# The Bottom Line

**A data-driven look at the real costs and benefits of hospital financial assistance**

Written by Eli Rushbanks, Naman Shah, MD, Jared Walker, and Jennifer Zhang

Findings reveal that supporting patients through financial assistance benefits both hospitals and families.

## Introduction

Hospital financial assistance programs, often called charity care, are designed to help low and middle income patients avoid unaffordable medical bills. Federal law and some state laws require nonprofit hospitals to offer these programs, and most for-profit hospitals provide them voluntarily.[1] Nonprofit hospitals receive tax exemptions to support caring for these patients. Still, only 29% of eligible patients ultimately receive this help.[2] This gap leaves millions of households facing collections, legal actions such as eviction and wage garnishment, and a cycle of persistent poverty.

While hospitals want what is best for their patients, many operate on small margins and could be hesitant to promote their financial assistance program. This report asks: **If hospitals granted charity care to every single eligible patient, how would it impact their financial bottom line?**

### By the Numbers

**Only 29% of eligible patients receive financial assistance, but covering everyone would *only* reduce hospital revenue by 0.7%**

## Findings

Using 2023 national hospital expenditure data, Medical Expenditure Panel Survey (MEPS) income-based out-of-pocket (OOP) spending shares, and standard sliding-scale charity care thresholds, we estimate that U.S. hospital net revenue would decline by at most 0.7% on average if charity care were granted to all eligible patients.

# Methodology

We used data from the Centers for Medicare and Medicaid Services (CMS) 2023 National Health Expenditure (NHE) dataset, as this best reflects the provider perspective. We used OOP data from the 2023 MEPS dataset of the Agency for Healthcare Research and Quality to estimate the share of OOP provider revenue among different income groups. We applied sliding-scale charity care thresholds ranging from a 100% discount for patients making < 200% of the Federal Poverty Level (FPL) and a 50% discount for patients making 201-400% of the FPL. For a family of four, 200% of the federal poverty level corresponds to an annual income of about $60,000. We should note that, although these are national benchmarks, living costs vary significantly by region. Patients were not excluded from charity care eligibility based on other factors, such as the type of care received, insurance status, or residency. Charity care eligibility was solely based on household income; eligibility based on hardship or catastrophic expenditure was not considered in the analysis.

For each patient, OOP spending was calculated by summing all MEPS OOP payments for outpatient, emergency room, and inpatient care for the facility share. To estimate the national distribution, each patient's OOP amount was multiplied by their national weight, provided by the MEPS dataset. For each of three poverty strata: < 200% FPL, 201-400% FPL, and > 400% FPL, the share of national OOP spending was calculated by dividing the stratum-weighted total by the overall weighted total across all strata. From the CMS NHE dataset, total hospital expenditure (net revenue consisting of gross patient revenues less contractual adjustments, bad debts, and charity care plus government tax appropriations, non-patient, and non-operating revenues) and OOP expenditure were used. **OOP payments made up 2.5% of total net revenue for all hospitals.**

Patients with incomes < 200% FPL represented 13.1% of OOP revenue, patients with incomes 201-400% FPL represented 30.6%, and patients > 400% represented 56.3%. Extrapolating from the MEPS dataset, OOP payments from patients with incomes < 200% FPL represented 0.3% of total net revenue, and OOP payments from patients with incomes 201-400% represented 0.8%. In total, OOP from all patients eligible for financial assistance accounted for 1.1% of the total net revenue for all hospitals. **If universal sliding-scale financial assistance were awarded, OOP revenue would decrease from 2.5% of total net revenue to 1.8%, a 0.7% reduction.**

# Context

The estimated 0.7% reduction of hospital revenue is likely an overestimation for several reasons:

*This analysis applies financial assistance discounts to all OOP payments*

We included all OOP payments from patients with qualifying household income. However, financial assistance eligibility requires both that the patient be eligible, and that the medical services be considered medically necessary. Many elective and outpatient services are not eligible for financial assistance.

*The analysis does not include potential cost savings to the hospital*

Granting more financial assistance decreases a hospital's collection costs – a savings that is not offset in this analysis. Collection costs related to staff, calls, mail, lawsuits, etc., would likely offset lost revenue, at least in part.

*The analysis does not include increased DSH payments*

Many hospitals receive Disproportionate Share Hospital (DSH) payments from the federal government. These payments are based on how much bad debt a hospital carried, and how much financial assistance it granted over the course of a year. For every dollar that a hospital can report as financial assistance for an insured patient that would have otherwise been reported as bad debt, the hospital will receive a higher DSH reimbursement.

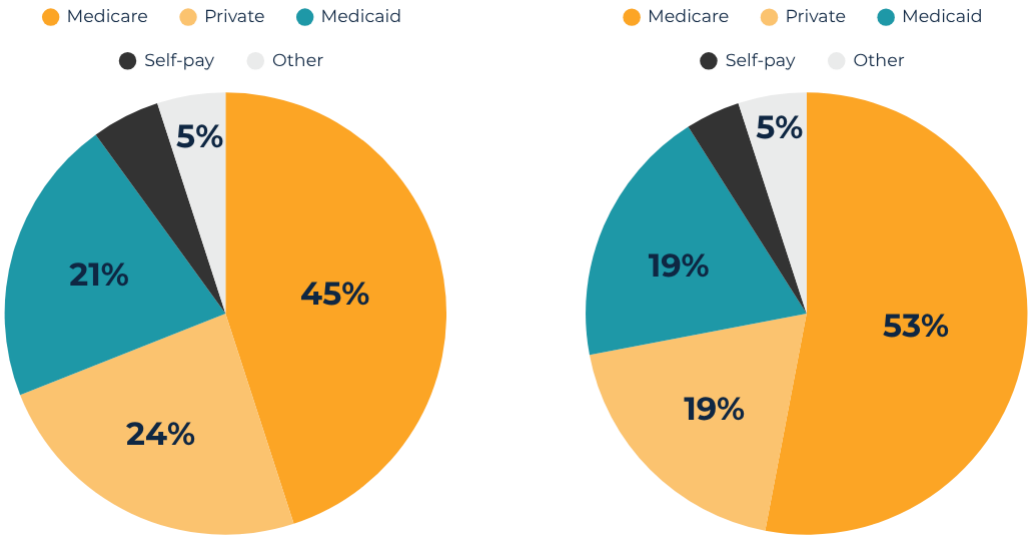
## Variations across hospitals

The estimated 0.7% reduction in total net revenue is the average effect across all hospitals. Variation among hospitals would be driven by the share of patient revenue relative to other operating income, and mostly from the payor mix among patient OOP amounts, including eligible uninsured patients and patients paying co-pays and coinsurance. At 2.5%, OOP is the smallest source of hospital revenue.[3]

One area of possible concern is the cost to rural hospitals, many of which face a precarious financial situation.[4] However, it is unclear whether rural hospitals would forgo more revenue than urban hospitals, as the latter have higher Medicaid and self-pay populations.

**Medicare Covered a Larger Share of Hospital Discharges in Rural Than Urban Areas While Private Insurance Covered a Smaller Share in Rural Than Urban Areas in 2023**

Distribution inpatient dischanges by payer in urban and rural areas, 2023




Note: Analysis of community hospitals. Excludes hospitals in U.S. territories. Urban is defined as metropolitan and rural is nonmetropolitan. "Private" reflects discharges classified as non-Medicare, non-Medicaid third-party payers. Percentages do not sum up to 100% for both urban and rural areas due to rounding.
Source: KFF analysis of AHA Annual Survey Database, 2023

Urban hospitals tend to have a higher proportion of privately insured patients on average, while rural hospitals have a higher proportion of Medicare patients. Private insurance reimbursement rates are nearly double that of Medicare[5] which contributes to the tighter margins that rural hospitals report. At the same time, financial assistance grants for Medicare patients will be lower as hospitals will classify more of these accounts as bad debt to obtain partial reimbursement. Overall, rural hospitals have less margin room for any decrease, but their forgone revenue may be comparable or lower than that of an urban hospital on average.

## Rural Hospitals Are Not the Exception

**Despite common assumptions, it is not clear from the data that rural hospitals would be more heavily impacted by increased financial assistance grants than urban hospitals.**

### Relationship to Medicaid

Many eligible patients are also Medicaid income-eligible but uninsured due to coverage gaps, administrative churn, red tape, or Medicaid disenrollment. Hospitals caring for these patients often end up with uncollectable "bad debt." This is likely

to worsen when certain provisions of H.R. 1 are implemented. For example, starting Jan. 1, 2027, the Medicaid retroactive coverage period will shrink from 90 days from the Medicaid application date down to just one month.[6] For hospitals serving a higher percentage of Medicaid populations, much of the increase in financial assistance giving would come from bad debt. Essentially, these hospitals would be shifting the "debt" from one column of uncompensated care (bad debt), to the other (financial assistance). While this may increase financial strain on hospitals, that strain will not be helped by sending otherwise Medicaid or financial assistance-eligible bills to patients.

It is essential to note that financial assistance, by definition, is intended for patients with limited financial means. The number of medical bankruptcies due to medical bills is strong evidence that OOP is at the upper limit of what it can bear as a category in a hospital's payor mix.[7] Put another way, patients simply cannot afford to pay any more OOP than they already are providing. Compensation for unreimbursed Medicaid, or treatment to an unenrolled but otherwise Medicaid-eligible patient, simply cannot be made up for by sending bills to patients. One cannot get blood from a stone.

### The Policy Shift That Pays Off

**By providing financial assistance to all eligible patients, hospitals can reduce costs, offer enhanced community benefits, and increase government reimbursements for uncompensated care.**

## Conclusion

For hospitals, these findings should give confidence that they can afford to grant financial assistance to many more patients. For policymakers, these findings provide assurance that robust financial assistance laws and regulations will not only help patients but also protect hospitals. In context, the individual and societal benefits of relieving medical debt through financial assistance massively outweigh the effect on hospital budgets. When patients cannot afford medical bills, they experience bankruptcies, hunger, homelessness, and general financial distress.[8] This research shows that much of this pain can be alleviated with a marginal effect on a hospital's bottom line. Dollar For has proposed comprehensive policy solutions to ensure that every eligible patient is granted financial assistance. We invite hospitals and policymakers to join us to make this reality possible.

Over the next few years, hospitals will need to navigate a challenging financial landscape. Federal policy changes are likely to result in Medicaid disenrollment and fewer insured patients. Many hospitals may, understandably, implement a culture of belt-tightening and austerity. Further, many policymakers may be hesitant to introduce laws that could be perceived as kicking hospitals while they are down.

Yet, it is clear that decreasing financial assistance is not the solution to these very valid concerns. In fact, financial assistance can be an important and unique lifeline for patients facing the same difficult landscape. **Hospitals and policymakers should view financial assistance as a powerful tool to help more patients without harming hospitals.** Financial assistance is not part of the problem that hospitals will face, but it is part of the solution for patients.

## Who Is Dollar For?

### WHY OUR WORK MATTERS

**Dollar For is a national nonprofit that eliminates medical debt by making hospital financial assistance known, easy, and fair. We've helped more than 36,000 patients access financial assistance, securing over $115 million in hospital bill forgiveness. Our policy work is grounded in real-world experience and the stories of people we've helped.**

**Through research, patient advocacy, and systems change, Dollar For is transforming a broken process into a pathway to financial relief. We know what works, because we're doing it every day.**

## Endnotes


1. See 26 CFR 501(r); Kona, M. (2024, January 11). *State options for making hospital financial assistance programs more accessible*. The Commonwealth Fund. https://www.commonwealthfund.org/blog/2024/state-options-making-hospital-financial-assistance-programs-more-accessible

2. Dollar For. (2024). *The Path to Charity Care: Exploring the Journey and Roadblocks to Financial Assistance for Medical Bills. Report.* https://dollarfor.org/wp-content/uploads/2024/04/Dollar_For_Path.pdf

3. Levinson, Z., Hulver, S., Godwin, J., & Neuman, T. (2025, February 19). *Key facts about hospitals.* KFF. https://www.kff.org/health-costs/key-facts-about-hospitals/

4. Levinson, Z., Godwin, J., & Neuman, T. (2024, December 18). *Hospital margins rebounded in 2023, but rural hospitals and those with high Medicaid shares were struggling more than others.* KFF. https://www.kff.org/health-costs/hospital-margins-rebounded-in-2023-but-rural-hospitals-and-those-with-high-medicaid-shares-were-struggling-more-than-others/;

5. Lopez, E., Neuman, T., Jacobson, G., & Levitt, L. (2020, April 15). *How much more than Medicare do private insurers pay? A review of the literature.* KFF. https://www.kff.org/medicare/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/

6. KFF. (2025, July 8). *Tracking the Medicaid provisions in the 2025 reconciliation bill.* https://www.kff.org/medicaid/tracking-the-medicaid-provisions-in-the-2025-budget-bill/

7. Himmelstein, D. U., Woolhandler, S., Lawless, R. M., Thorne, D., & Foohey, P. (2019). *Medical bankruptcy: Still common despite the Affordable Care Act.* American Journal of Public Health, 109(3), 431-433. https://doi.org/10.2105/AJPH.2018.304901

8. Himmelstein, D. U., Dickman, S. L., McCormick, D., Bor, D. H., Gaffney, A., & Woolhandler, S. (2022). *Prevalence and risk factors for medical debt and subsequent changes in social determinants of health in the US.* JAMA Network Open, 5(9), e2231898. https://doi.org/10.1001/jamanetworkopen.2022.31898