

Paying for Health Care When You're Uninsured: How Much Support Does the Safety Net Offer?

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1. Mark Rukavina, Executive Director The Access Project

Opening statement

Welcome, I'm Mark Rukavina, director of The Access Project of Brandeis University. The Access Project serves as a national resource center for groups seeking to expand or improve access to health care in their communities.

Thank you for joining us at today's press conference for the release of our report: *Paying for Health Care When You're Uninsured: How Much Support Does the Safety Net Offer?* I'd like to briefly provide background for this report and then introduce our presenters, who will each speak for 2 to 3 minutes.

It seems appropriate to begin with a quote from the Reverend Dr. Martin Luther King, Jr., who was born 74 years ago today. He said "Of all the forms of inequity, injustice in health care is the most shocking and inhumane."

With funding from the Robert Wood Johnson Foundation, The Access Project conducted a survey of people with no health insurance to better understand their experiences when seeking health care in their communities. Most people we surveyed received care at safety net hospitals or clinics. These are providers with a mission to serve people without health insurance. Today's report is based on this survey.

Our findings challenge the myth that Americans without health insurance receive free care.

In doing our research, we learned that many patients had outstanding bills. We heard of people too ashamed or embarrassed to go back for follow-up treatment because they owed money. People without insurance being expected to pay higher prices than those with private coverage. Families hounded for payment. Medical bills turned over to collection agencies. And people forced to declare bankruptcy because of medical debt.

An unfortunate finding of our work is that people without health insurance too often trade medical problems for financial problems.

This is a crisis, especially since it is projected that the number of people with no health insurance will continue to climb. According to the U.S. Census, there were 41.2 million uninsured people in the United States in the year 2001. As states implement Medicaid cuts, up to 2 million additional individuals are projected to lose their health coverage. At the same time, employers are asking their workers to pick up a larger share of the cost of health insurance, which may cause many workers to drop coverage because they can no longer afford it.

A health care system that leaves people so exposed financially is ineffective for the patients and the institutions that serve them.

We have five speakers today. The first, Dr. Dennis Andrulis, is from the State University of New York, Downstate Medical Center. Next will be B. J. Reese of West Virginia, who has a personal story to tell. Our third speaker is Dan Hawkins, a Vice President for the National Association of Community Health Centers. Our fourth speaker is Michael Beachler, Director of the Rural Health Policy Center at Penn State College of Medicine. Our final speaker will be Sonia Bouvier, Director of Hampshire HealthConnect at the Cooley Dickinson Hospital in Northampton, Massachusetts.

Let me introduce another resource person available during the question and answer session. Dr. Charlotte Yeh has more than 20 years experience as an emergency room physician. She is past chair of the Task Force on Health Care and the Uninsured for the American College of Emergency Physicians. She is currently the medical director for a Medicare Part B Insurance Carrier. Dr. Yeh is particularly qualified to answer questions related to the emergency department findings.

Closing statement

Let me sum up by saying we hope this report will be a call to action for health policy makers and administrators at healthcare institutions. More must be done to help uninsured people pay for their care and to address the problem of medical debt.

First, eligibility screening and financial counselling must be made more widely available to uninsured patients. Hospitals, clinics and all providers must work to ensure that these services are available to patients seen in all medical settings. Special effort must be made to ensure that uninsured patients using the emergency room have access to this information.

Second, more must be done to ensure that uninsured patients are able to get the medications prescribed by their physicians. This is especially important as pharmaceuticals play an increasingly important role in health treatment plans.

Third, federal, state and local policy makers must adequately fund the safety net so uninsured patients do not face financial barriers to care or trade medical problems for financial problems.

Special attention must be paid to rural patients and providers. They need financial assistance in order to address the disparities in access that exist between urban and rural residents.

However, even if these recommendations are widely implemented, the problem will persist. To fully address the issues identified in our report, we must, as a nation, find a way to provide health care coverage for all of our residents.

We know that medical debt has a negative affect on people's lives. The Access Project is completing several research efforts that build on the findings in this report. We will soon release information that details the experiences of people in selected communities with some of the issues raised here today. Future reports will explore the implications of medical debt for health care access, access to credit and housing, and the public policies causing the problem, as well as potential policy solutions.

Let me remind everyone that the full report is available on our website: www.accessproject.org, along with a listing of our community research partners, 24 local reports, personal stories, contact information for national experts and local spokespeople, and links to related reports and websites

Thank you all very much for joining us today.

2. Dennis Andrulis, Research Professor

State University of New York, Downstate Medical Center, Brooklyn

Good afternoon. My name is Dennis Andrulis. As lead author of this report, I also want to acknowledge my co-authors, Lisa Duchon, Carol Pryor and Nanette Goodman.

Our results focus on survey responses from almost 7,000 uninsured individuals who used a hospital emergency room or outpatient clinic or were seen at a community clinic or health center in urban or rural settings during 2000. These survey respondents had gotten care at 32 hospitals and 19 clinics and community health centers located in 18 states across the United States, with most being safety net providers in their communities.

Their responses document great need for help in paying medical bills and the difficulty in getting financial assistance in clinics and hospitals and especially in emergency rooms. They also show that out-of-pocket costs keep some from getting prescriptions filled, and that a large number of uninsured leave the hospital or clinic in medical debt. In all, it puts to rest the “myth of free care.”

Four key findings from our survey frame the financial challenges facing the uninsured:

First, the need for assistance in paying for medical care among the uninsured is great no matter where they get care, ranging from about half who got care in community health centers or clinics to over 85% of those who got care in emergency rooms. The need for help in paying for prescription drugs was also high—over half of the respondents.

Second, many who reported needing assistance in paying their medical bill rarely or never received it. Overall, about half reported that staff never offered to help, but that proportion reached 70% in emergency rooms.

Third, medical debt—a potentially significant deterrent from using health care in the future, affected about half of all respondents. However, we found that where health care providers offered help, the proportion of uninsured respondents with outstanding medical bills was much lower than those who never received help—45% vs. 70%.

Fourth, our respondents spelled out the potential consequences of unaffordable costs and medical debt. About one in seven reported they could not get some or all of their prescription medications, and one in four said that their debt would deter them from using the health care provider again.

The reported experiences of these patients demonstrate the need for financial help among uninsured patients, the inconsistent if not missed opportunities to provide assistance, and other consequences of medical debt. At the same time, setting aside the importance of obtaining insurance, this report offers providers a persuasive argument for developing more effective means to offer assistance alternatives. It also reinforces the importance of making pharmaceutical assistance available to these safety net providers in a way that assures all will receive needed medications.

In an era of growing numbers of unemployed and uninsured, and in the absence of major health care reforms, the voices of these individuals point us toward incremental changes that can relieve financial stress as well as improve the likelihood of receiving adequate care now and in the future for those whose health may be seriously at risk.

3. Dan Hawkins, Vice President

National Association of Community Health Centers

My name is Dan Hawkins, and I am policy director for the National Association of Community Health Centers, which represents health centers all across the country. For almost 40 years, health centers have been providing preventive and primary health care to low-income people and families who live and work in rural and inner-city communities that lack basic health care services. Today, health centers are the family doctor and health care home for more than 12 million Americans, 5 million of whom have no health insurance at all. They have done their job so well that a recently issued report by the highly-regarded Institute of Medicine identified health centers as part of the overall solution to the health care crisis in America, because they provide “primary care at its best.” President Bush has also made an expansion of health centers to serve twice as many people over the next five years a centerpiece of his Administration’s health strategy.

Community Health Centers have compiled an impressive record of success for many reasons, not least of which is because their mission is about dedication, not dollars. Today’s report reveals a

world of diminishing and costly health care options for the poor; but it also demonstrates that an uninsured patient will fare better at a Community Health Center than anyplace else. Can all safety net providers do a better job of helping patients afford care? Of course we can. But the real solution to this crisis will have to address some of the very serious failures in our *overall* health care system, failures that the safety net – health centers, public hospitals, and other providers that serve large numbers of low-income uninsured people – have neither the resources nor the power to fix on their own.

As health centers, we know well the faces of the uninsured in America: they are our hardworking neighbors and friends whose jobs do not provide them coverage and who work for wages that keep private insurance out of reach. Our physicians are able to provide vital, life-saving preventive and primary health care to every man, woman and child who comes through our doors – usually in less than 15 minutes from the moment they arrive. But securing other needed services for our uninsured patients, like specialty and inpatient care, or prescribed drugs and diagnostic tests, has proven increasingly difficult, and, in too many cases, all but impossible. So while building more health centers over the next five years will certainly do much to open the doors of health care to more of the uninsured, it alone will NOT solve the health care crisis we face today.

To us, what is happening, and what today's study underscores, is a disturbing financial trend in our health care system. Private insurers are demanding deep discounts in the rates they pay for care. Cost savings that providers once used to cover the cost of caring for uninsured people are drying up. Now providers like community hospitals and private practice physicians are being forced to cut back on charity care, leaving safety net providers struggling with limited resources to meet the needs of an ever-growing patient population.

Today's report shows that we in the health care safety net – and indeed all providers – need to do a better job of reducing financial barriers to care and assisting our patients to apply for coverage and other forms of help. But more still needs to be done. Quite simply, we believe that the *health* of our families should not be determined by the *wealth* of our families. That is why we support the idea that we *must*, as a nation, stand four-square behind *any* reasonable effort to extend meaningful, affordable coverage to individuals and families who are currently uninsured, or may soon be. In the long run, that is the **ONLY** viable solution to this crisis.

4. Michael Beachler, Director

Rural Health Policy Center at the Penn State College of Medicine

Good Afternoon! I am Michael Beachler, Director of the Rural Health Policy Center at the Penn State College of Medicine. I have the opportunity to work closely with rural hospitals and health centers in underserved communities in 13 states as a result of my involvement in foundation and federal government funded grant programs. Many of these states are the same that were surveyed in this study.

I will focus my comments on two findings of the study that are a much greater problem in rural areas. The study found that:

- Between two thirds and three fourth of emergency room and hospital outpatient patients from **rural** areas reported they needed help to pay for medications – as compared to 56% of overall survey respondents.
- Almost 30% of **rural** respondents said that they did not get all of their prescribed medications due to unaffordable costs, as compared to 13% overall.

Finding through this study that these pharmaceutical access problems are worse in rural areas should not come as a surprise. Individuals living in rural areas are more likely to be poorer, older, less healthy and uninsured than their urban and suburban counterparts. Small rural hospitals are likely to be very financially fragile and heavily dependent on Medicare revenue (often more than 40% of their base). In addition, rural hospitals don't get paid as well as urban facilities for the same cases. Older Americans have great needs for medications and we don't have a Medicare prescription drug benefit in this country to help them. All of these factors combine to make this pharmaceutical access issue a bigger problem in rural communities.

Fortunately, in some of the states in which I work, there are hospitals, community health centers and clinics starting to recognize the importance of this problem and taking action. For example, small hospitals and clinics in Northwest Arkansas (Arkansas River Valley Rural Health Cooperative) and South Central Louisiana (Vermillion Parish) have developed programs that help the uninsured and underinsured obtain free or low-cost medications through the pharmaceutical assistance programs offered by some drug companies. Clearly much more needs to be done by hospitals, clinics, policy makers and the pharmaceutical companies to make progress on this issue.

Thank you for the opportunity to share another perspective on this critical issue that affects so many Americans.

5. Sonia Bouvier, Director
Hampshire HealthConnect at Cooley Dickinson Hospital

My name is Sonia Bouvier, and I am the Director of Hampshire HealthConnect, a program of Cooley Dickinson Hospital in Western Massachusetts. Our mission is to help uninsured and underinsured people access health coverage and health care services.

Our program came into being when members of our community came to our hospital and expressed an interest in improving access to health care for uninsured residents. Cooley Dickinson agreed to partner with this group, and successfully sought grant funding from the Blue Cross Blue Shield Foundation of Massachusetts. The hospital also contributed funding and we began serving local residents last March.

At Hampshire HealthConnect, we screen and help people to apply for all available health care services. These include MassHealth, our state's version of Medicaid, other insurance and health care programs, as well as prescription and dental assistance. We also help patients apply for a state program that can wipe out their hospital bills and help to partially reimburse the hospital.

We work very hard to make sure that all uninsured people who come to Cooley Dickinson hospital can access our services. Every uninsured patient who comes to the emergency room is given a flyer about the program. Patients can call to make an appointment, come to our office on a walk-in basis, or get help over the phone if they are not able to travel. We do targeted outreach to offer assistance to every uninsured person who is admitted to the hospital or scheduled for surgery. After helping patients complete the applications, we continue to be available to them to answer questions and to advocate on their behalf if needed.

Many of my clients have experienced the issues described in this report, and have not sought needed medical help because they were afraid of the bills. One woman I worked with had stopped seeking chemotherapy for breast cancer because of her medical bills. When she contacted Cooley Dickinson Hospital, she was immediately referred to our program. I found that she was eligible for Medicaid and helped her to apply. Later, when she was admitted to our hospital, she had coverage in place. It was a huge relief both for her and her family. However, it would have been much better for her if she had had help to access financial assistance and coverage earlier.

We have had increasing numbers of referrals from local service agencies and by word-of-mouth. The hospital has agreed to expand the program, and currently we are in the process of hiring another full-time staff person. It's truly a win-win situation for the hospital and for our patients. Bills are more likely to be paid, which helps keep the hospital financially viable. And patients are more likely to seek the care they need and be linked with preventive care and prescription assistance, and that can help keep them from becoming seriously ill.

Our program has helped many people, but it is not a cure-all. If someone is not eligible for health coverage, there is often little we can do for someone who needs surgery or follow-up with a specialist, unless those providers agree to see the patient at a reduced cost. I anticipate that we will be able to serve 1,000 to 1,500 people this year, but we know that there are between four and six thousand uninsured people in Hampshire County alone. And with anticipated state cuts to Medicaid, those numbers are likely to grow. Thank you very much.

Speakers' Biographies

Dennis P. Andrulis is a research professor at the State University of New York/Downstate Medical Center/Brooklyn, where he conducts state and national policy research and development. He has published on a wide range of issues affecting safety net providers, vulnerable populations and their communities. Recent projects include authoring *Managed Care in the Inner City: the Uncertain Promise for Providers, Plans and Communities*; developing a cultural competence self-assessment tool for health care organizations; and organizing a national conference series on Quality Health Care for Culturally Diverse Populations. He has also published *The Social and Health Landscape of Urban and Suburban America*, a collection and analysis of national data sources on the nation's 100 largest cities and their surrounding areas. He holds a Ph.D. in Educational-Community Psychology from the University of Texas at Austin and a Masters of Public Health from the University of North Carolina at Chapel Hill.

Michael Beachler is director of the Rural Health Policy Center and Associate Professor, Department of Family and Community Medicine, Penn State College of Medicine. He also serves as the National Program Director for The Robert Wood Johnson Foundation's Southern Rural Access Program, an effort to improve access to basic health care in eight of the most underserved rural states in the country. He has recently been appointed to the Board of Directors of Capital Link, a national technical assistance center to improve access to capital for community health centers and the Community Health Facilities Fund, a national intermediary designed to improve access to capital for not-for-profit behavioral health providers.

Sonia Bouvier is director of Hampshire HealthConnect, a program of Cooley Dickinson Hospital, whose mission is to help uninsured and underinsured residents of Hampshire County, Massachusetts access health care and health coverage. Previously she consulted with human service programs in several states in the areas of tobacco control, HIV/AIDS prevention, domestic violence and child abuse prevention. She received a Masters in Public Health from University of Pennsylvania, East Stroudsburg. In May 2000, she was one of five graduate students in Pennsylvania to receive the Outstanding Graduate Student of the Year award.

Dan Hawkins is Vice-President for Federal, State, and Public Affairs at the National Association of Community Health Centers, Inc. (NACHC), where he has worked for over 20 years. He provides NACHC members and public officials with policy development, research, analysis, information, and advocacy services. Prior to joining NACHC, Dan served as a VISTA volunteer, Executive Director of a migrant and community health center in south Texas, and assistant to HHS Secretary Joseph Califano during the Carter Administration. He has written numerous articles and monographs on health care and health center issues and provided testimony before several Congressional Committees. He has been named one of America's 1000 most influential health policy makers.

Mark Rukavina is executive director of The Access Project, a program to assist communities in their efforts to address barriers to healthcare access. He has more than 17 years of experience as a community organizer and policy advocate. He is responsible for overall operation of The Access Project, as well as development of strategies for linking local campaigns to state or national health policy issues. Before joining The Access Project, Mr. Rukavina worked with several advocacy organizations, including the Massachusetts Senior Action Council and Health Care For All. Most recently, he was the Program Director for the Somerbridge Community Health Partnership in Somerville and Cambridge Massachusetts, where he managed a Community Care Network National Demonstration Program site. Mark is a graduate of the University of Massachusetts, Amherst, and completed his MBA at Babson College.