needed to change the health system. It seeks to enhance the knowledge and skills of community leaders to strengthen the voice of underserved communities in the public and private policy discussions that directly affect them.

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## Executive Summary

According to the most recent census figures, over 41 million people in the United States — nearly 15 percent of the population — are uninsured. This number is expected to grow. Rising health care costs are leading some employers to shift more of the costs of insurance premiums to employees, making coverage unaffordable for some; other employers may stop offering coverage altogether. At the same time, the current economic downturn is causing people to lose coverage when they lose their jobs, just when many states, facing serious budget deficits, are reducing funding for public insurance programs. Much research documents that lack of insurance reduces access to care: for example, the uninsured are more likely to delay or not receive needed care.

While some attention has been paid to the cost to health care institutions of providing care for the uninsured, less has been focused on the cost to the uninsured themselves, although research indicates that the financial consequences of getting care can be severe. A recent national survey found that more than one-quarter of families in which one or more members were uninsured had to “change their way of life significantly” to pay medical bills; this figure rose to 40 percent when all family members were uninsured.

To obtain needed treatment, the uninsured often rely on local “safety-net” institutions — hospitals and clinics that treat a large proportion of Medicaid and uninsured patients. Many people assume that the uninsured can always get needed care at these facilities, and that this care is free. However, a recent survey of public hospitals showed that most, in the face of financial pressures, have instituted cost sharing plans, and almost 1 of 5 did not offer reduced rates to the uninsured.

This report presents findings from a survey conducted between May and August of 2000 on the experiences of uninsured individuals in trying to pay for their medical care and prescription medications at primarily safety-net hospitals and health centers. The sample included 6,884 respondents who received ambulatory (outpatient) health care at local facilities in the previous year, while uninsured. The facilities were located in urban/suburban or rural communities in 18 states. The findings indicate that uninsured people face serious financial barriers to obtaining care, even at safety-net facilities, and are often burdened with debts as a result of obtaining care. Moreover, these debts may deter them from seeking future care.

### KEY FINDINGS

- Three of five respondents reported needing help paying their medical bills. The need for help was highest among respondents using hospital emergency rooms (ERs), or ERs and hospital outpatient departments (OPDs).
- Fifty-six percent of respondents prescribed medications reported they needed help to pay for the medications. ER and hospital OPD patients

“ I haven't worked since I had open heart surgery. I just filed for bankruptcy. ”

“ It is difficult to pay. That is why I try to stay away from the hospital. ”

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“It is difficult but you pay what you can. Then the bills start stacking up.”

“I am scared to go back because I owe a lot.”

from rural areas — between two-thirds and three-quarters — were the most likely to need help.

- Thirteen percent of respondents reported obtaining none or only some of their medications because of cost. Among respondents who received care in a rural hospital ER, or rural ER and OPD, nearly three in ten said they did not get all of their medications due to cost.
- While only 3 of 10 respondents said staff “always” offered to look into possible assistance for them, nearly half — 48 percent — said staff “never” offered such help. Respondents who used an urban/suburban hospital ER — 7 of 10 — were most likely to say staff never offered to find out if financial assistance was available.
- When financial assistance was offered, it was most often an offer to allow payment of the full bill in installments (32%), as opposed to discounting (12%) or waiving (13%) the bill.
- Nearly half of all respondents — 46 percent — reported having unpaid bills or being in debt to the facility where they received care. Respondents who used a hospital ER, or ER and OPD, were most likely — about 2 of 3 — to report being in debt to their facility.
- Staff offers of assistance made a difference; the more often that staff offered to find out about financial assistance, the less likely that respondents reported being in debt to the facility.
- About one-quarter (24%) of respondents with unpaid medical bills said their debts would deter them from seeking care at the same facility in the future, with responses varying little by the setting of care or geographic location.

## IMPLICATIONS AND RECOMMENDATIONS

This study contradicts a common belief that the uninsured can always get care when they need it — and do so for free. Substantial proportions of respondents in all settings had difficulty paying for care, and nearly half went into debt in order to obtain care. Federal, state, and local governments need to consider comprehensive ways of ensuring affordable care for all, such as expanding public health insurance programs and adequately funding safety-net institutions. Unfortunately, in the near future there is likely to be less funding rather than more to spend on health care for the poor and uninsured. In this environment, incremental responses to alleviating the financial burdens of the uninsured need to be explored.

**Improve Systems of Financial Screening and Counseling of Uninsured Patients**

A significant portion of uninsured respondents reported that facility staff did not offer to find out about financial options to help them pay for their medical care. At the same time, receipt of such assistance was associated with a reduced likelihood of becoming indebted to the facility where care was obtained. Health care providers need to implement systems that ensure that patients without insurance consistently get information about financial assistance programs they may be eligible for, such as public insurance and hospital charity care programs. In addition, programs and policies for the uninsured that set limits on cost-sharing based on patient incomes may need to be expanded.

“They did not provide any information about receiving any form of assistance.”

**Ensure That Systems for Financial Screening and Counseling Include Uninsured Emergency Room Patients**

Uninsured people seen in hospital ERs were least likely to be asked about the need for financial assistance in paying for care, and the most likely to be in debt to their facilities. Hospitals must pay special attention to ensuring that ER patients without insurance are informed about financial assistance programs they might be eligible for.

**Include Uninsured Emergency Room Patients in Drug Assistance Programs**

Along with having less access to information about programs to pay for medical care, uninsured people seen in ERs, and especially in rural ERs, were much more likely to need help paying for prescriptions and to obtain none or only some of their medications than those who used hospital OPDs or health centers. Hospitals should make certain that ER patients have the same access to pharmacy assistance programs as uninsured patients who are seen in other ambulatory care settings.

“We were paying what we could afford each month faithfully, \$50 to \$75. But the hospital told us if we couldn't pay the whole bill in six months, we'd be turned over to a collection agency.... We have \$16,000 of medical bills....”

**Address the Special Barriers Faced by Uninsured Patients Who Receive Care in Rural Facilities**

Respondents who received care in rural facilities were more likely than those who obtained care in urban/suburban settings to report needing help paying for medical care and prescription drugs. In hospital ambulatory settings, rural respondents were more likely to be offered financial help than urban/suburban respondents, yet they were equally likely to be in debt to a facility. The findings may reflect greater neediness among rural respondents and/or fewer resources available to rural facilities. In any case, the uninsured in rural areas may require special assistance to ensure their access to affordable care.

## I. Introduction

Lack of health insurance coverage is a growing threat to the health and security of millions of Americans. The most recent census figures put the number of uninsured in the U.S. at more than 41 million — nearly 15 percent of the population.<sup>1</sup> With health care costs rapidly rising, many more are expected to join the ranks of the uninsured as employers pass along premium increases to employees, who may then find their share of costs unaffordable, and some employers may drop coverage for employees altogether.<sup>2</sup> The downturn in the economy has also led to increased unemployment, causing many to lose their employment-based coverage, just at a time when many states, facing serious budget deficits, are tightening Medicaid eligibility criteria to save money.<sup>3,4</sup> These cutbacks will almost certainly lead to increased numbers of people without health insurance.

A substantial body of research shows that the uninsured are less likely to have a regular source of care and more likely to delay care and report not receiving needed care than those with insurance coverage.<sup>5,6</sup> The uninsured also experience more financial hardship paying for medical care than the insured, in part because they generally have lower incomes, spend a greater portion of their income on health care, and have less ability to borrow — even though the majority of uninsured adults are employed.<sup>7,8</sup> Moreover, the uninsured may be charged more for the same services than people with insurance. Anecdotal evidence suggests that the prices health care providers charge the uninsured may be two to three times the amount negotiated by private insurers.<sup>9,10,11</sup> In one survey, only a quarter of families with at least one uninsured person reported having received free or reduced-charge care in the past year.<sup>12</sup>

The long-term consequences of high medical care costs can be dramatic, particularly for the uninsured. A recent national survey found that more than one-quarter of families in which one or more members were uninsured reported having to “change their way of life significantly” to pay medical bills; this figure rose to nearly 40 percent when all family members were uninsured.<sup>13</sup> According to a broader study that included the insured, half of personal bankruptcies are the result of health problems or large medical bills.<sup>14</sup>

To obtain needed treatment, the uninsured often rely on local “safety-net” institutions. These institutions provide a significant level of services to the uninsured, Medicaid recipients, and other vulnerable populations. Safety-net providers include public hospitals, private hospitals with a strong community mission to serve patients regardless of ability to pay, community health centers and clinics, and local health departments. Safety-net facilities may also include teaching hospitals and other types of specialized provider facilities, such as family-planning and school-based clinics.

Many assume that uninsured people can easily obtain needed medical care at safety-net hospitals for little or no cost. One likely reason for this perception is the 1986 Emergency Medical Treatment and Active Labor

“ I am ashamed to take my kids to the physician because I think he knows I owe \$35. ”

“ I owe \$20,000 to the hospital and because I couldn't pay the bill they would call my home.... I was willing to pay \$1,000 but they didn't want it. ”

Act (EMTALA), which requires all hospitals with emergency rooms that participate in Medicare to screen and, if necessary, stabilize any patient seeking care; hospitals are prohibited from delaying treatment to inquire about patients' insurance status or other means of payment.<sup>15</sup> The purpose of EMTALA is to prevent "patient dumping," the practice of refusing to provide emergency care to patients unable to afford treatment. EMTALA makes the hospital emergency room virtually the only place where the uninsured are guaranteed care without having to provide prior proof of ability to pay.<sup>16</sup> However, while EMTALA requires hospitals to treat the uninsured in their emergency rooms, it only requires that they provide acute (but not preventive or primary) care, and it does not require that they provide the care for free or at a discount.

In fact, safety-net providers do not automatically offer free care to the uninsured. A recent National Association of Public Hospitals and Health Systems (NAPH) study found that more than 80 percent of public hospitals surveyed have implemented cost-sharing plans based on a sliding scale, a flat fee, or a co-payment schedule for outpatient services.<sup>17</sup> Increasingly, public hospitals have also implemented pharmacy co-payment plans, with amounts typically ranging from \$2 to \$10 per prescription.

Public hospitals have implemented cost-sharing programs for a variety of reasons: to meet state or county requirements, provide care to those without coverage at a reduced cost, or as a means to conduct financial assessments to determine if patients are eligible for Medicaid or other indigent care programs (although some hospitals only conduct screenings retroactively, after the patient has received a bill). However, 18 percent of NAPH-surveyed hospitals do not offer care at reduced cost for indigent patients and most of these hospitals bill patients at full charges and follow up on accounts, often using collection agencies to maximize revenues.<sup>18</sup> At the same time, more than half of surveyed safety-net institutions reported negative margins in 2000, suggesting that the revenues they can use to subsidize charity care are declining.<sup>19</sup>

This issue brief focuses on the financial experiences and perceptions of uninsured individuals who received ambulatory (outpatient) health care services primarily from safety-net providers, namely public and non-profit hospitals or free-standing clinics and health centers. The Access Project gathered this information through the Community Access Monitoring Survey. Survey respondents were uninsured adults who received care in the previous year at selected local health care facilities.

Results of the survey confirm that the uninsured often face enormous challenges in paying for their medical care — even when they seek care from safety-net providers — and are often burdened by debt as a result of obtaining care. The majority of respondents reported needing help to pay for medical care and prescription medications and nearly half reported having unpaid bills or being in debt to the facility where they received care. Respondents who used a hospital emergency room (ER), or a combination of an ER and hospital outpatient department (OPD), generally experienced

“ My two radiology bills are \$300 each, and I can't pay.”

“ They just billed me and threatened to turn me over to collections.”

“ I was forced to sign a promissory note. I felt it was necessary so my daughter could get treatment. I've been served papers for collection.”

more financial difficulties than those who used a hospital OPD only or a free-standing health center. Respondents who received care in rural areas were more likely than those in urban/suburban areas to report both needing help paying for medical care and medications and obtaining none or only some of their medications due to cost.

## II. Survey Methods, Data Sample and Analysis

### SURVEY METHODS

The Access Project designed the Community Access Monitoring Survey (CAMS) project to help local organizations enhance their effectiveness in promoting increased access to health care for the uninsured in their communities. The Access Project provided financial and technical assistance to community organizations to survey over 10,000 uninsured patients receiving care in 58 hospitals and clinics. To be eligible to participate, respondents had to have received care during the previous year, while uninsured, at one of the facilities included in the study. The survey thus did not include uninsured adults who might have been screened for eligibility in public programs and then enrolled, nor did it include those who were unable to obtain care.

Conducted between May and August 2000, the survey was based on a non-probability sample. Community groups chose facilities based in part on their ability to identify a sufficient number of uninsured who had received care at the facility in the past year. These were primarily safety-net institutions, that is, institutions that serve a large proportion of uninsured and Medicaid clients relative to privately insured patients. Surveyors recruited respondents at the facilities or in neighborhoods served by targeted facilities, at places such as community centers, meal programs, grocery stores, employment offices, and by going door-to-door.

The survey asked respondents a range of questions about their experiences at the facility, including the facility's reputation for treating the uninsured; how medical and support staff treated them; ease of access to services; difficulty paying for prescription drugs and medical care; need for financial assistance to pay for medications and care; indebtedness to the facility and whether it would affect future use of the facility; interest in using the facility in the future if insurance paid for care; and need for and access to interpretation services for those with limited proficiency in English.

### DATA SAMPLE AND ANALYSIS

This issue brief analyzes the survey responses of 6,884 uninsured respondents who received ambulatory care at either a hospital-based facility or a free-standing health center or clinic that provided care on a sliding scale. Respondents who received inpatient care or obtained care at a free clinic were excluded from analysis. Respondents may have received

hospital-based care in a public or private hospital, urban teaching hospital, or rural hospital. The free-standing, sliding-scale health centers that provided care to respondents were largely one or more of the following types: a Federally Qualified Health Center, a community health center, a migrant workers' health clinic, and/or a volunteer clinic. Sliding-scale health centers/clinics offered uninsured clients a variety of payment arrangements; most involved a percentage discount or flat fee based on income. Some did not charge a fee in cases of "hardship," such as for homeless individuals. A number of health centers/clinics provided free care for particular services, such as breast or pelvic exams and child screening tests, and/or had programs that offered prescription drugs for a low flat fee or a percentage discount based on income. Some had arrangements with drug manufacturers that allowed them to offer certain classes of drugs for free. (See Appendix B for a list of facilities included in the study.)

For purposes of analysis, the sample was split into two groups: those who received care in an urban/suburban facility and those who received care in a rural facility. Within these groups, responses were categorized according to the setting in which respondents received care: those who obtained care in a hospital emergency room (ER) only; those who got care in a hospital outpatient department (OPD) only; those who used both an ER and a hospital OPD; and those who received care in a sliding-scale health center/clinic.

Nearly three-quarters (73%) of respondents obtained ambulatory care in an urban/suburban community, with 39 percent served by a hospital-based facility and 34 percent by a sliding-scale health center/clinic. Approximately 26 percent of respondents obtained care in a rural community, with 15 percent served by a hospital-based facility and 11 percent by a health center. Those who received care at urban facilities were mostly black and Hispanic, while those who received care in rural facilities were predominately white. However, the five rural sliding-scale facilities included in the sample were clinics for migrant workers, at which over half of the respondents were Hispanic. Overall, respondents were more likely to be female than male, although the proportion was more evenly divided among respondents who used the ER only. (See Table 1, Appendix A.)

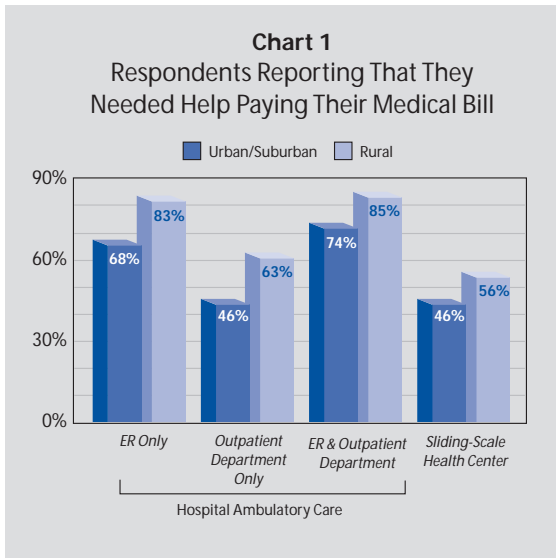
Within the urban/suburban and rural classifications, each group was compared to the other three independently, using a one-way analysis of variance (ANOVA). Unless otherwise noted, reported results are significant at the 5% level ( $p < .05$ ).

### III. Key Findings

#### PAYING FOR MEDICAL CARE

Overall, 60 percent of respondents reported that they needed help paying for their medical care. The proportion needing help varied significantly by the facility type and geographical location in which respondents received care. Two-thirds or more of those using an ER only, or an ER and hospital

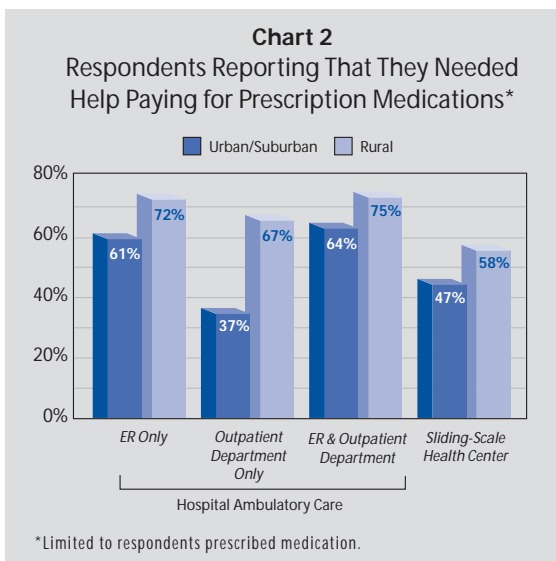
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OPD, said they needed help paying for care. A much lower but still considerable portion who used sliding scale health centers, which by definition adjust fees based on patients' income, reported needing financial help to pay their medical bills — 46 percent at urban/suburban health centers and 56 percent at rural health centers. Respondents who received care at rural ERs, or ERs and OPDs (83% to 85%), were more likely than those who received care at urban/suburban ERs, or ERs and OPDs (68% to 74%), to report needing help. (See Chart 1 and Table 2, Appendix A.)

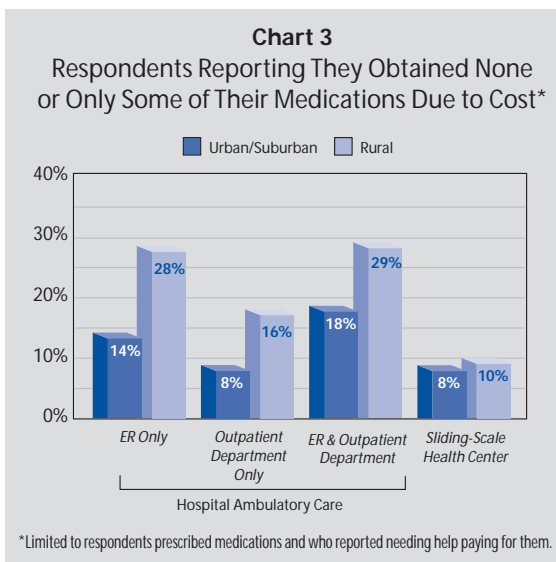
**PAYING FOR AND OBTAINING PRESCRIPTION MEDICATIONS**

More than half of respondents who received prescriptions — 56 percent — reported that they needed help to pay for their medications. Among respondents who received prescriptions, those who used an ER only, or an ER and a hospital OPD, were more likely to say they needed help to pay for medications than those using a hospital OPD only or a health center. Respondents who used an urban hospital OPD were least likely to report needing help paying for prescription drugs (37%). (See Chart 2 and Table 2, Appendix A.)



Respondents who received care at rural facilities were also more likely than those who received care at urban/suburban facilities to report needing help paying for prescribed medications. The largest difference was among respondents using a hospital outpatient department, with rural patients almost twice as likely as their urban/suburban counterparts to report needing help.

Not surprisingly, the groups most likely to need help paying for their medications were also most likely to report they obtained none or only some of them due to cost. Respondents who used rural facilities were up to twice as likely as those who used urban/suburban facilities to say they obtained only some or none of their medications. Nearly 3 of 10 respondents using a rural ER, or ER and hospital OPD, reported not obtaining any or only some of their prescription medications. (See Chart 3.)



**FACILITY RESPONSES TO PATIENT FINANCIAL NEEDS**

Patients who reported that they needed help paying for their medical care were asked whether staff at the facility offered to find out if financial assistance was available to help cover the cost. Among all respondents, only 30 percent said staff “always” offered to look into possible assistance for them, while nearly half — 48 percent — said staff “never” offered. Another 22 percent said staff “often” or “sometimes” offered to find out about financial assistance on their behalf. (See Table 2, Appendix A.)

Respondents who used urban/suburban facilities were much more likely than those who used rural facilities to say staff never

offered to look into available assistance for them, with respondents who used an urban/suburban ER only — 7 out of 10 — the most likely to report never being offered help. Those who used health centers, whether in urban/suburban or rural settings, were least likely to say staff never offered to look into the availability of financial assistance. About a quarter (24%) of respondents from rural health centers and a third (34%) from urban/suburban health centers reported that assistance was never offered. (See Chart 4.)

Patients who reported that staff sometimes, often, or always offered to find out if financial assistance was available were asked what kind of assistance the facility offered.\* Among all respondents offered assistance, the most common type was a plan to pay the full amount of the bill in installments, offered to nearly one third (32%).<sup>o</sup> Twelve percent reported having their bill reduced by some amount and 13 percent had their bill waived altogether. Hospital-based respondents using urban/suburban facilities were more likely than their rural counterparts to be offered an installment plan only, with more than half (55%) of urban ER-only patients offered this option. Among those using health centers, however, more than twice as many rural as urban/suburban respondents were offered this option only (42% vs. 20%). (See Chart 5 and Table 2, Appendix A.)

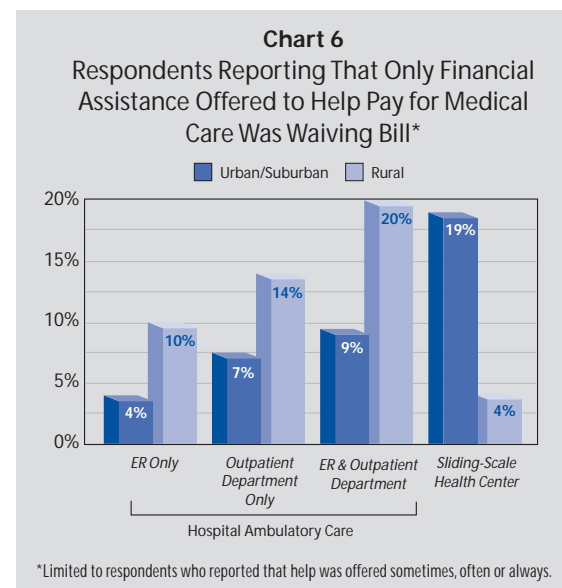
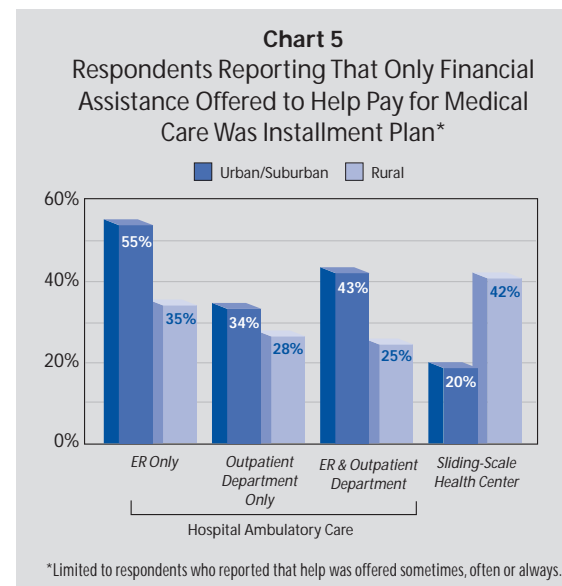
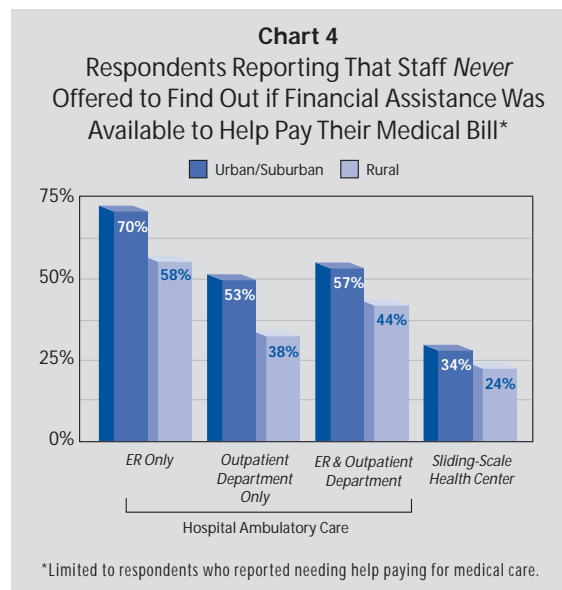
The same groups of respondents most likely to be offered an installment plan only were also least likely to have their bill waived altogether. Only 6 percent of respondents obtaining hospital-based ambulatory care in urban/suburban settings reported having their bill waived, compared to 15 percent of those in rural settings. By contrast, respondents who used urban/suburban health centers were nearly five times as likely as their rural counterparts to say their medical bill was waived (19% vs. 4%). (See Chart 6 and Table 2, Appendix A.)

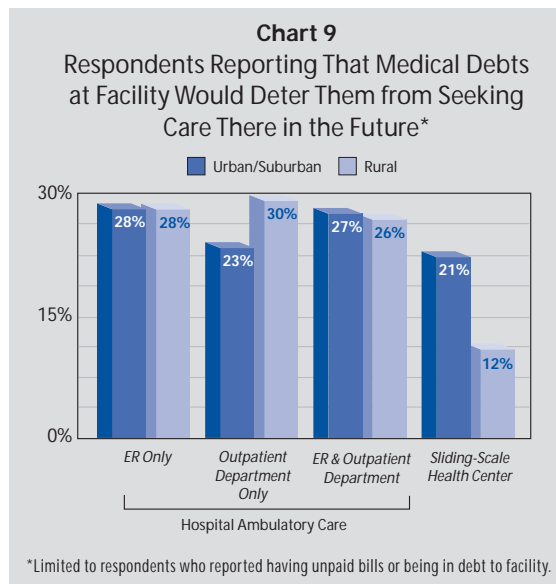
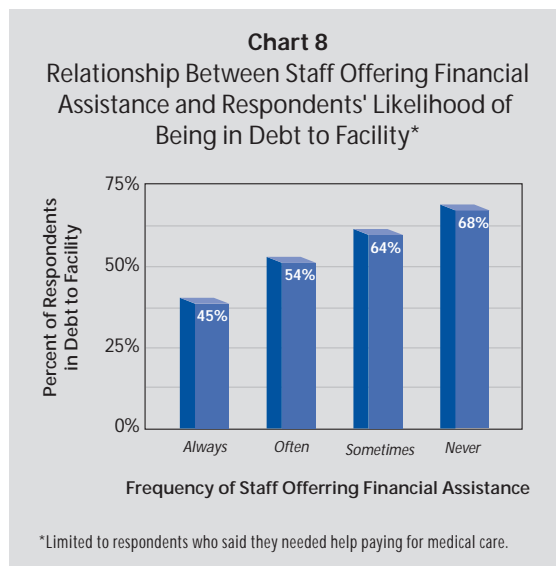
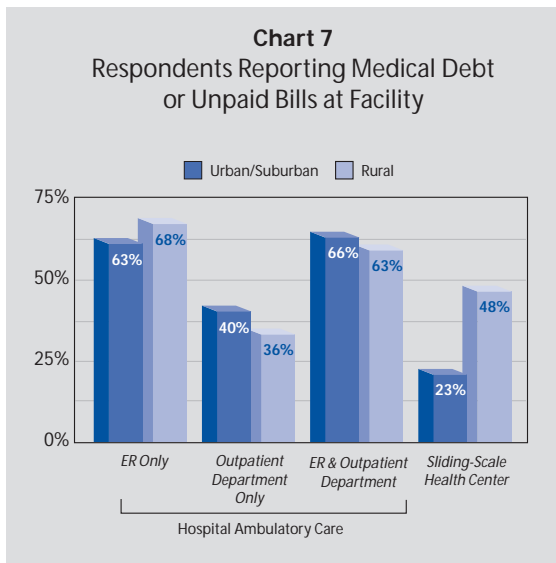
## MEDICAL DEBT

Nearly half of all respondents — 46 percent — reported having unpaid bills or being in debt to the facility where they received care. Just as respondents at both urban/suburban or rural facilities who used the ER only, or ER and hospital OPD, were most likely to say they needed help paying their medical bills, they were also most likely —

\*Screening for a public program was not listed as a possible answer for this question.

<sup>o</sup> Interviews with administrators at health centers and clinics indicate that these facilities generally determine uninsured patients' eligibility for a reduction in charges prior to providing treatment. This may also be the case in some hospital OPDs. We did not have specific data on patients' income or eligibility or on the fees they were charged, and thus could not determine whether some respondents received discounts that they were not aware of. It is possible that some respondents who obtained care in these settings and reported that the only financial assistance offered was an installment plan had been approved for a discount at an initial visit that was then automatically applied to subsequent bills, or that they had been screened but, based on their income, did not qualify for a reduction in the standard charge.





about 2 of 3 — to report being in debt to their facility.

Respondents who obtained care at urban/suburban health centers were not only the least likely to be offered an installment plan only to pay off their bills in full, but also the least likely to report having outstanding medical bills or being in debt to the facility (23%). About 2 of 5 respondents who used the hospital OPD, whether urban/suburban or rural-based, also reported being in debt or having unpaid bills owed to the facility. (See Chart 7.)

Based on this finding, we examined the relationship between how often staff looked into financial assistance for respondents and whether or not respondents reported being in debt to the facility or having unpaid medical bills. Results showed that the more often staff offered to help respondents obtain financial assistance, the less likely that respondents reported having outstanding bills. Forty-five percent of respondents who said that staff “always” offered to find out if financial assistance was available reported being in debt to their facility. In contrast, more than two-thirds (68%) of those who said staff “never” offered such services reported having outstanding medical bills. (See Chart 8.)

### LIKELIHOOD OF FUTURE USE OF THE FACILITY

Among those with unpaid medical bills or debts, 3 of 4 (76%) would continue to seek care at their facility despite the debts. However, a significant minority — nearly one-quarter (24%) — said their debts would deter them from seeking care at the same facility in the future. Responses varied little by the setting of care or geographic location. Those who used rural health centers, however, were less likely than other groups to say that outstanding bills would keep them from seeking care at the facility in the future. (See Chart 9 and Table 2, Appendix A.)

## IV. Implications and Recommendations

The experiences of respondents in this study when trying to pay for medical care contradict the common belief that the uninsured can always get medical care when they need it — and do so for free. No matter where services were provided — health centers or clinics, hospital outpatient departments, and/or emergency rooms — substantial proportions of respondents faced challenges paying for health care, and nearly half were in debt as a result of obtaining care.

Difficulty in paying for care may cause uninsured people to delay care, lose continuity of care, or not seek care at all, with potential effects on health. In addition, this difficulty may threaten the

overall financial stability of the uninsured and their families. As the numbers of uninsured rise, these problems are expected to worsen.

Clearly, federal, state and local governments need to look at ways of ensuring affordable care for the uninsured. Unfortunately, in the short term, given a weak economy, budget shortfalls, and political gridlock, there is likely to be less money rather than more to spend on health care for the poor and uninsured; many states have or are contemplating cuts in Medicaid eligibility and services. In this climate, it is important to look at incremental responses to alleviate the financial burdens experienced by the uninsured.

### IMPROVE SYSTEMS FOR FINANCIAL SCREENING AND COUNSELING OF UNINSURED PATIENTS

In all ambulatory care settings included in this study, respondents reported needing help paying for care — figures ranged from 46 percent of those getting care in urban/suburban health centers to over 80 percent of those getting care in rural ERs (or ERs and OPDs). However in all settings, a significant proportion of respondents reported that staff never offered to find out about options to help them pay for care — from a quarter of those who received care in rural health centers up to 70 percent of those who sought care in urban/suburban hospital ERs. As the findings also indicate that getting such information helps people avoid medical debt, one response is to create or improve systems to ensure that all uninsured patients, wherever they receive care, are made aware of and screened for eligibility for available financial assistance programs.

Such systems might be implemented in a variety of ways. In Oregon, for example, advocates worked with the Oregon Association of Hospitals and Health Systems to develop a model statewide charity care policy that included a common application process, sliding fee scale, written materials in appropriate languages, and continuing education for health care employees so that information is available in key hospital areas.<sup>20</sup> In Massachusetts, which reimburses hospitals for charity care through a state Uncompensated Care Pool, state regulations specify standard criteria for eligibility for free or reduced-cost care. The regulations also require hospitals to inform patients of the availability of free care through conspicuous signs in patient areas and notices on bills. Hospitals that violate the regulations may lose eligibility for reimbursement from the Pool.<sup>21</sup> Better enforcement of existing federal regulations that require stationing Medicaid eligibility workers in safety-net institutions, so that uninsured patients can apply for coverage at the time that they seek care, would also be useful.<sup>22</sup> In addition, programs and policies for the uninsured that set limits on cost-sharing based on patient incomes may need to be expanded.

“ This medical debt has caused us to get a bad credit rating and we won't be able to buy a home. ”

“ I was taken to a collection agency. I'm still paying. ”

“ I have a lot of bills that could have been paid, if they told me sooner about the office that helps you pay... Instead, my bills are now in a collector's office. ”

## ENSURE THAT SYSTEMS FOR FINANCIAL SCREENING AND COUNSELING INCLUDE UNINSURED EMERGENCY ROOM PATIENTS

While the need is clear for information about financial assistance programs in all sites of care, special attention needs to be paid when care is provided in ERs. This study indicates that uninsured patients who obtained care in this setting had uniformly more negative experiences in paying for care than those who received care elsewhere. Staff in ERs were the least likely to discuss financing options or to otherwise provide financial assistance to uninsured patients. Not surprisingly, uninsured ER patients were also the most likely to report unpaid bills and to be in debt to their facility; their rates exceeded those of patients who received care in hospital OPDs as well as those served in health centers.

This finding may be the result of a number of factors. For example, because EMTALA requires hospital ERs not to delay medical screening and stabilization in order to gather financial information, some hospitals may be reluctant to financially screen ER patients or provide information about income eligibility for sliding scale payments for fear of violating the law. Moreover, while ERs are open 24 hours a day, financial counselors may not be available after normal work hours.<sup>23</sup> Further research is needed to determine which factors most contribute to uninsured ER patients' reduced likelihood of getting information about financial assistance. Nonetheless, hospitals need to investigate programs to inform ER patients about financial assistance options in ways that don't raise concerns about EMTALA violations. A hospital in Massachusetts, for example, provides all ER patients with information about contacting a financial counselor if they need help paying their bills; patients can then contact the counselor during regular work hours to get assistance.<sup>24</sup>

## INCLUDE UNINSURED EMERGENCY ROOM PATIENTS IN DRUG ASSISTANCE PROGRAMS

“ I still owe about \$70 for the medication. ”

Prescription medications have become an increasingly important part of many treatment regimens. Patients' inability to get needed medications may result in unnecessary return visits, increased severity of their conditions, and a need for more expensive treatment later on. If they are unable to afford medications, patients may also be discouraged from seeking care altogether. This study found that, in both urban and rural settings, uninsured ER patients (or ER and OPD patients) were more likely to obtain none or only some of their medications due to cost, compared to patients who received care in OPDs only or in sliding scale health centers.

A recent article highlighted uninsured patients' limited access to pharmaceuticals as a growing problem at many safety-net institutions.<sup>25</sup> Our study suggests that it is especially important to understand the additional barriers experienced by the uninsured who get care in ERs. The Section 340B program of the Public Health Service Act, implemented in 1992, allows

safety-net providers to purchase pharmaceuticals for outpatients at discounted rates and pass the savings on to patients.<sup>26</sup> Yet ERs may find it difficult to sort out uninsured people admitted to the hospital from those treated as outpatients, and ensure that the latter have access to discounted medications purchased through this program.<sup>27</sup> Additionally, some hospitals that administer pharmacy assistance programs offered by various drug manufacturers do not enroll patients into these programs through the ER.<sup>28</sup> ERs may also need to comply with regulations and procedures that limit the number of days for which they can dispense medication, or that make distribution of free drug samples more difficult than in other sites of care.<sup>29</sup> Further research is needed to verify these or other hypotheses on why uninsured ER patients are less likely to get all of their medications. Most importantly, safety-net hospitals should examine their policies and procedures to make certain that uninsured ER patients have the same access to pharmacy assistance programs as uninsured patients who receive care in other ambulatory settings.

### ADDRESS THE SPECIAL PROBLEMS FACED BY UNINSURED PATIENTS WHO RECEIVE CARE IN RURAL FACILITIES

While uninsured ER patients in both urban and rural settings faced special barriers to getting all of their medications, the problem was particularly acute for those who obtained care in rural hospital ERs. Nearly 30 percent of respondents seen in rural ERs (or ERs and OPDs) reported that they did not receive some or all of their medications due to cost, compared to 14 to 18 percent who sought care in the corresponding urban settings.

Moreover, uninsured patients in rural settings were more likely to face other barriers to care compared to respondents in urban settings. They were more likely to report needing help paying for medical care and prescription drugs. In all ambulatory settings, rural respondents were more likely to say that staff offered to find out if financial assistance was available. Yet in hospital ambulatory settings — even though rural respondents were more likely than their urban counterparts to say their bill was waived — they were equally likely to be in debt to the facilities.

The reasons for these findings are not clear. They may reflect greater levels of poverty among uninsured adults in rural areas, such that the relative levels of assistance that are provided remain inadequate. It may also be that rural facilities, and especially rural health centers, have fewer resources available to subsidize charity care. In any case, the uninsured in rural areas may require special assistance to ensure their access to affordable care.

### CONCLUSION

The recommendations included in this report should help improve uninsured patients' access to information about the options available to help them pay for their care. However, in and of themselves, these measures are not sufficient to eliminate the financial burdens the uninsured face when

“ I wrote a bad check to get the medication. ”

“ It's very difficult to pay. There are so many different bills, it's hard to decide who to pay first. I send a little to each one so they don't hound me about it. ”

getting care. A variety of programs have attempted to provide more affordable sites of care for the uninsured and reduce the costs they are expected to bear. For example, some communities across the country, left to deal with the problem of large numbers of uninsured residents, have instituted programs that provide coverage or care to those who are not eligible for other public or private programs.<sup>30</sup> The current federal initiative to fund 1,200 new or expanded community health centers is also intended to improve access to care for the uninsured,<sup>31</sup> but it is likely to be only part of the solution. In the longer term, the federal and state governments will need to implement more comprehensive approaches to ensuring affordable health care for all.

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**Table 1**  
**DEMOGRAPHICS OF RESPONDENTS**

	Urban/Suburban Ambulatory Care						Rural Ambulatory Care				
	Total Sample	HOSPITAL-BASED			FREE-STANDING	Sliding Scale Health Center	HOSPITAL-BASED			FREE-STANDING	Sliding Scale Health Center
		ER Only	Outpatient Dept. Only	ER & Outpatient Dept.	Total		ER Only	Outpatient Dept. Only	ER & Outpatient Dept.	Total	
# of Respondents	6884	1346	519	837	2702	2351	448	255	340	1043	788
# of Facilities	51	—	—	—	23	14	—	—	—	9	5
Respondents as % of Total Sample*	100	20	8	12	39	34	7	4	5	15	11
<b>Race/Ethnicity</b>											
% Black	38	53	41	55	52	42	19	16	24	19	20
% White	24	13	9	10	12	22	72	79	68	72	24
% Hispanic	31	30	44	29	31	28	4	3	2	3	53
% Other	7	4	6	6	4	8	5	2	6	5	3
<b>Gender</b>											
% Male	37	47	37	37	46	31	47	30	35	43	37
% Female	63	53	63	63	54	69	53	70	65	57	63

\*Percentages may not add up to 100 due to rounding.

**Table 2**  
**FINANCIAL EXPERIENCES OF UNINSURED RESPONDENTS WHO RECEIVED AMBULATORY CARE IN THE PREVIOUS YEAR**

	TOTAL	HOSPITAL AMBULATORY CARE								FREE-STANDING	
		ER Only		Outpatient Dept. only		ER and Outpatient Dept. only		Total		Sliding Scale Health Center	
		Urban/ Suburban	Rural	Urban/ Suburban	Rural	Urban/ Suburban	Rural	Urban/ Suburban	Rural	Urban/ Suburban	Rural
Needed help paying the medical bill	60%	68%	83%	46%	63%	74%	85%	66%	79%	46%	56%
Needed help paying for medications	56	61	72	37	67	64	75	57	73	47	58
Obtained none or only some of prescribed medications*	13	14	28	8	16	18	29	14	27	8	10
Staff offered to help find out if financial assistance was available**											
Always	30	13	30	18	47	15	45	14	39	42	50
Often or Sometimes	22	18	12	29	15	28	12	23	13	25	26
Never	48	70	58	53	38	57	44	63	49	34	24
What kind of financial assistance did they offer?***											
Installment plan only	32	55	35	34	28	43	25	46	30	20	42
Reduction of bill only	12	5	5	12	5	7	9	7	6	13	22
Waiving of bill only	13	4	10	7	14	9	20	6	15	19	4
Charitable organization only	9	13	10	10	5	13	14	13	10	9	2
Other or combination	35	23	40	37	48	28	33	28	39	39	31
Currently has unpaid bills or is in debt to facility	46	63	68	40	36	66	63	60	59	23	48
Unpaid bills or debt would make respondent not seek care at facility in the future****	24	28	28	23	30	27	26	27	28	21	12
If respondent had insurance that paid for medical care, he/she would use this facility in the future											
Yes	83	81	89	65	85	82	93	78	89	83	90
No	17	19	11	35	15	18	7	22	11	17	10

\* Limited to those who received prescriptions for medications during their visit.

\*\* Limited to those who reported needing help paying for medical care.

\*\*\* Limited to those who reported that help was offered at least sometimes.

\*\*\*\* Limited to those who reported having unpaid bills or debts to the facility.

## Appendix B

### HOSPITALS AND HEALTH CENTERS/CLINICS INCLUDED IN THIS STUDY

#### Urban/Suburban Hospitals

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<b>Facility</b>	<b>Location</b>
Cleveland Clinic	Cleveland, OH
Community Hospital	Fresno, CA
Earl K. Long Medical Center	Baton Rouge, LA
Halifax Hospital	Daytona Beach, FL
Huron Hospital	Cleveland, OH
Inova Alexandria Hospital	Alexandria, VA
Magic Valley Regional Medical Center	Twin Falls, ID
Memorial Hospital	Deland, FL
Mercy Medical Center	Nampa, ID
Metrohealth Hospital	Cleveland, OH
Montefiore Medical Center	Bronx, NY
North Central Bronx Hospital	Bronx, NY
Palmyra Medical Center	Albany, GA
Phoebe Putney Memorial Hospital's Emergency Center	Albany, GA
Regional Medical Center	Memphis, TN
Sunrise Columbia/HCA	Las Vegas, NV
Tallahassee Memorial Healthcare Emergency Room	Tallahassee, FL
University Hospital	Cincinnati, OH
University Hospital	Cleveland, OH
University Medical Center	Fresno County, CA
University Medical Center	Las Vegas, NV
Wake Medical Center	Raleigh, NC
Yuma Regional Medical Center	Yuma, AZ

#### Rural Hospitals

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<b>Facility</b>	<b>Location</b>
Boone Memorial Hospital	Madison, WV
CHRISTUS Jasper Memorial Hospital	Jasper, TX
Clinton County Hospital	Albany, KY
North Adams Regional Hospital	North Adams, MA
North Lincoln Hospital	North Lincoln, OR
Pacific Communities Hospital	Newport, OR
Russell County Hospital	Russell Springs, KY
Southwest Georgia Regional Medical Center	Cuthbert, GA
Wayne County Hospital	Monticello, KY

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**Sliding Scale Urban/Suburban Health Centers/Clinics**


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<b>Facility</b>	<b>Location</b>
Berkeley Primary Care Clinic	Berkeley, CA
Bond Community Health Center	Tallahassee, FL
Dr. Rafael Peñalver Clinic	Miami, FL
Family Health Services	Twin Falls, ID
Jefferson Reaves Health Center	Miami, FL
Leon County Health Department	Tallahassee, FL
Mile Square Health Center	Chicago, IL
Neighborhood Health Services	Tallahassee, FL
Planned Parenthood of Houston	Houston, TX
R.M. Gunnar/Circle Family Care	Chicago, IL
Sequoia Health Foundation Clinics	Fresno, CA
Terry Reilly Health Services	Nampa, ID
West Berkeley Family Practice	Berkeley, CA
WOMENCARE	Scott Depot, WV

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**Sliding Scale Rural Health Centers/Clinics**


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<b>Facility</b>	<b>Location</b>
Albany Area Primary Health Care	Albany, GA
Clay County Primary Care	Clay, WV
Sunset Health Center	Somerton, AZ
United Health Centers-Mendota	Mendota, CA
United Health Centers-Parlier	Parlier, CA

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