Not There When You Need It:
The Search for Free Hospital Care

October 2003

This report was written with support from the Surdna Foundation, the Jessie B. Cox Charitable Trust, and The W. K. Kellogg Foundation.

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Acknowledgments

Community Catalyst would like to express its appreciation to the consumer advocates and community monitors whose work made this report on hospital free care possible. Their commitment to improving community access to health care is truly awe inspiring, and their achievements have been remarkable. In particular we would like to thank Yolanda Cruz at Building Parent Power in Hartford, CT; Trey Daly at the Legal Aid Society of Greater Cincinnati; Jim Duffett at Campaign for Better Health Care in Chicago, IL; Rose Guercia and Donna Kass at the Long Island Health Access Monitoring Project; Claudia Lenhoff at Champaign County Health Care Consumers in Champaign, IL; Cathy Levine at UHCAN-Ohio in Columbus, OH; Sylvia Portillo and Jon Liss at Tenants' and Workers' Support Committee in Alexandria, VA; and Ellen Pinney at the Oregon Health Action Campaign in Salem, OR. We would also like to thank The Access Project which provided significant support during the course of the Free Care Monitoring Project. Finally, we would like to thank Angela Lusk and Toure Muhammed of SEIU's Hospital Accountability Project in Chicago, IL.

We are also indebted to Vince Stehle, Ed Skloot and the Surdna Foundation; Rachel Pohl and the Jessie B. Cox Charitable Trust; and Terri Wright and the W. K. Kellogg Foundation. Their support of Community Catalyst's community benefits and other work over the years has contributed to fundamental alterations in the ways non-profit health care institutions and their local communities relate to each other. It has also contributed to concrete policy changes in a number of areas — including hospital free care — that will improve access to health care. Both Community Catalyst and the community organizations we work with are stronger as a result of their generosity.

Finally, we would like to thank Terri Langston and the Public Welfare Foundation. The Foundation's commitment to consumer health advocacy, and its willingness to back that commitment up with financial support to the organizations that participated in the Free Care Monitoring Project as well as to Community Catalyst, have immeasurably strengthened the health care justice movement.

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Community Catalyst

Community Catalyst, based in Boston, Massachusetts, is a national nonprofit advocacy organization that builds consumer and community participation in the U.S. health system to secure quality, affordable health care for all.

Since its founding in 1997, Community Catalyst has worked with organizations representing disadvantaged constituencies in over 30 states to create self-advocacy capacity for policy and system change in health and related human services. Its multi-disciplinary staff uses a capacity-building approach to providing community leaders, consumer organizations, policymakers, and the participating public with policy analysis and strategic support that helps them create tangible improvements in the health of families, individuals and communities.

Not There When You Need It: The Search for Free Hospital Care was produced as part of Community Catalyst's Community Benefit and Free Care Initiative. Other Community Catalyst projects include the Community Health Assets Project, a joint undertaking with the West Coast Regional Office of Consumers Union, which works to preserve health care access amid for-profit pressures on hospitals and health plans; the Prescription Access Litigation Project, which works to lower prescription drug prices; the Physician Diversity Project, which is focused on increasing minority participation in the physician workforce; and RealBenefits, a program which facilitates access to crucial public health and human services for low-income families and individuals.

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Executive Summary

What happens to low -and moderate- income families who don't have health coverage when one person gets sick?

The public perception is that one way or another, anyone who needs hospital care can get it, regardless of ability to pay.The reality, though, is that a steep hospital bill will usually follow, and help paying that bill is hard to find. This is the conclusion of the Free Care Monitoring Project, an undertaking of Community Catalyst and eight grassroots organizations in nine communities across the country. Since 1999, the project has investigated how easy – or difficult – it is for consumers to get information about free or reduced-price hospital care. The investigation, which had looked at more than 60 non-profit hospitals as of Spring 2003, consists of a series of telephone calls and visits to hospitals by "community monitors" – community residents from a variety of backgrounds, including some who are uninsured. Using a prepared script, the monitors ask whether free care is available; if it is, they also ask about the application process.

This is what the monitors have found to date:

- Most callers are told that free care is not available. If there is a free care policy, front-line hospital staff are almost universally unaware of its existence. Nor do these staff members know who to refer callers to for information about free care.
- The typical response from hospital staff is that emergency care will be provided without proof of ability to pay, but the patient will be billed for those services.
- If the community has a public "safety net" hospital, the staff typically tell the monitors to go there for free care.
- Monitors who are not fluent in English generally are out of luck. They are almost never connected with a hospital staff person who speaks their language, even if the language is a common one like Spanish.

Non profit hospitals, which are exempt from federal, state, and local taxes and receive many other advantages as a result of that status, have an obligation to provide community benefits. And according to the IRS, the provision of free care is a significant indicator that a non profit hospital is meeting that obligation. For-profit hospitals should provide free care as well: health care is an essential service, just as public utilities are. All providers of that service have an obligation to meet the public need in some measure.

Hospital free care is the *ultimate* safety net. With over 43 million uninsured people in the United

States, and a rapidly growing number of people who are underinsured, the need for free care has never been greater. When people can't get free care, they often suffer serious health consequences, including late diagnosis of – and poorer prognosis for –life-threatening conditions, and less aggressive treatment of conditions when they do get care. They also suffer financial consequences: astronomical bills that are sent to collection, resulting in liens on property, wage garnishments, and, in the worst cases, personal bankruptcy. And when people can't get free care, there may be serious public health consequences: the spread of undiagnosed and untreated communicable diseases and the clogging of hospital emergency rooms with people who have no alternative source of care.

A number of steps must be taken to address both the specific problems highlighted by the community monitors *and* the broader issues identified by the Free Care Monitoring Project.

1

Hospitals should adopt and actively implement free care policies that, at a minimum, provide full free care for uninsured and underinsured people with incomes up to *at least* 200% of the federal poverty level (FPL), partial free care for people with incomes up to *at least* 400%, and financial assistance for others with catastrophic medical bills. Communities should work with the hospitals to ensure that those policies are carried out, and that the hospitals' other community benefits respond to community needs. Policymakers should promote mechanisms for assessing hospital free care performance – and for enforcement when performance falls short.

2

All parties, including employers, insurers, government, hospitals and other providers, and consumers, should work together to develop mechanisms – including explicit cost shifting, if necessary – to ensure that the free care burden is shared equitably across all hospitals and all significant payers. Increasing reliance on the marketplace to control health care costs has had an impact on the ability of some hospitals to meet their free care obligations. Competition has made it more difficult for them to spread the cost of caring for the uninsured across their patient populations. It has also threatened the survival of some efficient, high-quality hospitals that are committed to their missions to care for everyone who comes through their doors. Private third-party payers, employers, providers and government have all contributed to the problem, and they all need to contribute to a solution. Right now, the shortage of free and low-cost primary, preventive, and hospital care is a burden that is falling disproportionately on the uninsured and underinsured. That burden must be spread, and it's incumbent on all system "players" to develop mechanisms – e.g. uncompensated care pools, redirection of public funds — for ensuring that happens.

3

All interests – private and public – need to come together to develop a plan for achieving universal health care coverage before the current system collapses under its own weight. The need for free care will not be eliminated until there is universal health coverage. Free care is not an adequate substitute for comprehensive health benefits. And focusing solely on strengthening the safety net is not a sustainable strategy. Only when all government, business, and provider interests are accountable for the provision of free care will they exert the political pressure necessary for universal coverage.

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Part I: Introduction

Background

Rose Shaffer never thought a hospital bill would ruin her life, but she discovered that without health insurance, the road to bankruptcy hits middle class professionals as well as the poor. Shaffer, a registered nurse, works two jobs in order to make ends meet. She serves as director of nursing at a long-term care facility in Chicago, and she also has a part-time nursing position. Her full-time job provides her with insurance through a PPO plan.

It was a different story in 2000, when Shaffer worked at a home health agency that did not provide health coverage. In October of that year, Shaffer suffered a major heart attack. She was rushed to one Chicago-area hospital, where she was kept for two nights, then transferred to an affiliated hospital where she stayed for another night. Her hospital bill for those 3 nights totaled $18,000.

A hospital social worker asked about health insurance. When Shaffer told her she had none, the social worker promised to send her a financial assistance application. Shaffer never received the form. She eventually called the hospital to track it down, but nobody could tell her anything – she kept getting transferred, and eventually she was cut off. She tried again, but to no avail.

Although the application never came, the hospital was able to find her to serve a summons for non-payment of the hospital bill. Rose appeared, accompanied by a lawyer, but she never saw a judge. "We went into the hall with the hospital's lawyer. My lawyer tried to get him to work out a payment plan, but the hospital's lawyer said he wasn't authorized to do that. My heart attack and the bills threw my whole life out of kilter – my house is in foreclosure, my debts have climbed." Shaffer was told that there was nothing that could be done for her at court, and the hospital would start to garnish $350 from each paycheck.

Her doctor told Shaffer to avoid stress, but the lawsuit and debt are taking a toll. She recently filed for bankruptcy. Says Shaffer, "The hospital saved my life and now they're trying to take it."

Rose Shaffer's experience is not an isolated one. The popular perception is that one way or another, everyone can get the hospital care they need, but the reality is that many vulnerable people pay a very high price for it – both literally and figuratively. Shaffer is a good example. Instead of receiving the help she needed Shaffer was sued, and she's still suffering the consequences. But Rose Shaffer is not the only one to learn that free hospital care is hard to come by. The problem is pervasive and only likely to get worse according to the Free Care Monitoring Project, a nationwide undertaking of state and local consumer health advocacy organizations.

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Since 1999, eight of these organizations have monitored hospital free care practices in nine communities, most recently in Spring 2003. The investigation consists of a series of telephone calls and visits to hospitals by "community monitors" – community residents from a variety of backgrounds, including some who are uninsured. Using a prepared script, the monitors ask whether free care is available, and if it is, they ask about the application process.

The purpose of the monitoring is to determine how easy it is for consumers to get information from hospitals about free care. Free care (also known as charity care) is medical treatment that a hospital or other provider gives without expecting to be paid. The provider has determined – usually in accordance with an institutional policy or a government statute or regulation – that the patient is eligible to receive care at no charge or at a reduced rate. In calls and visits to more than 60 non profit hospitals, the community monitors found that few have systems in place for informing people that free or reduced-price care is available or for helping them obtain such care. Indeed, most hospitals indicated that they would provide care, but the patient would be billed.

The monitoring results to date are consistent both across communities and over time, but the need for free care has grown substantially since the project began. The most recent U.S. Census Bureau data indicate that 43.6 million people – 15.2% of the population – were uninsured throughout 2002, up from 41.2 million the year before. And, according to health policy experts, the number of people without health coverage continues to grow. Even people with insurance coverage are finding that their benefits are being cut back and their out-of-pocket medical expenses are increasing. These "underinsured" – particularly those with serious or chronic illnesses – may also need access to free care if their out-of-pocket expenses for hospital care exceed their ability to pay.

Without free care, the health of individuals and families, as well as the health of communities is jeopardized. For example:

- People who owe hospitals money often delay seeking essential medical care. This often leads to avoidable hospitalizations, late-stage diagnoses of cancer and other serious diseases, and the unchecked spread of communicable diseases.
- Hospital collection activities, which are becoming increasingly aggressive, often result in unworkable payment plans, damaged credit ratings, court judgments that permit wage garnishment, seizure of bank accounts, forced sales of family homes, and bankruptcy. All of these harm individuals and can undermine the economic stability of communities.
- Health disparities are exacerbated because racial and ethnic minorities – who have higher rates of uninsurance – have less access to care.

The expectation that hospitals will provide at least some free care to those in need arises from a number of sources. In some cases, communities have established public hospitals that have explicit missions to serve those who don't have financial resources. In the case of non profit hospitals, the obligation is rooted in their tax-exempt status. The *quid pro quo* for relieving an institution of its tax burden – federal, state, and local – is the expectation that it will provide benefits to the

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community. In addition, a number of states expect hospitals to provide some level of free care, generally in exchange for receiving various public funds.

There is also a growing expectation that special responsibilities attach even to for-profit hospitals because health care is an essential service. For-profit hospital ownership is becoming more prevalent, – and for-profit hospitals are becoming major forces in some communities. An analogy can be made to banks that, like for-profit hospitals, operate pursuant to publicly granted charters. Banks are required by law to meet the credit needs of their communities. Similarly, for-profit hospitals – particularly in areas with few other acute care providers – arguably have an obligation to provide some amount of free care as a contribution to meeting the health needs of their communities.

Many private non profit hospitals – which are the primary focus of this report because of the obligations related to that status – would acknowledge a responsibility to provide some measure of free care as part of their mission. Indeed, some hospitals provide significant amounts of free care. And the industry as a whole says that in 2001 alone it provided $21.5 billion in uncompensated care (although that figure combines free care with bad debt). Based on the project's findings, though, there is a "disconnect" between what hospitals report and what consumers actually experience. When the community monitors showed the results of their investigations to hospital leaders, a number of them acknowledged problems and agreed to address some of them. In Marion and Polk Counties in Oregon; Columbus, Ohio; and Suffolk and Nassau Counties in New York, for example, hospital officials, acting individually or as a group, have agreed to publicize the availability of free care, make applications readily available, and educate staff about free care policies and processes. Some of the hospitals have also agreed to uniform free care applications and eligibility standards. And some of these efforts have blossomed into broader collaborations between the community groups and the hospitals. Community members *can* be effective in pushing for change, and hospitals have enormous potential to demonstrate leadership on access issues like free care.

Yet the problem of access to health care is not for the hospital industry to solve by itself. Hospitals clearly have a responsibility to deliver some amount of free care, and because of the nature of that obligation, they must be held publicly accountable. But other parties bear some responsibility, and they, too, must be held accountable. Private physicians could be doing more to provide free primary, preventive, and outpatient specialty care. Employers and the insurance industry have obligations as purchasers of health care, particularly because some of their purchasing practices have reduced the subsidies that formerly helped some hospitals finance free care. State and federal governments – as purchasers of health care *and* formulators of public policy – must use their resources and their authority to address the broader access issue.

The ultimate goal for all parties *must* be universal coverage. Focusing attention and resources solely on strengthening the safety net, rather than working simultaneously to create a system of universal health insurance, is not sustainable. All parties – hospitals, business, and insurers – need to do their fair share to ensure access for the uninsured *now*, but they should also advocate for broader, comprehensive solutions that will eliminate the need for a safety net.

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PROJECT GOALS

The Free Care Monitoring Project was undertaken to document the barriers consumers face when trying to get information about hospital free care. The local monitoring activities revealed that those barriers are pervasive in each community *and* consistent across all sites. As a result, the project goals have broadened commensurately. They are:

- To educate communities about free care generally – what free care is, why it's important, and who is obligated to provide it;
- To galvanize communities to seek accountability from local health care institutions and secure their commitment to improve access to free and reduced-price free care;
- To demonstrate that hospitals can – and have – shown leadership in reducing barriers to free care and building trust with community members and organizations;
- To engage other parties whose policies and practices affect access to free care – such as employers, insurers, and government – in efforts that eliminate those barriers; and
- To begin building a broader constituency – one that includes all providers, employers, insurers, suppliers, and policymakers – to advocate for universal coverage.

The report includes two companion pieces:

- The Hospital Free Care Model Act: legislation that communities and advocates can use to address free care access issues; and
- A 50-state compendium of the laws that address free care.

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Part II: The Community Monitoring Activities

SETTING THE STAGE

In 1999, Community Catalyst began working with a number of grassroots organizations around the country that were concerned about problems low-income people were facing when they needed hospital care but were uninsured or underinsured. There were stories of people being turned away from hospitals or being asked to pay deposits before they were seen. And there were stories of people being pushed into bankruptcy after receiving hospital bills for thousands of dollars. Finally, there were stories of people too ashamed to go back to the hospital where they owed money until a treatable medical problem became a crisis that landed them in the emergency room – adding to the already crushing medical debt.

At the same time, hospital trade associations were touting the amount of care the industry provided "to those who could not afford it."[1] Prompted by the dissonance between the stories they were hearing and the hospitals' claims, Community Catalyst and the grassroots groups decided to develop a community monitoring project that would test how easy – or difficult – it is to get information about the availability of free or reduced-price care at local hospitals.

The goal of the project is two-fold:

- ⇨ First, the groups want to document hospital practices. Where practices need to be improved, the groups attempt to negotiate with the hospitals.
- ⇨ Second, the groups want to build support among other constituencies – including the hospitals and the broader community – for advocacy efforts that expand and improve access to health care.

The centerpiece of the work is a monitoring of local hospitals' free care policies and practices, conducted by community members from a broad range of backgrounds. To date, eight grassroots organizations in nine communities across the country have undertaken the exercise, most recently in Hartford, Connecticut, in Spring 2003. And additional ones are being planned.

The monitoring exercise assesses:

- ⇨ Whether hospitals have explicit free care policies;
- ⇨ Who is covered by those free care policies; and
- ⇨ Whether hospitals have procedures and processes in place for facilitating access to free care.

The project is not intended to assess whether the hospitals actually provide free care. Rather, the findings indicate whether a hospital has an *active* commitment to vulnerable individuals and families in the community who need care but can't afford it – i.e., whether free care policies and

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procedures are transparent and reasonable, and whether hospitals affirmatively reach out to community members who might need free care. The findings also measure hospital compliance with any applicable state or local law regarding access to free care.

The methodology is simple. In each site, the grassroots organization recruits and trains community members – including people with and without health coverage and employees of social service and faith-based organizations – to make telephone inquiries and personal visits to local hospitals, asking about the availability of free care and the policies for providing it. Using protocols designed by Community Catalyst, these "community monitors" call and visit the hospitals and track the responses. Calls are made to the hospitals' general information numbers and patient accounts offices. Some groups also have their monitors contact hospital admitting offices and emergency rooms. At least one monitor visits each hospital to look for signs publicizing the availability of free care. Typically, the monitors look for these signs in the hospitals' various patient reception areas. In some cases, monitors doing these site visits actually question hospital employees about the availability of free care.

To determine the consistency of hospital responses, multiple calls are made to each hospital. The calls are made during the day and evening and – in some communities – on the weekend. In communities with large non-English speaking populations, there is an effort to ensure that at least one of the calls is made in a language commonly spoken within the community – typically Spanish.

Once any caller connects with a member of the hospital staff, he or she asks the following questions:

- Do you give free care if someone's income is limited?
- Do you have a written free care policy you can send me?
- If there an application or other paperwork?
- What services are covered?
- Who do you talk to at the hospital to get free care?

The sites surveyed as of Spring 2003 – and the community groups that did the monitoring – are:

Long Island, NY – Long Island Health Access Monitoring Project

Columbus, OH – Universal Health Care Action Network of Ohio

Washington, DC – Health Care Now

Chicago, IL – Campaign For Better Health Care

Marion and Polk Counties, OR – Oregon Health Action Campaign

Portland, OR – Oregon Health Action Campaign

Champaign County, IL – Champaign County Health Care Consumers

Alexandria, VA – Tenants' and Workers' Support Committee

Hartford, CT – Building Parent Power

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WHAT THE MONITORS FOUND

Despite the diversity among the nine sites, the findings of the community monitors were surprisingly consistent.

Callers to the hospitals invariably were told that free care was not available. If there was a free care policy, front line staff were almost universally unaware of its existence, nor did they know who at the hospital the monitors could be referred to for information about free care.

"One woman told me that she didn't think there was such a thing as free care because if there was the hospitals wouldn't be able to go on. She told me to go to a clinic."
- Community monitor, Hartford, CT

"Hospital free care is the best-kept secret in town." - Health advocate, Long Island, NY

A common response was that the person should go apply for Medicaid.

"The person I spoke with said there was no free care program. She told me to file for Medicaid and stressed this throughout the conversation." - *Community monitor, Columbus, OH*

Even when monitors could reach the hospital billing office, they invariably were told either that the staff person had no knowledge of a free care policy or that free care was not available.

"The person in patient accounts told me 'Free care does not exist here. If they need free care, they should call and go to the county medical center.'" *- Community monitor, Long Island, NY*

Callers often got caught in voicemail loops or were transferred from staff person to staff person, without getting any information.

"When I called Admitting, I had to call twice, and both times I was transferred three times. Finally a woman said 'You have to talk to a doctor, honey.'" *- Community monitor, Columbus, OH*

If the community had a public "safety net" hospital, staff generally told the monitors to go there for free care.

"The hospital person told me 'If someone doesn't have the $36 deposit, we wouldn't see them. If they needed service, we would discontinue it if there was no way the hospital would get paid. It they can't pay anything, they should go to Cook County Hospital.'" *- Community monitor, Chicago, IL*

When callers pressed hospital staff for information, the accommodation that was offered most frequently was the opportunity to work out a payment plan.

"If the person calls up and says I can't pay, then the hospital tries to work out a payment plan and does not necessarily offer the option of financial assistance unless the person specifically asks." - *Community monitor's description of conversation with a hospital staff member, Washington, DC*

On the limited number of occasions when staff indicated that the hospital had a free care policy, almost all staff refused to send information on it to the caller or indicated that the policy would only be available when the person was admitted or after services were rendered.

"The woman I spoke with did not want to give out the income or family size scale for free care because 'patients tend to lie.'" - *Community monitor, Columbus, OH*

"A security guard approached me and asked what I was looking for. I told him I was looking for information about free care. He said 'All there is is what you see.' I felt very intimidated and left. I would not feel comfortable going to this hospital for care."
- Community monitor, Hartford, CT

A typical response from hospital staff was that emergency care would be provided without proof of ability to pay, *but* the patient would be billed for those services because there was no free care.

"They told me 'If it was a life threatening emergency, we would take you to stabilize you, but you would be billed for everything.'" - *Community monitor, Chicago, IL*

Signage containing information about free care was non-existent in the majority of hospitals. To the extent there was signage, it was not readily visible. Signs in patient areas typically addressed non-discrimination and denial of care in general terms, but they did not affirmatively state that free care was available.

"I went to visit the hospital's emergency room. I didn't see any free care policy postings or information." - *Community monitor, Hartford, CT*

It was particularly difficult for individuals with limited English proficiency to get information. Hospital personnel often hung up on non-English-speaking callers or referred them to other personnel who could not speak their language. In the few cases where callers did reach someone who spoke their language, that staff person had no knowledge of the free care policy.

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THE AFTERMATH

Once the group, working with Community Catalyst, compiled its findings, each organization developed its own strategy for using the data. Some groups set up meetings with hospital leaders to discuss the findings. Others decided to release the report publicly, first giving the hospital the opportunity to agree to cooperate to address the problems identified. The organization's press release would note when the hospital agreed to that cooperation. One group opted simply to release the report to the community: they thought their local hospitals would be unresponsive.

Hospital responses were mixed. Some were angry. Several hospitals felt the reports questioned their commitment to providing care to everyone member of the community, even though the organization focused narrowly on whether hospitals had policies and processes in place that made it easy for consumers, including non-English speakers, to get information about free care.

"Private health care providers already provide over two-thirds of the uncompensated care in the city…. I will not waste a minute defending [the hospital] against your foolish accusations." - *Hospital CEO, Washington, DC*

"We're providers of care. We're not the United Nations." - *Ohio Hospital Association executive*

Other hospitals were exemplary. Several hospital executives admitted that they had been unaware of the barriers to free or reduced cost care.

"The policy is to provide access to care. If there are [hospital employees] who are not communicating that policy clearly, we have got to make changes and we will make changes." - *Long Island hospital executive*

Hospital leaders in Marion and Polk Counties in Oregon, Columbus, Ohio, and Suffolk and Nassau Counties in New York, agreed to address some issues raised by the monitoring projects. In Oregon for example, hospital leadership in Marion and Polk Counties worked with the community group to develop a model free care policy that included:

- Eligibility for full free care at 150% of the Federal Poverty Level (FPL) and a sliding fee scale above that;
- A commitment to negotiating reasonable payment arrangements, i.e. based on the individual's ability to pay rather than a hospital-imposed formula;
- A uniform application and a commitment to staff education about free care policies and the application process;
- Visible postings about free care.

> "We learned there was a lot of weakness in the implementation [of free care programs.]" - Oregon Association of Hospitals and Health Systems

The model policy was subsequently adopted by hospitals in the Portland metropolitan area and in Lincoln County. In Lane County the hospitals are considering adopting a policy that goes even further. And the Oregon Association of Hospitals and Health Systems has recommended that all of its member hospitals adopt the model policy.

In Columbus, the hospitals came together as a group to work with the community organization. Together they agreed to:

- Create better signage about the availability of free care, in English and in other languages commonly spoken in the community;
- Develop easy-to-read brochures in six languages about free care policies and procedures and Medicaid eligibility;
- Train staff on free care policies and application processes;
- Develop procedures to ensure patients learn about financial assistance before leaving the hospital (and not just when the billing starts).

In addition, hospitals with policies that limited free care eligibility to the state-mandated level of 100% FPL increased the ceiling to 200% FPL for partial free care or, in some cases, *full* free care.

In Nassau and Suffolk Counties in New York, individual hospitals have met with the community monitors and reached agreements about the free care application process and the method for publicizing free care availability. Two hospitals – Nassau Medical Center and Winthrop-University Hospital – have convened consumer advisory boards to address community/hospital relations and other areas of community concern related to hospital performance. North Shore University Hospital has revised and expanded its free care policy, and it is working with its affiliate hospitals to adopt the same policy. The Long Island Health Access Monitoring Project was able to go further though and generate enough community support to get laws passed in both Suffolk and Nassau Counties. The laws require the hospitals to develop free care policies, post clearly visible signs about free care, and notify *every* patient that free care is available. Both laws also establish telephone hotlines for the reporting of complaints, and they provide for penalties for hospital non-compliance. The Nassau law also requires hospitals to file annual reports with the county's health department that include enough data to enable community members and the county to evaluate individual hospital free care performance. The data will also be used by the health department and the legislature to identify health care access problems that exist in the county.

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Although a number of implementation issues remain to be addressed, advocates in Oregon, Ohio and New York feel that the hospitals can and will address them. And this leads to another positive project outcome: it has opened new lines of communication between institutions and their communities. In some cases, these relationships already have proven to be mutually beneficial. A number of hospitals appreciate the closer connection to the communities they serve, and they have achieved a better understanding of community concerns. The community organizations, in turn, better appreciate the constraints under which local hospitals operate.

The collaboration between the Oregon Health Action Campaign and many of the hospitals has led to joint efforts to reach out to the low-income uninsured – who otherwise might need free care – and enroll them in the state's Medicaid program, the Oregon Health Plan. It has also led to better linkages between hospitals and community health centers. Hospitals benefit because they have a place to refer the uninsured who they treat in their emergency rooms who then need follow-up care. Community health centers benefit because they have a place to refer their patients who may need inpatient or specialty care.

In Columbus, the hospitals asked for – and got – UHCAN's support in promoting a bill that would put a moratorium on the building of for-profit specialty hospitals. And when a large hospital system decided to transform a small community hospital into an outpatient center, it went to UHCAN Ohio and requested assistance in identifying community needs, and then it sought community collaboration in addressing those needs. By doing so, it obtained community support for the plan instead of community opposition. Finally, when state budget constraints threatened Medicaid eligibility for 60,000 low-income Ohio residents earlier this year, the Ohio Hospital Association and individual hospitals joined together with health care advocates and were successful in stopping the cuts.

But for the efforts of the community monitors, the gap between institutional rhetoric and institutional performance – as experienced by people "on the ground" — would not have come to light. Nor is it likely that any of these very important improvements would have occurred. In places where communities and hospitals have come together, there is a now a recognition of the potential for these collaborations to lead to a whole range of mutual aid and support, including grant applications, certificate of need proceedings, and special health access initiatives. And in communities where hospitals have refused to come to the table, the experience has strengthened the resolve of community members to force those institutions to deal with them.

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Part III: About Free Care

WHAT IS FREE CARE?

Free care – which is also called charity care — is medical treatment provided by a hospital or other provider for which the provider *does not expect* to be paid. The provider has determined – usually in accordance with an institutional policy or a statute or regulation – that the individual is eligible to receive care at no charge, or at a reduced charge, based on his or her income.[2] Free care is not recognized as a receivable on the hospital's accounts. In contrast, "bad debt" is revenue a hospital expects to receive but that goes uncollected – typically after collection efforts.[3] Most bad debt results from unpaid insurance claims rather than the unpaid bills of individuals.[4]

FREE CARE VS. BAD DEBT - WHY IT MATTERS

Whether money owed for medical treatment is characterized as free care or bad debt generally is up to the hospital, but its decision makes an *enormous* difference to the uninsured or underinsured person. If the hospital classifies the services as free care, then the hospital does not pursue collection activities. If it's bad debt, then failure to pay almost certainly leads to collection efforts by the hospital or its collection agency. Medical debt – as will be described in more detail later – can have a significant impact on a family's health and finances. People who owe money to a hospital – or who fear incurring a debt they can't pay – often avoid seeking necessary care. And when a hospital bill goes to collection, things can escalate rapidly to the point where a credit rating is ruined, a paycheck is garnished, a bank account is seized, or a lien is placed on a home.[5]

The distinction between free care and bad debt also is a significant measure of institutional behavior. In the case of non profit hospitals, the amount of free care provided is one indicator of whether non profit status is justified. In the case of for-profit institutions, it's an important indicator of whether a hospital is socially responsible. Bad debt is a cost of doing business in any industry. In contrast, free care is tangible evidence of a hospital's commitment to the health and well-being of the community that supports it.

WHO NEEDS FREE CARE?

Free care is the ultimate safety net for many of the almost 44 million uninsured in the United States.[6] Of these, around 75% are in working families with incomes under 200% federal poverty level (FPL) – less than $30,520 for a family of three.[7] Many of the uninsured work for small employers and in service positions – jobs that are less likely to include health coverage.[8] While it is possible for people to purchase coverage in the "non-group market," those premiums can be very expensive – ranging from $3,000 to more than $5,000 annually for an *individual*, depending on the person's age and whether there is pre-existing medical condition. Family coverage would be substantially higher.[9] Moreover, not every state requires insurers to offer insurance to people with pre-existing conditions, so some people can't get coverage at any price. Even when an employer offers coverage, a substantial percentage of the low-income uninsured choose not to enroll: they can't afford the employee's share of the premium, which in 2003, averaged $2,970 for the year for family coverage through a small business.[10]

As the number of people without insurance grows, so will the demand for free care. From 2001 to 2002 alone, the number of uninsured grew by 2.4 million. The primary factor behind the increase is an erosion in both adults' and children's private health insurance coverage, driven by the weak economy, rising unemployment, and the increasing cost of health care.[11] Because employment-based health insurance is the principal source of coverage for people under age 65 in the United States, the erosion is alarming. It's also a trend that is accelerating. In the last ten years, the percent of U.S. workers who have health insurance through their jobs has decreased *from 63% to 45%.*[12]

The most recent data also show that more middle-class families are losing their insurance coverage. The number of uninsured families with incomes under $25,000 remained stable in 2002, but the number of uninsured in each higher category of household income *grew*. The biggest increase was in the $25,000-to-$50,000 category.[13] These families are only slightly better equipped to pay hospital bills out of pocket than lower-income families. Thus, it's reasonable to expect that this trend will increase the demand for free or reduced-price care.

The need for free care falls disproportionately on minorities. Minorities are much more likely to be uninsured than white Americans. The rate of uninsurance for non-elderly Latinos, African Americans, Asian Americans (including Pacific Islanders), and Native Americans is higher than it is for whites. The problem is most acute for Latinos.[14] The lack of readily accessible free care plays a role in the health disparities documented among racial and ethnic minority groups.

The number of uninsured would have been higher in the last two years if enrollment in public programs like Medicaid and the State Children's Health Insurance Program (SCHIP) had not grown.[15] There is evidence, though, that growth in these programs is slowing as states are facing large budget deficits. A number of states have taken steps to limit eligibility or reduce benefits. Some states are also imposing cost-sharing on segments of the Medicaid population. Oregon, for example, now requires some recipients to pay a $250 copayment for each hospitalization. Because Medicaid – and most SCHIP – recipients are, by definition, low-income, they have no alternative but to rely on free care when they lose coverage.

Underinsurance is an increasingly common problem. A recent study found that low- and moderate-income individuals *with insurance* were struggling with levels of medical debt comparable to those of uninsured individuals.[16] Faced with several years of double-digit increases in health insurance premiums, employers are shifting more of the cost to employees, not just in the form of increased premium contributions but also in deductibles, co-payments, and co-insurance amounts. In 2003, the average annual deductible for conventional coverage was $785 – up from $580 in 2000. The average co-payment for a hospital admission is $202, and typical office co-payments have increased from $10 to $15 or more. Adding *only* the deductible to the average employee premium contribution, families paid close to $4,000 out of pocket for their health care in 2003.[17] The worst impact of these increases is felt by individuals and families who are both low-

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income *and* suffer from serious or chronic health conditions. And that is the segment of the underinsured population that is most likely to need free care.

Certain insurance company practices leave people with high out-of-pocket expenditures. Many insurance companies exclude coverage for treatment related to pre-existing medical conditions like cancer, diabetes, or high blood pressure. This means the covered person is responsible for any expenses the insurance company considers to be related to the condition. Other insurance policies may limit the number of "episodes" of medical treatment they will pay for. For example, some plans cover only a single mastectomy. If a tumor is found later in the second breast, the cost of treatment is not covered.[18] Finally, many plans impose a lifetime limit on the amount of benefits they will pay. Lifetime caps, historically in the $1 million range per individual, are being reduced, some to as little as $300,000. Lower caps, in combination with rising health care costs, will mean that sicker individuals "max out" their policies more quickly and join the ranks of those who need free care.[19]

Debunking the Myth of Access

Despite almost daily media coverage of the growing number of uninsured and underinsured in the United States, most believe that people have access to necessary medical care.[20] The reality is that access to care depends substantially on employment status, categorical and financial eligibility for public programs, and institutional benevolence. The traditional safety net providers – community health centers and public hospitals – are increasingly unable to meet the demand for free care. For one thing, not every community has a safety net provider. For another, too many of these institutions face increasing financial constraints – triggered in many cases by Medicaid managed care plans that siphon off Medicaid-covered patients and redirect them to private providers.[21] Private hospitals – and non profit institutions, in particular – need to help fill the gaps that have been created by this market dislocation.

The need for hospital free care would be reduced if free and low-cost primary and preventive care services were more readily available, *but it would not be eliminated*. A centerpiece of the current Administration's health care agenda is to increase the availability of primary and preventive services by expanding the capacity and number of community health centers – the principal site for delivery of these services to the uninsured. Few could argue with the importance of having accessible primary and preventive care, but this expansion is too limited in scope and in dollars to even make a dent in the broader access problem.[22] Indeed, recent research shows that community health center physicians often are unable to get hospitals to agree to provide specialty or non-emergency hospital care for their uninsured patients.[23] This interruption in the continuum of care – and the medical consequences that flow from it – could be addressed if both inpatient and outpatient hospital free care were more readily available.

THE ILLUSION OF EMTALA

A significant contributing factor to the public perception that health needs are met is the federal Emergency Medical Treatment and Active Labor Act.[24] EMTALA was enacted to prevent hospitals from refusing to treat uninsured patients with medical emergencies by sending them to other – usually public – institutions. The law requires any hospital that participates in the Medicare program to provide a medical screening examination to anyone who comes to the emergency room and requests treatment. If the screening examination confirms that the person has an emergency medical condition, the hospital must provide the treatment necessary to stabilize the condition.

The hospital may *not* delay the screening examination or stabilizing treatment in order to find out whether the person has insurance coverage or is otherwise able to pay. But EMTALA *does not* protect the uninsured from hospital bills or collection efforts after the services have been provided.

Moreover, once the condition is stabilized, the hospital is under no obligation under EMTALA to provide further treatment if the patient is uninsured and can't otherwise pay. And hospitals have *no obligation* to treat non-emergency conditions if an individual doesn't have insurance or can't demonstrate an ability to pay. For example, a low-income, uninsured woman may need chemotherapy, but unless her condition meets the statutory definition of an emergency, EMTALA does not require the hospital to treat her.

EMTALA - An "emergency medical condition" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. 42 U.S. Code Section 1395dd(e)(1)

The requirements of EMTALA "…are not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment." Federal regulations governing EMTALA, 42 CFR 489.24(d)(2)

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The Limitations of Public Programs

The popular perception that people get the care they need is also attributable to a general lack of knowledge about the two largest public coverage programs, Medicare and Medicaid. Both programs have contributed enormously to public health and improved the quality of life for countless millions of Americans since their creation almost 40 years ago. But as good as they are, the programs have significant gaps.

Medicaid covers 47 million low-income and disabled Americans. Program costs are shared by the state and federal governments, with the federal government paying on average 57% of the cost of each state's program.[25] Medicaid is an "entitlement" program, which means that anyone who applies and meets the eligibility standards must be enrolled. To be eligible, a person must meet both categorical *and* financial requirements. The categories of people eligible for Medicaid coverage are low-income children and parents, the elderly, and the disabled. Financial eligibility requirements vary by state within certain federal guidelines. For example, federal guidelines *require* states to cover pregnant women and children below age 6 if family incomes are below 133% FPL. Most states, though, have raised that level to an average of 200% of FPL. In contrast, most states have adopted the federal income "floor" of 74% FPL for elderly and disabled individuals.[26] And except under very limited circumstances, Medicaid recipients must be American citizens.

The universe of low-income people who *aren't* eligible for Medicaid is substantial. The largest group are low-income, non-disabled adults with no children in the home. This is a significant gap because those individuals represent *62%* of the adult uninsured population –about 35 million people.[27] In addition, almost 7 million low-income immigrants do not qualify.

The State Children's Health Insurance Program, (SCHIP) a joint state and federally financed program created by Congress in 1997, has made significant inroads in reducing the number of uninsured children. Where Medicaid coverage generally is limited to coverage of children under the age of 6, SCHIP generally covers children up to age 18, and it also raises income levels, in most cases to 200% FPL. In the wake of state budget crises, though, many states are tightening SCHIP eligibility standards or freezing enrollment. As a result, many more children may be needing free hospital care.

Medicare Gaps

Even the Medicare program has gaps that function as a barrier to hospital care for some elderly and disabled. While just about every American age 65 and older is covered by Medicare, many lower-income beneficiaries have substantial out-of-pocket expenses. For example, Medicare has a hospital deductible of $860 for each benefit period; after the 60th day of a hospital stay, the cost rises to $210 *per day*. Most Medicare beneficiaries have supplemental coverage – either purchased on their own or through a former employer – that covers these out-of-pocket expenses and caps the annual amount of personal liability. Still, a sizable number of beneficiaries cannot afford supplemental coverage.[28] It is this segment of the elderly population – those who are too poor to afford supplemental coverage but too rich to qualify for Medicaid – who are most likely to need free care to cover the Medicare hospital deductible and coinsurance expenses.

A Word About the Federal Poverty Level

The perception that people get the care they need may also be attributable to a lack of knowledge about federal poverty level (FPL) guidelines.[29] The guidelines are also used primarily to determine eligibility for various public benefit programs, yet the FPL does not correlate very closely to the actual cost of living in most parts of the country. What does it mean, for example, to a family of three – a single parent with two young children – in Colorado with an income of $30, 520 – or 200% FPL? The family income is too high for Medicaid, which caps eligibility at 185% FPL, or $28,231. But it's well below $39,923 which represents the "self-sufficiency standard" – that is, the income necessary for an individual or family to adequately meet basic needs without public or private assistance.[30] It's hard to imagine this family could pay for hospital care on its own, even with a substantial discount.

> "The nation's official poverty rate rose from 11.7 percent in 2001 to 12.1 percent in 2002..."
> U.S. Census Bureau press release, September 26, 2003.

The relationship of this to free care is clear. While Medicaid, SCHIP, and Medicare represent a significant safety net for many, there are substantial gaps. As the scope of these public programs narrows further in response to state and federal tax cuts and the resulting fiscal pressures, *and* as the number of people living in poverty increases, the demand for free care will increase as well. In the absence of broad support and pressure for universal coverage, hospitals will need to be active participants in providing it.

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The Importance of Free Care

> "Uninsured patients were as likely as privately insured patients to receive intensive care but significantly less likely to have an operative procedure."
> "Acutely Injured Patients with Trauma in Massassachusets,"
> - Hass and Goldman

Free care is often the *only* safety net for uninsured and underinsured individuals and families. When free care is not easily accessible, individuals and communities both feel the consequences. And diagnoses of serious illness or disease among people without health coverage or access to free care are more likely to occur at later stages, when treatment is less likely to succeed. For example, death rates for uninsured women with breast cancer are significantly higher than those for women with insurance.[31] Even when individuals break through the barriers and get hospital care, there is evidence that they receive less and poorer care than their counterparts who have insurance coverage or the means to pay. They are also more likely to die in the hospital than their counterparts.[32]

Fear of medical debt causes people to avoid seeking medical care. The community monitoring and the accompanying research demonstrate that people will delay or avoid seeking care if they expect they will be charged. In addition, people who owe money to a facility often will avoid seeking care out of fear of being treated badly because of the debt.[33] Indeed, many providers now require cash deposits or payment up front. And other providers tell individuals without coverage to seek care elsewhere – typically at a public hospital.[34]

When free care isn't readily available, people rely on emergency rooms, which are not optimal sites for care. Many people without health coverage know that if all else fails, they can go to an emergency room and receive a minimum level of treatment without having to prove they can pay. Emergency rooms are good for treating emergencies, but they leave something to be desired from a care perspective. Urgent medical problems may be addressed, but an emergency department allows little opportunity for coordination of care, follow up, or provider continuity. It is also the most expensive setting for delivering care, so people are more likely to accumulate substantial medical debt when they are treated there.[35]

The lack of access to hospital free care can result in serious, lasting damage to the economic stability of individuals and families. Hospital billing, payment, and debt-collection practices too frequently lead to ruined credit ratings, liens and foreclosures on property, seizure of bank accounts, and bankruptcy. They can also compromise the ability to obtain basic necessities like food and shelter.

The uninsured are charged the highest prices for hospital care. The starting point for the downward trajectory set in motion by medical debt typically is the size of the hospital bill. Hospitals, like most businesses, have "list" prices – prices that reflect what the hospital charges in

the absence of any discount. These list prices – generally referred to as *charges* – have been described as "marketing fictions designed to allow a hospital to offer substantial 'discounts.'"[36] Virtually no one pays charges *except* people who have no insurance. Private third-party payers can negotiate discounts because they can guarantee hospitals a steady flow of patients. The federal and state governments – which set Medicare and Medicaid rates, respectively – can pretty much tell hospitals what they will pay, although they may use charges as a reference point. The only people who don't have anyone negotiating on their behalf are the uninsured.

The difference between what the uninsured are charged and the rates that are negotiated by third-party payers is substantial. A number of recent reports by different advocacy groups around the country provide a sense of the magnitude. In Cook County, Illinois, for example, uninsured patients were charged $12,240 per hospital stay on average, compared with $4,930 for patients with health coverage.[37] In the Los Angeles area, some uninsured individuals were charged almost *five* times what the hospitals accepted as payment in full from some health maintenance organizations.[38]

The difference between what the uninsured are *charged* and what it *costs* the hospital to provide the services is also substantial. In the 1970s and '80s, hospital prices often were regulated, with limits on how much hospital charges could deviate from the actual cost of providing the service. The deregulation of hospital rates over the last decade has changed all that. In New York State, for example, rate regulation had prohibited hospitals from setting charges that were more than 30% above their costs. Now that rate regulation has been eliminated, charges average 87% above costs. In California, one of the nation's most competitive health care marketplaces, charges are now 178% above costs. In contrast, charges are only about 28% above cost in Maryland, the only state that still has rate regulation.[39] At least one state – Connecticut – has recognized the impact of the cost/charge differential on consumers: it now prohibits hospitals from collecting more than the *cost* of providing services from uninsured patients.[40]

Current advocacy efforts to reduce the amount that hospitals charge the uninsured will lower the amount of medical debt incurred, but it is equally important to press hospitals to provide more free care. Using the Cook County example above, a bill for $4,930 is certainly preferable to a bill for $12,240. But the typical uninsured person – with an income under $17,960, or 200% FPL – probably will have difficulty paying even the reduced amount. It would be preferable for that person not to be charged at all. At higher income levels, a reasonable approach would be to guarantee that the uninsured individual's payments do not exceed a modest percent of income.

Hospital concerns about Medicare fraud laws are unfounded. Hospitals say they can't charge the uninsured less than their list price or even routinely write off their bills because that would violate Medicare fraud laws.[41] It is true that the Medicare program is obligated to ensure that hospitals and other providers do not routinely shift costs associated with non-Medicare patients to the program, and vice versa. This obligation has been broadly construed by the hospital industry to mean that hospitals may not discount fees for Medicare beneficiaries or uninsured

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patients. Nor may they relax collection efforts for those patients. This is a misconception. Hospitals are explicitly permitted to waive or reduce fees based on a patient's income. There is no violation of law if a hospital has a policy – including eligibility criteria – for identifying people who can't pay their hospital bills *and* applying that policy uniformly to *all* needy patients.[42]

Because they are billed at full charges, uninsured individuals start off at a disadvantage from a debt perspective. Hospital credit and collection policies and practices can – and do – make the situation worse. For example, the accommodation offered most frequently by hospitals to consumers who have trouble paying hospital bills are payment plans. Community monitors in all sites typically were told that hospital bills could not be waived or discounted, but the hospital might agree to let the individual pay the bill over time. In other studies, individuals reported pressure from hospital financial counselors to accept unaffordable payment terms. The counselors made little or no inquiry as to whether a person had the means to make even those payments.[43] It should be noted that even after payment plans were negotiated, respondents reported that they were still likely to be refused care or asked to pay cash up front because of their debt.[44]

People who owe hospitals money, including those who fall behind in their payments, are at particular risk because the hospital industry has been stepping up its collection efforts. In response to government efforts to slow the rate of growth in Medicare and Medicaid hospital reimbursements, many hospitals have initiated – or increased – "revenue maximization" activities. A principal change has been to step up collection efforts.[45] And indeed, there is growing evidence that hospital collection practices are becoming more aggressive.[46] In one recent study of low-income individuals, 61% said that a collection agency had contacted them about medical debt.[47] Some reported daily calls and even visits by collection agents. In several cases, the tactics included the threat of jail. A study of *very*-low-income residents of Baltimore found that four out of five had been contacted by a collection agency, despite the fact that the average income of those surveyed was $7,864 and the average debt was $3,409 – *nearly half of the average income*.[48]

A number of high-profile media stories about hospital debt collection practices have highlighted the issue. Yale-New Haven Hospital's practices recently came under scrutiny when it was reported that it routinely referred the unpaid accounts of uninsured patients to collection agents without making any effort to see if they needed financial assistance. This was the case despite the fact that the hospital had both a free care policy *and* a $37 million "free bed" fund – money that donors had specified should be used to provide free care. If payment was slow, the collection agents would initiate court actions that resulted in wage garnishments, seizure of bank accounts, placement of liens on debtors' homes, and, in a number of cases, foreclosure proceedings.[49] In a disproportionate number of these collection actions, the individuals being sued *were eligible for free care under the hospital's own guidelines*. They had not been informed of their eligibility or otherwise assisted in making reasonable financial arrangements – a finding that was consistent with the experience of the community monitors.

Daisy Makeupson was being sued by Cincinnati's University Hospital for $1159 - money she owed for a series of outpatient visits. Despite heart disease, high blood pressure, diabetes and arthritis, Mrs. Makeupson, who is 59, works 6 hours a week as a home health aide. The rest of the time she's caring for her disabled husband and 3 children in her custody. She doesn't qualify for Medicaid even though her income is below 200% of the federal poverty level, but she is eligible for free care at University Hospital. Instead here she was in court.

Her lawyer, Trey Daly, described the scene. "The courtroom was jammed with other people who owed money to University and some other hospitals. The hospitals' lawyer told us all to go out to the hall and talk to his paralegal.

"I looked around at the people waiting with us, and my guess was that many of them also had incomes low enough to qualify for free care. It made me mad, so I shouted 'Has anyone heard of the Hospital Care Assurance Program?' There were heads shaking no, so I explained that in Ohio, hospitals have to provide free care for people with incomes below 100% of the federal poverty level. I also told them that University has a program that covers people up to 200%. I had the federal poverty guidelines with me, and right away people started coming up to ask me where they fit."

Daly said "It made me angry that many of these people were being put through this process for something they had no control over. And maybe some of them were not going for medical care because they didn't want to owe the hospital more money. The point is that here was a group of people who probably were qualified for free care, but the hospitals had done nothing to help them apply, let alone tell them it was available. We might be able to help Mrs. Makeupson and some of the other people who were court today. Who's going to help the others that show up next week or next month in the same situation?"

The nation's two largest for-profit hospital chains – Tenet and HCA – have also come under media scrutiny for engaging in practices similar to Yale-New Haven's.[50] When it was publicized that they routinely charged self-pay patients the highest rates and utilized wage garnishment, seizure of bank accounts, and property liens, both chains agreed to modify their collection tactics with respect to low-income people. In its "Compact With Uninsured Patients," Tenet agreed to offer discounted rates to the uninsured, subject to their acceptance of "reasonable . . . payment plans." It also pledged not to pursue legal action for non-payment of bills against any patient who is unemployed or without significant income, and it stated it would not place liens on patients' homes if that were the only available recovery. HCA says it will provide full free care to patients with incomes up to 200% FPL for *non-elective services*, and it will discount the bills of those with incomes up to 400% FPL. It also modified its collection policy so that it will not place liens on primary homes worth less than $300,000 or garnish wages of patients who have "a proven inability to pay."

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Advocates will need to monitor implementation of these policies. For example, Tenet's Compact has no apparent provision for qualifying individuals for free care up front. Does this mean that relief will not be provided until a bill is in the collection process? And HCA indicates that financial relief is limited to *non-elective* treatment.[51] This could mean that only emergency treatment – assuming the hospital has an emergency department – will be eligible for free or reduced-price care.

Most people with medical debt would pay it off if they could. Many report being ashamed that they owe money for medical treatment, even though they believe they have little control over the situation.[52] Perhaps because of this embarrassment, consumers dig themselves even deeper into debt. Increasingly, hospitals and other providers encourage patients to use credit cards to pay for their care, and desperate patients are willing to comply. The provider is guaranteed payment and doesn't have to worry about collection – the credit card company handles that aspect. For the individual, though, credit-card debt carries a high rate of interest, and the debt grows quickly.[53] Property owners with medical debt also report taking out second mortgages or home equity loans to pay medical expenses.[54] Failure to meet the terms of the loan typically means loss of the home.

One of the most telling gauges of the impact of medical debt is the role it plays in families who file for bankruptcy. While the typical view of bankruptcy is that it provides an opportunity for a fresh start, more typically it is the "ultimate declaration of financial collapse for middle-class Americans."[55] A recent survey of middle-class families who filed for bankruptcy in 1999 in eight jurisdictions across the country found that one third – almost 435,000 families – had substantial medical bills not covered by insurance in the prior two years.[56] The idea of a "fresh start" is meaningless to people with serious and chronic health problems. Their medical debt will start to grow all over again in the absence of a change in circumstances – such as a job with comprehensive health benefits or access to free or discounted medical care.

As the community monitors discovered – and as other studies and media stories confirm – many hospitals make it difficult for people to find out about free care. Community monitors saw few signs or other written information about free care. Moreover, front-line staff typically had no information about the availability of free care or how people could find out about it. In the Yale-New Haven report, the majority of debtors interviewed said they were unaware the hospital had a free care program, and a few had specifically asked whether free care was available. These experiences were consistent with the finding of a survey of almost 7,000 uninsured individuals in 18 states. Nearly half of the respondents reported that they were never offered assistance with their medical bills.[57]

One problem that arises when hospitals don't adhere to uniform standards is that the burden of the uninsured falls disproportionately on certain hospitals. Physical location clearly is a factor. Hospitals in urban centers and those in poorer rural areas see far more Medicaid recipients and uninsured patients than hospitals in affluent suburbs. Reputation may also be a factor, though. Some of the citizen monitors noted that in places served by several hospitals, those hospitals often

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have very different reputations among community members - based on factors such as how respectfully they treat the uninsured, and how aggressive they are in their collection activities.[58] Those with good reputations in these regards are more likely to see greater numbers of people who need free care. Thus hospitals that are" doing the right thing" are more likely to find themselves in financially vulnerable situations when the burden is not shared equitably among all hospitals in an area.

There may be financial incentives for hospitals to pursue collection rather than qualify people for free care. When a bill is considered uncollectible, hospitals typically write it off as bad debt. If the bad debt is attributable to someone on Medicare, the amount written off usually can be considered in Medicare's calculation of the hospital's reimbursement if the hospital has made "reasonable collection efforts." And Medicare explicitly permits hospitals to use collection agencies and court actions to obtain payment.[59] In contrast, free care is not reimbursable by Medicare.[60] Thus, it may be more financially advantageous for a hospital to be aggressive in its collection activity than to provide free care to a Medicare beneficiary. In several states, including Connecticut, New York, and California, the write-off of a patient debt can also trigger payments to hospitals from special funds used to reimburse hospitals for some uncompensated care – i.e., free care *and* bad debt. The amount of free care a hospital provides is a factor in calculating a hospital's payment from these funds, but characterizing money owed as bad debt may be more advantageous financially, because nothing prevents the hospital from continuing collection efforts *even after it has written a bill off*. A hospital can, in effect, "double dip" by collecting from a patient even after it has used the write-off to maximize these special payments.[61]

In many instances, the lack of information about free care is an oversight, rather than a deliberate strategy to discourage uninsured people from seeking free services. This is evidenced by the response of some hospital officials to the community monitoring reports. In most cases hospital leadership believed that policies were in place and they were unaware of what people were actually experiencing when they sought free care. Indeed, the American Hospital Association recently issued a member advisory in response to media stories about hospital collection practices suggesting that hospitals perform an "audit" of their free care and collection policies and ensure that staff and governing board are familiar with them.[62] *In other cases*, though, the practice of withholding information about the availability of free care may be an intentional strategy to limit the amount of free care the hospital provides.

"The record in the case shows that such free service as did exist was deliberately not advertised out of fear of a 'deluge of people' trying to take advantage of it. Instead, every effort was made to recover payment for services rendered. Utah Valley Hospital even offered assistance to patients who claimed inability to pay to enter into bank loan agreements to finance their hospital expenses." From the decision in County Board of Equalization of Utah County v. Intermountain Health Care, Inc., 709 P.2d 265, 274, (1985), a challenge to a hospital system's tax exempt status under state law.

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Would offers of assistance in paying hospital bills make a difference to those mired in medical debt? In a word, yes. The more often medical facility staff offer to find out about financial assistance, the less likely respondents are to be in debt to the facility.[63] A recent Massachusetts study found that, in many cases, the patients who were responsible for hospital bad debt are of low enough income that they would have been eligible for free care or for enrollment in a public program if they had been screened appropriately.[64] Hospital failure to screen means a lost opportunity to qualify a person for a public program that would ensure reimbursement for services rendered. Moreover, determining eligibility for free care early in the process would save the hospital the administrative costs of trying to collect from a person with few, if any, resources.

The Community Impact When Free Care is Hard to Find

When people can't get free hospital care, the health of the entire community is placed in jeopardy.[65] If people avoid seeking care because they can't pay for it, there is a danger that disease prevention and surveillance programs will miss a critical mass of individuals. If an infectious disease is involved, the potential for a public health problem is magnified. For example, 20 percent of individuals with HIV do not have health insurance. Many with the disease may also be unaware that they have it because they don't seek care, which increases the chance of transmission.[66] The risk of transmission presumably would be reduced if people knew they could go to a hospital clinic for diagnostic testing and treatment for free or at a reduced rate.

The unavailability of free care also affects the broader community through the impact on emergency room use. Hospital emergency rooms are required by federal – and in some cases, state – law to provide medical screenings to anyone with an emergency, and to stabilize any emergency condition, *without* requiring the individual to demonstrate proof of ability to pay. Thus, people who are sick but have no other options are likely to show up at emergency rooms even with routine medical problems. The overcrowding that results means that everyone – regardless of insurance status – must wait longer for care. It also creates the risk of ambulance diversion from the nearest emergency facility, with potentially disastrous consequences. If hospitals offered free or reduced-cost outpatient care, or alternatively, if they supported local primary care networks to provide free care, emergency room use would be reduced, and the entire community would benefit.

Tracking Hospitals' Free Care Performance

Assessing how much free care hospitals actually provide is not easy. The principal focus of the Free Care Monitoring Project is how difficult it is for consumers to get information about free care, but assessing how much free care hospitals actually provide is a much more difficult undertaking. One reason is that the right data is not always readily accessible or easily interpreted. Like most businesses, hospitals submit to annual audits. Generally accepted auditing and accounting principles require hospitals to report bad debt and free care separately.[67] A number of states require hospitals to file audited financial statements annually with a designated state agency, which makes the statements available to the public.[68] But even when these audits are available, a person needs a degree of expertise in hospital finance to develop an accurate picture from the

statements of how much free care a hospital provides in relation to its overall financial picture.

Some states also require hospitals to provide information to the public on the community benefits they provide as the quid pro quo for their tax-exempt status.[69] This community benefit obligation will be described in more detail later, but the important thing to note here is that different states utilize different definitions. Some allow hospitals to lump free care, bad debt, and hospital-calculated losses on Medicaid and Medicare business together and report it as "uncompensated care." Only a few states require hospitals to report free care exclusive of bad debt. Thus, even in states that explicitly recognize a hospital community benefit obligation, it can be difficult for the public to assess institutional commitment to serving all members of the community.

Most public reporting of hospital data is done through hospital industry associations, and they rarely differentiate between free care and bad debt when publishing financial data. Instead, they use the terms "uncompensated care" - or "unsponsored care" - which is the sum of free care and bad debt.[70] From the industry perspective, a principal function of reporting such data is public relations - whether to generate broad public support or to influence legislators and regulators. Thus, the industry prefers to report the uncompensated care figure, no doubt in part because it is a much bigger number.

Using industry-reported uncompensated care - or even free care - data as a yardstick for assessing institutional commitment to vulnerable populations is complicated by the fact that it typically reflects hospital *charges* for the care, rather than the *cost* of providing that care.[71] As was described earlier, hospital charges are substantially higher than hospital costs. Thus, reporting uncompensated care figures using charges is somewhat misleading. It results in a much higher figure, complicating efforts to assess the level of hospital commitment to the community.

Some non profit hospitals provide detailed descriptions of their community benefit activities on the annual, publicly available filing they make with the Internal Revenue Service -the Form 990. These descriptions sometimes include dollar amounts related to free care, but there is no requirement to include this data. Nor are there uniform definitions or a standard reporting format. While Form 990 may provide a good starting point for assessing community benefit performance, more inquiry usually is required.

A fair amount of research has been done on the hospital industry's uncompensated care performance, using uncompensated care as a proxy for free care. A smaller body of research focuses on hospital free care performance. The issue has been studied in a number of different contexts, including the conversion of public and non profit hospitals to for-profit entities, and the delivery of community benefits. Generally, the research suggests that while many hospitals provide a significant amount of uncompensated and free care, many provide very little. Among the findings are these:

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- ⇨ The percent of total hospital expenditures attributed to uncompensated care has remained relatively constant over the last decade.[72]
- ⇨ Relatively few hospitals provide the bulk of free care.[73]
- ⇨ Teaching hospitals, as a group, provide higher levels of free care than community hospitals.[74]
- ⇨ A hospital's free care performance is tied to the level of poverty in the community - less poverty results in less provision of free care.[75]
- ⇨ The amount of community benefits (e.g. free care, research, teaching, illness prevention and health promotion activities) provided by non profit hospitals appears to fall short of the level that would justify tax-exempt status.[76]

THE FREE CARE OBLIGATION

The expectation that private hospitals will provide some level of free care arises from several different but equally important sources.

- ⇨ ***Tax-exempt status***: All non-profit hospitals have certain community benefit obligations related to their federal tax-exempt status. The provision of free care is considered an important indicator of how well they are satisfying those obligations. Some states have also imposed explicit community benefit requirements on non-profit hospitals.

- ⇨ ***Statutory or regulatory requirements:*** The majority of states address the provision of free care in either a statute or regulation. The approach to providing – and financing – free care varies widely. The existence of these provisions constitutes a public acknowledgment that government needs to address the gaps in access to health care, even if only in a limited way.

- ⇨ ***"Earmarked" funds:*** Many hospitals receive funds that are intended to reimburse them in part for free care they provide. These include public funds paid through the Medicaid and Medicare programs for hospitals that serve large numbers of Medicaid and Medicare beneficiaries and low-income uninsured. They also include Medicare funds that are paid to teaching hospitals for expenses related to training new physicians. In addition, many hospitals receive contributions from donors who direct that they be used specifically for free care.

- ⇨ ***Corporate social responsibility:*** There is a broad – although less well-defined – obligation attached to both non profit and for-profit corporations to behave in a socially responsible fashion. Addressing pressing community health needs – including providing free care to at least some low-income people – is an appropriate example of socially responsible behavior.

Tax-Exempt Status

Despite the evolution to a market-based health care system, most U.S. hospitals are still non profit institutions. To be non profit means, among other things, to be exempt from most federal, state, and local income, sales, property, and excise taxes. But those are not the only benefits. Others include:

- Access to tax-exempt financing of capital projects, which represents a substantial savings over financing they would otherwise have to obtain from commercial lenders;
- Access to federal loans and research grants;
- Limits on tort liability in many jurisdictions; and
- Access to donations that are tax-deductible for the donor.

Moreover, in contrast to for-profit hospitals which must return value to shareholders, non-profit institutions use any excess revenue solely to reinvest in their buildings and operations, medical education, training, and research. Hospital access to low-cost financing and research funds has helped many institutions achieve national stature as centers of cutting-edge research and treatment. Moreover, the public perception that non profit hospitals are mission-driven – as opposed to profit-driven – institutions engenders a degree a community trust and general goodwill that eludes many for-profit hospitals.

So what is – or should be – expected of hospitals in exchange for these very substantial benefits? They are expected to operate in ways that benefit the broader community – not just those individuals who are patients.[77] The concept of a hospital community benefit obligation was initially developed is a federal law.[78] Now a number of states require non profit hospitals to acknowledge a community benefit obligation and to report on community benefit activities. There may also be local expectations that hospitals will "give back" to their communities. Yet even where there are no explicit requirements, the obligation exists because the hospital reaps substantial benefits from its tax-exempt status.

What kinds of activities satisfy a hospital's community benefit obligation? Although the health care environment – like the role of hospitals within that environment – has evolved over the years, the Internal Revenue Service continues to view the provision of free care as a significant indicator that a hospital is meeting its federal community benefit obligation.[79] The IRS also has identified an array of other activities that can be characterized as community benefits, including: the operation of an active and accessible emergency room; an open hospital admission policy with respect to Medicare and Medicaid patients; a medical staff open to physicians practicing in the community; and a board of directors drawn from the community.

The IRS has also made it clear that when it assesses community benefits as part of a hospital audit to determine if tax-exempt status is still justified, the institution must be prepared to demonstrate that the benefits it claims to provide are not illusory. If, for example, a hospital claims that it provides free care, it has to do more than produce its free care

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policies; it must be prepared to demonstrate that it has actually delivered free care in accordance with those policies.[80] Moreover, even though the IRS has not specified what level of free care a hospital needs to provide or under what circumstances it should be provided, it has suggested that this must be more than a token amount.[81] To this end, the IRS has developed a set of questions for use by its field examiners when they audit hospitals that claim to provide free care as a community benefit. Some of those questions are:

- Does the hospital have a specific, written plan or policy to provide free or low-cost health care services to the poor or indigent?
- Under what circumstances may, or has, the hospital deviated from its stated policies on providing free or low-cost health care services to the poor or indigent?
- Does the hospital broadcast the terms and conditions of its charity care policy to the public?
- What documents or agreements does the hospital require poor or indigent patients to sign before receiving care?
- Does the hospital maintain a separate account on its books that segregates the costs of providing free or reduced-cost care to the poor or indigent? Does this account include any other items, such as write-offs for care to patients who were not poor or indigent?[82]

If a hospital qualifies for tax-exempt status at the federal level, states and cities or towns generally follow suit and grant their own exemptions, but they are not required to do so. Standard local expectations of tax-exempt hospitals are evolving. Formally, these taxing authorities seemed to be satisfied that if a hospital complied with federal requirements, then state and local tax exemption was also justified.[83] More recently, cash-strapped states and municipalities have begun scrutinizing hospital expenditures and service delivery decisions to determine whether the exemption continues to be justified. Indeed, when an institution receives tax-exempt status, most of the tax burden shifts to the state and to the city or town that would otherwise collect the property tax.

- Local property tax exemptions constitute 43% of tax-exempt value.
- State sales and income taxes constitute 30% of tax-exempt value (24% is sales tax, and 6% is income tax).
- Federal income taxes constitute 27% of tax-exampt value.[84]

One sign of the trend to scrutinize tax exemptions more closely has been the adoption, in at least 15 states, of community benefit laws, regulations, or voluntary guidelines.[85] While these vary considerably, the most consistent elements are: 1.) requirements that hospitals file regular reports with state oversight authorities on community benefit programs and expenditures, and 2.) that they undertake community benefit planning processes that include consultation with their communities on critical health needs.[86] The community participation requirement is based on the notion that community members are better equipped than hospitals to identify local health needs that can be addressed with community benefits. In addition, the community is the entity that contributes the biggest

portion of the hospital's tax-exemption dividend, so it is appropriate for it to play a significant role in determining the use of that dividend.

Some community benefit laws provide examples of the types of activities or services that would be considered community benefits; free care generally is included. A number of states also require hospitals to include the amount of free care they have provided during the relevant reporting period in their filings. A few laws are fairly prescriptive and actually specify minimum expenditures for hospital community benefit programs (e.g. Utah, Pennsylvania, Texas). For example, Texas - with the most prescriptive law - even specifies a minimum expenditure for free care.[87] Utah requires non-profit hospitals to "provide gifts to the community in excess of [the hospital's] annual property tax liability."[88]

Two associations of non profit hospitals - the Catholic Hospital Association and the Voluntary Hospital Association - have developed community benefit standards to serve as a guide to their members in fulfilling their community service missions and justifying their tax exemptions. Both sets of guidelines clearly view free care as an appropriate community benefit, and they envision a degree of transparency in the provision of free care. The community monitoring results suggest, though, that transparency has not been fully embraced by many hospitals.

What is tax exemption worth? Several health policy experts have developed frameworks for quantifying the value of tax exemption to measure non profit institutional performance.[89] Ideally, the value would equal the total worth attached to each tangible and intangible benefit of tax exemption, including:

The Voluntary Hospital Association guidelines recommend that member institutions:

- "Formally plan for and provide charity care or maintain an open-door policy to the extent of financial ability, and
- "Publicly disclose information about the health care organization's services, financial status, community benefit activities and charity care."

The Catholic Hospital Association has developed the "Social Accountability Budget" - a process for planning and reporting on community benefits. This budget assumes that all member hospitals provide free services to the poor as a key component of their mission. It is both a framework and a tool for helping institutions capture the value of those services, along with the value of all other community benefits, for purposes of both internal and external (i.e. public) evaluation of hospital performance.

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- ➪ The taxes that otherwise would have to be paid (e.g. income, real estate, sales);
- ➪ The difference between the cost of obtaining financing in the commercial market and tax-exempt financing;
- ➪ The amount of tax-exempt donations;
- ➪ The value of any limit on tort liability; and
- ➪ The value of the good will attached to tax-exempt status.

Depending on the location and size of the hospital, the value of tax-exempt status could be worth many millions of dollars. Yet this piece of data seems to have been the subject of little focused inquiry at the state or local level, except in communities that have negotiated "payments in lieu of taxes" agreements with local non profit institutions. When Texas and Massachusetts developed their community benefit law and guidelines, they identified the value of the tax-exempt benefits as an option that hospitals could use in establishing or measuring their community benefit expenditure level. Virtually no hospital chose that option.[90] Part of the reason may be that there is no easy way to quantify some of the less tangible benefits, but another reason may be that there is little motivation on the part of many hospitals – or the industry in general – to do that calculation, because the resulting figure could be substantial. Some of the data – such as property tax information – are more concrete and accessible. It should be possible for communities or regulators to develop those figures and use them as a baseline, with the understanding that they represent a significant understatement of the dollar benefit of tax exemption.

Statutory or Regulatory Requirements

Almost all states and some counties have statutory or regulatory provisions that address the availability of free care. As with community benefit laws, there is considerable variation among the approaches. Not all of the provisions impose an explicit obligation on hospitals, but it is clear from the various provisions that states understand that access to hospital care for the uninsured is a problem that needs to be addressed. Community benefit obligations have already been discussed in the context of tax-exempt status. Other approaches include the following:

- ➪ Uncompensated care pools or other funds that are earmarked specifically to reimburse hospitals for the costs of providing free care;
- ➪ Free care obligations attached to the "certificate of need" process;
- ➪ Obligations that are imposed on hospitals that are converting from non profit to for-profit status;
- ➪ "Loans" of public dollars; and
- ➪ Obligations that are imposed on hospitals as a condition of licensure.

A companion piece to this report – a 50-state compendium of free care laws – provides more detail on each state. A few representative examples are described briefly here to demonstrate the

spectrum of approaches.

Massassachusetts

Massachusetts finances free care through an uncompensated care pool. Pool funding is a shared obligation of the individual hospitals, private third-party payers, and the state. Pool revenues come from a uniform surcharge on hospital patient care revenues, a uniform surcharge on private payers' inpatient hospital expenditures, and a contribution from the state. The pool redistributes funds to hospitals to cover the costs of income-eligible patients.

The pool was adopted as a way of "leveling the free care playing field." Its goals are:

- To improve the financial condition of hospitals with high uninsured care loads;
- To ensure more equitably funded uncompensated care; and
- To improve access for the uninsured by removing disincentives for hospitals – private hospitals, in particular – to treat uninsured patients.[91]

Uninsured – and underinsured – individuals with incomes up to 200% FPL who are not eligible for any public coverage program are eligible for full free care for hospital inpatient and outpatient services. Those with incomes up to 400% FPL are eligible for partial free care based on their income. People above 400% FPL with catastrophic medical bills are also eligible for partial free care. Hospitals are required to broadly publicize the availability of free care and to assist people in the application process.

Idaho

Idaho's County Medical Indigency Care Program essentially "loans" money to low-income people, securing the loan through the automatic attachment of a lien on all of the individual's real and personal property. Program applicants need to provide detailed information on their medical conditions and the medical services they need, in addition to providing extensive information and documentation on income, assets, and household expenses. County clerks make the initial determination on the applications, then submit these to county boards for review. If an application is approved, the county will not pay more than $10,000 toward an individual's bill in any consecutive 12-month period. The county board sets the repayment schedule. If the individual falls behind, the county can go to court and force the sale of the real estate or personal property to satisfy the lien.[92]

Washington State

As a condition of licensure, Washington requires hospitals to provide full free care to individuals with incomes at or below 100% FPL and discounts from charges to individuals with incomes between 100% and 200% FPL. Hospitals are required to prominently display their policies within public areas of the hospital. In addition, when the state is deciding whether to issue a certificate of need to a hospital, one factor is whether the hospital "meets or exceeds the regional average level of charity care."[93]

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Rhode Island

As a condition of licensure, Rhode Island requires hospitals to meet a statewide "community standard" for the provision of charity care services. The department of health reviews each hospital's charity care performance annually. Rhode Island law also provides that when a non profit hospital converts to for-profit status, the parties to the conversion must describe how the new hospital will provide community benefits and charity care during its first five years of operation.[94]

San Francisco

Hospitals in the City of San Francisco and San Francisco County must notify patients of their charity care policies and file annual reports with the local department of health. Hospitals are required to inform patients of their charity care policies both orally and in writing, and they must post clearly visible signs in multiple locations throughout the hospital. Annual hospital charity care reports must include such data as the amount of charity care provided, the number of individuals who applied, the number who received it, and the type of services (e.g. emergency, inpatient, outpatient, ancillary) that were provided to free care patients. The data are used, among other things, to ensure that hospitals do not "dump" uninsured patients, and to inform the local health planning process by documenting the need for free care.[95]

The Hill-Burton Act

A few hospitals across the country continue to have obligations to provide free care pursuant to the *federal* Hill-Burton Act.[96] The 1946 Act was a massive construction program that made grants to hospitals to modernize their facilities. In exchange, the act required hospitals to provide "a reasonable volume" of services to people unable to pay. The obligation was to last for 20 years from the date of the grant, or until the amount of free or reduced-price care provided by the facility equaled the amount of the grant funds, whichever was longer. For years, Hill-Burton funds provided a significant safety net to low-income people, although they were also the frequent subject of litigation by poverty law advocates trying to enforce provisions of the law. Hill-Burton funds have not been distributed since 1975, but a few hospitals have residual obligations under the program.[97] Facilities that received funds under Title XVI of the Public Health Service Act, a successor to the Hill-Burton program, must provide uncompensated services in perpetuity.[98] While most of these facilities are community health centers, some hospitals are subject to this obligation. As with residual Hill-Burton obligations, there doesn't appear to be active enforcement. The burden of identifying, and pressing institutions to honor, these obligations generally fall on advocates.

"Earmarked" Funds

Hospitals receive substantial funds that are specifically intended to offset part of the costs they incur in providing uncompensated care. Sources of public dollars include such things as the

uncompensated care pools some states have created, the Medicaid and Medicare "disproportionate share hospital" (DSH) programs, and, in the case of teaching hospitals, graduate medical education funding through the Medicare program. Private sources include grants and donations. These payments typically are not associated with specific patients but rather are intended to defray the overall costs hospitals incur in providing care to the uninsured. Not all hospitals receive funds from all of these sources, and those that do receive them in varying amounts. The critical point, though, is that only in limited cases are hospitals required to have free care policies and procedures in place as a condition of receiving these funds. And when they publicly report the amount of uncompensated care they provide, that figure does not reflect any offset to reflect receipt of the funds.

"Yale-New Haven Hospital is counting taxpayer funding - state reimbursements, for example - as part of its supposed $52 million in free care…The hospital fails to mention that at least $14 million of the $52 million was reimbursed through …the disproportionate share payment program."
Connecticut Attorney General Richard Blumenthal, February 28, 2003

There are no legal constraints on the ability of federal or state governments to require hospitals to meet free care performance standards as a condition of receipt of these types of public funds. Masschusetts has chosen to put such standards into place. In contrast, New York State, which also has an uncompensated care pool, imposes no obligation on hospitals to provide free care. With respect to Medicaid DSH funds, states design their own programs for distribution of DSH dollars within broad federal guidelines, and they can attach conditions to those payments if they want to.[99] Ohio, for example, requires hospitals that receive DSH funds to provide free care to people with incomes at or below 100% FPL.[100] Georgia also uses its DSH funds to promote free care and access for low-income uninsured people. To receive such reimbursement, a Georgia hospital must agree to provide free care without charge to individuals with incomes below 125% FPL.[101] These two states appear to be exceptions though.

Private philanthropic funds represent an increasingly small source of hospital revenues - generally about 1-3%.[102] Nevertheless, donors often specify that contributions to be used to assist the uninsured. Depending on the hospital, those "free bed funds" can represent a significant amount of money. Yale-New Haven Hospital, for example, has $37 million in such funds.[103] The challenge for regulators and communities may be to ensure that the funds are used for their intended purpose rather than just absorbed to cover hospitals' general operating expenses.

Hospitals are by far the biggest beneficiaries of the public dollars earmarked for care of the uninsured even though they only deliver about two-thirds of the uncompensated care.[104] Moreover, some research suggests that the aggregate amount of the public and private

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funds available for care of the uninsured exceeds the aggregate amount of uncompensated care provided by hospitals.[105] The funds may be poorly targeted in that they may not be reaching the hospitals that provide the most free care. They might also be better deployed to provide insurance coverage for the uninsured. At a minimum though, their distribution should be conditioned on the recipients' agreement to provide free care consistent with standards that ensure access.

Corporate Social Responsibility

Although this report focuses on non profit hospitals, for-profit hospitals also have an obligation to provide some amount of free care as an exercise of their corporate social responsibility. In order to operate, corporate entities must obtain a charter – which essentially amounts to public permission to engage in business. Increasingly, that permission carries with it certain public expectations with respect to the corporation's legal, ethical, and commercial behavior.[100] While this notion applies broadly to all businesses, health care is different because it is an essential service. When provision of an essential service is left to the marketplace, there is a special obligation on all providers to address the inevitable gaps.[106]

When the market has failed to respond appropriately, government has shown that it will step in and impose obligations on non profit and for-profit entities alike. In the health context, Congress passed the Emergency Medical Treatment and Active Labor Act to address patient dumping. The law applies to all hospitals that participate in the Medicare program, regardless of whether they are for-profit or non profit. In recognition of the essential nature of health care, Congress has also imposed certain obligations on health insurers – both for-profit and non-profit – to ensure that individuals maintain their access to coverage. The Consolidated Omnibus Budget and Reconciliation Act of 1986 ("COBRA") imposes a requirement on employers and insurers to extend employment-based coverage to certain former employees and their families. The 1996 Health Insurance Portability and Accountability Act ("HIPAA") imposes an obligation on all insurers to provide continued coverage to individuals who lose employer-based coverage and to eliminate certain barriers to new coverage for workers in transition. In addition, a number of states have enacted small-group and non-group insurance reforms that, among other things, eliminate health-related barriers to coverage. These reforms apply equally to for-profit and non profit insurers.

Other industries that provide "essential services" historically have been obligated to operate in ways that serve the broader community, even though such obligations may make those services less profitable or add a degree of business risk. For example, the federal Community Reinvestment Act (CRA) requires banks to meet the credit needs of the communities within which they are chartered to operate.[107] Congressional intent in enacting the CRA was to encourage banks to invest in neighborhoods that they historically had ignored. Bank investment practices were widely viewed as contributing to urban decay and diminished quality-of-life issues in inner-city communities. An analogy to the health care context is that a failure to provide at least some reasonable amount of free care contributes to a degradation of the public health.

Utility companies historically have had a "duty to serve" – that is, a duty to provide service even where and when it may not be profitable. Examples are a duty to provide continuous, reliable service even in rural areas; a duty to provide advanced notice of service disconnection; and a duty, in some cases, to continue service even when a customer cannot make full payment.[108] Although these obligations arose in a context in which utility companies exercised monopoly power, states that have deregulated the industry generally have indicated an intent to retain basic service obligations.

The consistent theme is that government needs to intervene when there is a threat that individuals will be shut out of the market for certain essential services. This is true even if providing the service poses a degree of business risk. With regard to access to health care, we are faced with mounting evidence that reliance on the market is ineffective in controlling health care cost, quality, and access. The more than 43 million people lacking health insurance in the United States are ample evidence that the market does not work for large numbers of people. In response, policymakers in some states have imposed free care obligations on non profit and for-profit institutions alike.[109] This is an approach that should be broadly replicated.

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Part IV: Recommendations

There is a clear and growing need to improve access to hospital free care. The number of people who don't qualify for – or are losing – health coverage increases every day. The current health care safety net is not equipped to handle the demand. Nor is the safety net generally a comprehensive or broadly accessible system of care. While hospitals cannot – and should not – be expected to function as the sole solution to the access problem, the community survey results suggest they could be doing much more to help those who have no other options.

As a first step, hospitals should be required to have free care policies that meet the following minimum standards:

- Provisions for full free care for the uninsured - or underinsured - up to an income level that reflects the cost of living in the area served by the hospital, but not less than 200% FPL;
- Provisions for partial free care for the uninsured - or underinsured - whose income is between the limit for full free care and an upper limit that should not be less than 400% FPL;
- Provisions for free care for those whose income *exceeds* the upper limit for partial free care but whose medical expenses have depleted individual or family income and resources to the point that they cannot pay for medically necessary services;
- Provisions that individual or family liability for partial free care and medical hardship assistance be based on family income and *not* solely on a reduction of the amount charged;
- A definition of "free care" that includes any medically necessary service, whether delivered on an inpatient or outpatient basis, and any medically necessary prescription drug;
- A requirement that hospitals assist uninsured and underinsured patients in applying for public coverage programs (e.g. Medicaid, SCHIP, Medicare);
- A requirement that hospitals broadcast the availability of free care both inside their own institution and to the broader community;
- A free care application process that is as simple and as "applicant friendly" as possible;
- A requirement that hospital governing boards review and approve all collection policies, and a requirement that board authorization be obtained before the initiation of certain collection actions, including foreclosures, property liens, and wage garnishments;
- A provision for allowing patients to enter into reasonable payment plans, and limiting any interest on those payment plans to the lesser of 5% per year or the Consumer Price Index; and
- A requirement that hospitals file annual reports with a public agency that include the amount of free care, separate and distinct from bad debt, provided over the prior year, as well as other data that permit the public and the appropriate regulators to assess and compare local hospitals' free care performance.

Approaches to implementing these minimum standards range from voluntary hospital agreements at one end of the spectrum, to enactment of legislation at the other. Local and state policy environments will dictate what is feasible in any particular community. What follow are a number of recommendations for ensuring that the standards are adopted.

Local Government

Use local "permitting" authority to encourage hospital adoption of free care performance standards. Local government usually is the issuing authority for a range of licenses and permits most hospitals need to operate, including such things as building and zoning permits. Local authorities should consider encouraging hospitals to adopt – or improve on– the standards set out above as part of the permitting process. This may be particularly appropriate if the permit involves hospital building or expansion in an area with a concentration of low-income people. Given the fact, however, that the loss of insurance increasing cuts across socioeconomic levels, it would be appropriate to condition approval regardless of location.

Consider approaching hospitals for payments in lieu of taxes as a negotiation tool to win assurances around free care. The largest portion of the value of tax exemption is attributable to local property tax, a substantial point of leverage if local authorities choose to use it. An alternative to a demand for payment in lieu of taxes could be an agreement by the hospital to adopt the free care standards set out above.

Intervene in hospital efforts to obtain tax-exempt financing and certificates of need. A number of states make tax-exempt bond financing available to non profit health and educational institutions. They also require hospitals to obtain "certificates of need" when they want to expand their services or physical plant. Usually there is an opportunity for public input in these processes. Local government has an interest in the outcome of these processes. Thus it could request that issuance of bonds or a certificate of need be conditioned on hospital adoption of free care standards.

State Government

Enforce existing requirements. In states that have statutes or other requirements that address the provision of hospital free care, the appropriate oversight agency should enforce those requirements and use any available tools to ensure compliance.

Use the authority to license hospitals as a basis for requiring adoption of free care policies and for monitoring free care performance. As the entities that issue hospitals their licenses to operate, states have significant power to establish standards hospitals must meet as a condition of receiving and maintaining licensure. States should use this authority to ensure access to hospital care.

Be strategic in the distribution of Medicaid disproportionate share hospital (DSH) funds.

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States should use DSH monies to provide incentives for improvements in hospital free care policies. Hospitals that provide the largest amounts of free care should be the main beneficiaries of those funds. States should also consider using some of those funds to support access to primary and preventive care, heading off the need for some hospital free care.

Condition state approval processes on free care performance. State regulatory processes should consider free care performance as a factor in evaluating requests for such things as certificates of need and tax-exempt bonds. If necessary, state officials should strengthen state laws, regulations and requirements for these approvals to ensure that free care performance is a consideration.

Enact legislation that incorporates the standards. Some communities have found that voluntary efforts require too much vigilance. While the hospitals may mean well, free care efforts cease to be a priority in the absence of ongoing public scrutiny. A mandate actively enforced by the state may be preferable. Legislation should include both appropriate sanctions for hospitals that do not meet the standard and funding to allow the appropriate state agency to enforce the law.

Communities

Learn the local terrain. Communities should undertake "audits" to: (1) understand local hospitals' free care policies and their credit and collection practices; and (2) explore the impact of those policies both on individuals with unpaid bills and on the broader community. For example, is medical debt affecting home ownership or family stability? Is there a need for better financial counseling by hospitals? Should communities and hospitals work together to bring Medicaid outreach workers to hospital sites?

Use the information strategically. Try to establish a connection with local hospital leaders and use the audit information to gain voluntary policy improvements. Local circumstances may, however, make it more feasible to go directly to a regulator: if there are free care requirements that are being ignored; the legislature if passage of a law is necessary; or the media if community concerns are not being taken seriously.

Take advantage of the "public process" opportunities presented when hospitals are seeking government approvals. As described above, hospital applications for local permits and state approvals typically have a process for public input. Communities should monitor hospital activity in this regard and intervene when possible to ensure that free care performance is an element in the decision-making process.

Consider challenging the tax-exempt status – at the local, state and federal level — of hospitals that are performing poorly with respect to free care. Communities should try to determine what the hospital's tax liability would be but for its non profit status, and use that data in assessing its free care performance. Based on its assessment, the community should meet with the appropriate taxing authorities and press them to investigate hospital policies and practices with respect to free care.

Philanthropies

All foundations and donors should condition their grants or gifts on hospital adoption of the free care standards. Philanthropies should insist — as the IRS does – that a hospital document both that it has a policy in place and that the policy is being implemented.

All Parties

Work together to ensure that the free care burden is spread equitably across all third-party payers and providers. The burden of free care is not shared equally by all hospitals. Moreover, there are other parties - including private and public third-party payers - whose practices have an impact on hospital ability to provide free care. And communities certainly have an interest in the viability of local institutions and hospital access for local residents. All parties - perhaps convened by the state - should sit down together to address these issues and develop solutions that are fair *and* that preserve or expand access.

Advocate for universal coverage. Free care is not a substitute for comprehensive insurance coverage. All parties should have an interest in ensuring that such coverage is available to everyone. Experience has shown that states often lead the way in addressing health access issues (e.g., insurance market reform legislation, Medicaid expansions). All parties need to come together and develop workable proposals that have universal coverage as the goal. When that is achieved, hospital free care will cease to be an issue.

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