

SHORTCHANGED

How hospital financial assistance practices and policies fail Oregon patients with the greatest need

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Summary

“If there’s one thing I could tell the hospital, it’s that no one chooses to go into medical debt. We would avoid having this debt if we could.”

Kittie, Patient at Asante in Southern Oregon

Healthcare is becoming increasingly unaffordable for low-income patients, particularly when life-threatening medical emergencies can happen without warning and result in tens-of-thousands of dollars in debt overnight. In the six years before the pandemic, per-person healthcare costs in Oregon grew more than twice as fast as wages.¹

In exchange for generous tax breaks, nonprofit hospitals are required by federal law to reduce or eliminate medical bills for patients who can’t afford them. To further protect patients and hold hospitals accountable to their charitable missions, Oregon passed its own groundbreaking legislation in 2019. Yet even with clear laws governing these policies, a recent consumer protection lawsuit brought by the Washington state attorney general against Oregon’s largest healthcare system, Providence, raised alarm bells about compliance. The complaint alleges that Providence systematically enacted policies and practices that willfully disregard financial assistance rules and deny assistance to eligible patients.

“Taxpayers subsidize hospitals to help struggling, working-class Americans, but many nonprofits are not doing enough.”

Ge Bai, Johns Hopkins University
[Modern Healthcare](#)

To understand how widespread these issues might be, SEIU Local 49 reviewed publicly available documents related to financial assistance for ten of Oregon’s largest health systems.¹ This review indicates that many systems are currently out of compliance with Oregon law, and that most are employing practices that effectively obscure the availability of financial assistance or create unnecessary challenges for qualifying patients to complete the application process. These include:

- Making information about financial assistance difficult for patients to find and understand;
- Placing restrictions on which patients or services qualify for financial assistance beyond those allowed by law;
- Demanding that applicants provide information about assets (like savings and checking account balances), despite the law being clear that household income is the only criteria;
- Aggressively sending patients to collections well before their window to apply for financial assistance has closed; and
- Demanding patients complete detailed applications, despite having the information to determine eligibility.

Our analysis shows that there are significant issues with health systems’ adherence to the law, and these actions can have an immediate and often devastating impact on patients’ lives. However, to fully understand the scope of this problem, a thorough audit of health systems’ internal and operational practices is necessary. Until Oregon takes this issue seriously, patients will continue to suffer unnecessarily from medical debt that they should never have had to begin with.

¹ Health systems included in this analysis: Asante, CommonSpirit, Kaiser, Legacy, OHSU, PeaceHealth, Providence, Salem Health, Samaritan, and St. Charles.

Introduction

Much of American healthcare is provided by nonprofit, charitable institutions. In exchange for billions of dollars in tax breaks, nonprofit hospitals are required to reduce or eliminate medical bills for patients who struggle to afford them. Patients access these discounts through hospital financial assistance programs, also called “charity care.”ⁱⁱ

This assistance in paying for medical care has become increasingly important, especially as Oregon’s healthcare costs have been growing faster than the rest of the country for years.ⁱⁱⁱ In the six years before the pandemic, per-person healthcare costs in Oregon grew by nearly 50 percent.^{iv} Recently, the average cost of annual family health insurance premiums in Oregon reached close to \$20,000—about the cost of a new compact car every year.^v

While hospital financial assistance isn’t a solution to this fundamental problem of rising healthcare costs, it is an important tool to ensure that no one goes without care because they’re afraid of the cost; and that nonprofit hospitals are living up to their missions to make sure care is accessible to all.

In the summer of 2022, SEIU Local 49 conducted a review of the policies of ten of the state’s largest nonprofit health systems to understand if they were complying with their legal obligation to provide financial assistance to qualifying patients. Through this review, we gained deeper insight into how vulnerable patients in Oregon experience financial assistance programs. We also gathered stories from patients whose lives have been affected by medical debt, many of whom were not aware of hospital financial assistance or were unable to access it.

As hospitals are poised to resume many of the debt collection practices that were suspended during the COVID-19 pandemic, this analysis comes at a critical time and exposes a problem that requires urgent attention.

Nonprofit Hospitals are Less Charitable with Financial Assistance than For-Profits

A significant body of research has demonstrated that nonprofit hospitals are not earning the billions of dollars they receive in tax exemptions. For example, [a recent investigation by the Wall Street Journal](#) found that for-profit hospitals actually provide more generous financial assistance to patients than their nonprofit counterparts.

Consequences of Medical Debt

As healthcare costs continue to rise, medical debt has become more and more common—affecting 4 in 10 adults in the US.^{vi} The inability to address this debt can have serious consequences for individuals’ financial and physical health. Patients are hassled by collection agencies to pay bills they cannot afford, taken to court to have their wages garnished, and even threatened with liens. These practices ultimately force low-income people to make impossible choices, driving them to use up all of their savings or ruining their credit for years—or both.

There are also significant health equity ramifications, as medical debt is not experienced evenly among all groups.^{vii} For example, Black and Latinx adults are far more likely to report having medical debt than white adults. Due to structural racism, these groups are already more likely to be in poorer health or to be underinsured—but less likely to be able to afford unexpected expenses like medical bills. And by damaging people’s credit, this debt further disadvantages Black and Latinx adults, who are also less likely to be able to build wealth by buying property due to racist policies and practices.^{viii}

MEDICAL DEBT FAST FACTS

For those with medical debt:

Nearly 2 in 3 put off or **postpone getting healthcare** they need because of the cost.



About 1 in 5 **don't expect to ever be able to pay it off.**



More than 4 in 10 say they or a household member have **used up all or most of their savings.**



About 1 in 7 have been **threatened with a lawsuit or arrest.**



Source: Kaiser Family Foundation. [Health Care Debt In The U.S.](#) June 2022.

Oregon, a Leader in State Protections

The crushing consequences of medical debt is one of the reasons that nonprofit hospitals are granted tax exemptions in exchange for providing free or reduced-price care for patients who can't afford it.

While federal law mandates that nonprofit hospitals make investments in their local communities, Oregon passed its own groundbreaking legislation in 2019 to further hold hospitals accountable to their charitable missions. For example, ORS Chapters 442 and 646A currently require hospitals to provide:

- Complete bill forgiveness to patients earning up to 200% of the federal poverty level;
- Some bill forgiveness for those earning up to up to 400% of the federal poverty level;
- Financial assistance to patients who receive care at hospital-owned clinics; and
- Financial assistance screenings to patients before they are sent to collections.

The Catalyst: Washington Lawsuit Asserts Oregon's Largest Health System Violated the Law

Yet, even with clear federal and state laws governing financial assistance policies, a recent lawsuit brought by the attorney general in neighboring Washington state demonstrates how our state's largest system, Providence, may be operating in Oregon.

WA State AG Files Suit Against Providence for Consumer Protection Violations

In February 2022, the Attorney General for the State of Washington filed a consumer protection lawsuit against Providence Health & Services-Washington, along with its Washington affiliates, Swedish and Kadlec. It alleges that:

“Despite its mission, for years, Providence has engaged in unfair and deceptive practices that prevent many of the most vulnerable members of the communities it claims to serve from accessing free and reduced cost charity care... In the words of one of its own employees, Providence sends “the poor to bad debt,” while at the same time paying lavish compensation to its executives and receiving tax benefits based on its nonprofit status.”

The complaint alleges that in 2018, Providence paid a high-priced international consulting firm \$45 million for advice on how to obscure the availability of charity care and to maximize payments from patients who Providence (in many cases) knew were legally entitled to free care under Washington law. Even after high-level staff raised alarm bells about sending these patients' bills to debt collectors, the system did not change their practices.

From September 2019 through September 2021, Providence sent more than 45,000 accounts with outstanding balances of more than \$53 million to debt collectors—these accounts were held by patients with incomes between 151-200% of the federal poverty level. During the same timeframe, Providence assigned more than 8,000 accounts of currently enrolled Medicaid patients, totaling \$20.3 million dollars in charges, to debt collectors.

The complaint alleges that Providence systematically put in place practices that willfully disregard financial assistance rules by denying assistance to eligible patients, purposefully obscuring the availability of financial assistance options, and knowingly sending Medicaid patients to collections.

The details of the complaint paint a vivid picture of a sophisticated health system seeking to extract every dollar from patients who could not afford to pay. These revelations made it clear that taking a closer look at the implementation of Oregon's law across all health systems is necessary.

Methodology

In the summer of 2022,^{ix} SEIU Local 49 identified ten of Oregon's largest health systems² and reviewed publicly available documents related to financial assistance that they are mandated to provide, including full financial assistance policies, plain language summaries, application forms and related website text. Through our review, we set out to understand to what extent these documents were in compliance with legal requirements.

While this review was underway, SEIU also gathered stories from patients struggling under the weight of medical debt across the state. Many told us they were never informed that financial assistance was an option for them, despite being unemployed, underinsured or making so little that their children qualified for the Oregon Health Plan. Their stories are presented alongside our analysis of the most egregious issues we observed in our review of publicly available documents.

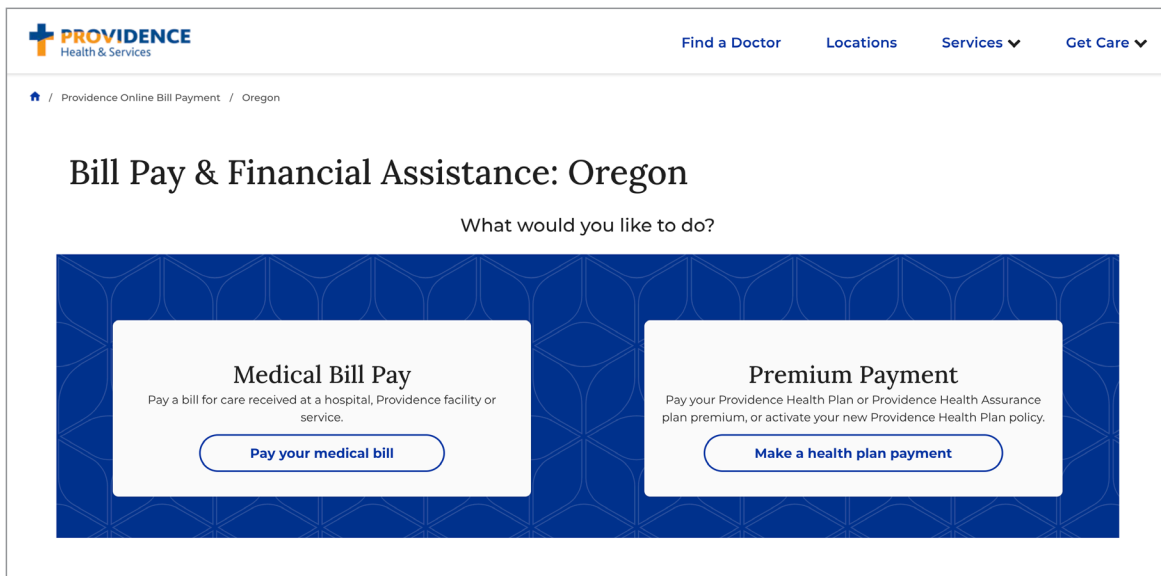
² Health systems included in this analysis: Asante, CommonSpirit, Kaiser, Legacy, OHSU, PeaceHealth, Providence, Salem Health, Samaritan, and St. Charles.

Findings: Many Oregon Health Systems are Failing to Comply with Financial Assistance Laws

Despite many nonprofit health systems' missions clearly proclaiming their primary goal is to care for the poor and the sick, our review revealed that they have set up roadblocks to accessing financial assistance programs and are currently out of compliance with Oregon law. Most are employing practices that obscure the availability of financial assistance or make it unnecessarily difficult to complete the application process. Our findings are detailed below.

Information about financial assistance is difficult to find and understand

Unless patients know specifically what to look or ask for, information about financial assistance can be difficult to find—despite legal requirements that hospitals “widely publicize” its availability.^x For example, the only reference to financial assistance on Providence’s homepage is in a menu at the very bottom, with a link to “Online Bill Pay and Financial Assistance.” And, once a patient reaches the page and chooses the region they are in, the reference to financial assistance disappears and patients are funneled to pick one of two payment options.



Despite written policies, systems may be obscuring the availability of financial assistance in practice.

Discussing financial assistance during the registration process can alleviate patient concerns regarding bills they may not be able to afford and be an important step in supporting those who qualify. While all the financial assistance policies we reviewed indicate that patients are informed about financial assistance in some way during their visit, the lawsuit against Providence in Washington points to how these policies may be playing out on the ground.

The lawsuit asserts that, “The only written information Providence proactively gives patients during registration regarding the availability of charity care is buried in broad-ranging and dense forms, which ... staff members review with patients in a rushed, cursory manner if at all.” The lawsuit also alleges that efforts to obscure the availability of financial assistance at Providence in Washington went much deeper into the organizational culture. For example, all employee teams that generate revenue (including teams that collect directly from

patients) had collection targets, and staff received specific training about how to avoid telling patients about the availability of financial assistance. (See text box below that includes excerpts of Providence staff training materials.)

4.29 Another scenario from this training involves registering a patient at their bedside in the emergency department and requesting payment of a \$275 copay. In this scenario, the patient responds: “I thought that you guys were nonprofit.” The training materials direct staff members to respond to as follows:

We are a nonprofit.

However, we want to inform our patients of their balances as soon as possible and help the hospital invest in patient care by reducing billing costs.

How would you like to take care of this **today**?

- If **unable** to pay in full, ask for a percentage/deposit amount.
- If **unable**, offer to document that they will pay in full when they receive the bill.
- If **unable**, offer to document that they would like to be contacted about a **6 months zero-interest payment plan**.

The training materials do not direct staff to provide any information about charity care in this scenario.

It is not always clear that financial assistance policies also cover services provided in clinic settings.

Patients are increasingly accessing care outside the hospital walls in outpatient clinics—many of which are owned by health systems. In recognition of this shift, Oregon law now requires nonprofit health systems to extend their hospital financial assistance policies to the clinics they own.

A review of the plain language summaries for all ten systems reveal that it still isn't obvious that financial assistance can be accessed at these clinics. Only two systems out of the ten reviewed (Kaiser and Asante) currently make it known that services at clinics are included. Two systems (Legacy and PeaceHealth) say only that hospital services are covered, while others add even more confusion with vague language referencing, “periodic screening for changes in eligibility for outpatient services” (OHSU) or that, “Financial assistance ... at our non-hospital facilities is governed by the policies of the Providence entity providing the care” (Providence).

Patient Story: Sarrah

Sarrah, a healthcare worker in Portland, went to Providence Portland Medical Center more than 10 years ago with a life-threatening infection. When she couldn't pay her original bill in full, she was sent to collections and ultimately sued over this debt. After years of on-and-off wage garnishments of up to 30% of her take-home pay, she's paid nearly \$5,000 to try to resolve this—more than the original debt amount. She still owes more than \$2,200 to debt collectors in interest and court fees. She told us “This has completely destroyed my credit and my life. Among other things, I've always had to live with roommates and haven't been able to establish a rental history because of this decade-old bill.”

Unlawful restrictions on patients and services eligible for financial assistance

Residency restrictions. Oregon law states that the only qualification for financial assistance is household income. However, half of the policies we reviewed included restrictions that screen patients out based on where they live (St. Charles, PeaceHealth, Asante, OHSU, and CommonSpirit).

Patient Story: Richard

When Richard, a caregiver at an assisted living facility in Klamath Falls, needed a hip replacement in 2018, he went to his local hospital, Sky Lakes Medical Center. Back then, he was making just \$36,000 a year and his wife, who has ALS, was on social security disability. He was never offered financial assistance on the \$12,000 bill he owed after insurance. Instead, he got a call before he even got his bill asking for payment. He was diligently making \$25-dollar payments to the hospital, but they demanded \$200 dollars per month. When he told them he couldn't afford it, they sent him to collections that same day. Since then, the collection agency has been garnishing his paycheck at \$200 dollars per month and even threatened to put a lien on his house. He told us, "That one thing alone has basically financially ruined me."

All of these systems make exemptions for emergency care, and most make exceptions for services that are not available in one's own service area. But patients are still left to navigate unnecessary and avoidable burdens to get the care they need. For example, CommonSpirit's policy states that patients who reside outside the hospital's service area must get prior approval from the Hospital Facility Chief Financial Officer and that the hospital can "request the ordering provider to re-evaluate the services and request the services be performed closer to the patient's residence."

Provider restrictions. Many systems also exclude entire doctors' groups or facilities from their financial assistance policies. This practice typically excludes providers who aren't employed directly by the hospital but clearly provide services to patients there; most often, these are emergency department physicians, anesthesiologists, and hospitalists. Troublingly, these are providers that patients often must access in emergency situations in which they

have no way of knowing who is employed by the hospital until after the services are received—and when delaying care could cost them their lives.

When the policies restricting assistance based on residency and providers are combined, it can create impossible situations for patients. For example, St. Charles makes an exception to their residency restrictions for out-of-area emergency department fees, but then excludes emergency physicians at their largest hospital from their financial assistance policy.

Application process is unnecessarily complex

Applying for financial assistance should be a straight-forward process, but our findings show that current hospital practices and policies are creating unnecessary barriers for those with the greatest need.

Limited and outdated options for patients to submit applications. In an age where every health system has an online bill pay option, the financial assistance application process remains largely stuck in the pre-Internet era—far behind the technological savvy and preferences of their patients. The majority of systems we reviewed appeared to only accept applications by fax, mail, or in person. Only a handful of systems provided the option to submit applications by email, and Kaiser and PeaceHealth were the only systems offering online applications.

The limited methods by which patients can apply for financial assistance can create barriers for those most in need. Very few low-income people have reliable access to a fax machine, and many do not have a way at to print documents at home—let alone the time to drop off an application in person. Meanwhile, 85 percent of US adults own a smartphone,^{xi} and research increasingly demonstrates that people with the lowest incomes and Black and Latinx adults are far more likely to be reliant on smart phones as their primary method of accessing the information on the Internet.^{xii}

“Unemployment, poverty, health challenges all generate enormous stress and, yes, this makes it harder to effectively and efficiently navigate what is needed in order to get help.”

Robert Sapolsky, Stanford University neuroscientist
The Atlantic

In addition, most systems encourage—or even require—that patients call their offices for help completing the application. While a phone conversation could be helpful, if it follows the script laid out in Providence’s training materials, it could also result in a patient feeling pressured to pay rather than receiving information about assistance they’re entitled to.

Outdated or overly burdensome application forms. In December 2021, SEIU Local 49 alerted the Oregon Association of Hospitals and Health Systems that the common financial assistance application form, which is maintained by the Association, was out of compliance with the law. While updates were made to the form, our recent review revealed that—nearly two years after the law went into effect—only two of the ten health systems used a fully compliant form. While the majority of health systems have continued to use the outdated and misleading prior version, some have gone a step farther off the path and created their own forms that ask for unnecessarily detailed information about household finances.

“Hospitals also often set up a gauntlet for patients who do apply for aid, with detailed document demands and deadlines that can be difficult and confusing. What’s more, advocates say, hospitals sometimes fail to fully inform patients that they may qualify for what assistance there is, sending them multiple bills before they even apply for aid.”

Wall Street Journal, “Big Hospitals Provide Skimpy Charity Care—Despite Billions in Tax Breaks”

One extreme example is Asante’s application form, which asks for information about patients’ monthly living expenses and requires them to complete 16 different fields including credit cards, property taxes, homeowners insurance, telephone bills and automobile gas. Not only are forms like these out of compliance, but the more time-consuming they are to complete, the less likely patients are to follow through successfully—or to even decide to apply

in the first place. Emerging evidence from a public benefit program in California demonstrates that when time-consuming paperwork is required to access benefits, eligible people drop out of the program for this reason alone.^{xiii}

Two Harvard researchers also recently found that the more administrative tasks a patient has to complete to get healthcare, the more likely they are to skip or delay that care.^{xiv} Unsurprisingly, they found that these

burdens were unequally distributed: adults with disabilities and women were more likely to have to complete these tasks, causing them to miss out on needed care. Conversely, white adults and adults with higher incomes, who likely have more time and resources to tackle these administrative hurdles, were less likely to delay or forego care because of them.^{xv}

Hospital demands for information about assets go far beyond Oregon law

Despite updates to ORS 442.614 in 2019, as well as formal guidance issued by the Oregon Health Authority in late 2021,^{xvii} eight out of the ten health systems we examined continued to ask patients to provide information about their assets when applying for financial assistance, without making clear that this information is optional.

All eight also included fields for patients to disclose their savings and checking account balances.

One of the most extreme examples is CommonSpirit, a national chain that owns two rural hospitals in Oregon. They require that applicants, “provide information on all assets owned by any family member ... proof of income for every identified asset source—such as current bank statement showing most recent three months for checking and savings; investments including stocks and bonds; trust funds, money market accounts, mutual funds or other investment funds that will not incur a penalty if funds are withdrawn.” One patient told us CommonSpirit recently rejected her application that otherwise qualified solely because she refused to provide bank statements, even after she cited Oregon law.

Patient Story

A nonprofit worker in Coos County has dedicated her career to helping people with developmental disabilities. Meanwhile, she’s struggled to afford care for herself and her children. After dealing with several high-risk pregnancies, accidents and chronic health conditions, she owes Bay Area Hospital more than \$70,000—more than she makes in a year—and has had her wages garnished by \$1,000 a month for as long as she can remember. She would like to file for bankruptcy, but the costs are too high. She told us, “All of this is from medical debt; I’ve never even had a credit card.” She was never told about financial assistance, just payment plans, despite her children being enrolled in the Oregon Health Plan.

Patients aggressively sent to collections well before window to apply has closed

Per federal law, patients have 240 days (or about 8 months) to apply for financial assistance. However, of the ten policies examined as part of this analysis, six policies indicate that bills will be sent to collections in half that time (120 days at the latest), and the rest did not specify a timeframe. Despite being technically permissible, sending patients to collections a full four months before their opportunity to apply for help has passed causes many patients to assume their window has closed.

In addition, at least one system (St. Charles) will send people to collections or continue collections actions while their financial assistance application is being processed, despite the patients taking active steps to resolve the debt.

Demanding applications, despite having the information to determine eligibility

Every system we reviewed had information in its policy documenting its ability to grant financial assistance without a formal application from the patient. It is common industry practice for health systems to purchase sophisticated software models that evaluate each individual patient’s ability to pay based on publicly available financial or other records (such as household income, household size, and credit and payment history) and “presumptively” qualify them for financial assistance.

Why would hospitals make patients complete a complex and time-consuming process, when it appears they have the information and ability to grant financial assistance without it? The Providence lawsuit suggests that by funneling patients into a traditional billing process, the health system might be able to get some of these patients to pay.

The Providence lawsuit provides significant insight into how these practices play out inside health systems:

Since 2018, Providence has used tools offered by Experian, a credit reporting agency, which predict patients' likelihood of paying their bill and eligibility for charity care. The propensity to pay tool evaluates accounts to determine whether patients have a "low," "medium" or "high" propensity to pay based on publicly available financial data such as credit history, combined with historical patient payment information from hospitals around the country.

Even though Providence knows that patients with low propensity to pay scores are likely charity care qualified as early as 45 days in the billing cycle, it takes no steps to inform patients of their likely eligibility for charity care. Instead, Providence continues to attempt to collect payment from those patients, including by sending bills at 60 and 90 days and a pre-collect letter, before it evaluates them for presumptive charity ... or sends their accounts to Debt Collectors.

Health systems appear to be using these predictive models to grant financial assistance after they have tried other methods of extracting payment, including, in some cases, sending patients to collections. While some systems clearly indicate that they use the tool prior to sending patients to collections (for example, OHSU and Samaritan), the majority do not explicitly outline how and when the tool is deployed.

One system (CommonSpirit) discloses in their written policy that it is at the point of abandoning the debt that a predictive model is used to forgive the patients' bills and proceed to take credit for their generosity by writing it off as "charity care" rather than bad debt. The policy states: "When the model is utilized, it will be deployed prior to bad debt assignment after all other eligibility and payment sources have been exhausted."

Taken together, these policies paint a disturbing picture of health systems' pursuit of payment from patients at all costs—even from those they know don't have the resources to pay.

Dollar For: Helping Patients Navigate the Financial Assistance Process

While conducting research for this report, SEIU Local 49 consulted with colleagues at Dollar For, a national nonprofit headquartered in the Pacific Northwest that advocates for patients to eliminate their medical debt. Since 2019, they have directly helped patients get approximately \$20 million in medical debt forgiven. All of their services are entirely free to patients.

Dollar For engages in a variety of activities to accomplish its mission. They offer hands-on support by connecting applicants with patient advocates who help them apply for charity care and negotiate with hospitals, debt collectors, and insurers on their behalf. In some cases, Dollar For handles the entire financial application (and appeal, if necessary). For patients who prefer self-help, Dollar For empowers them with forms and educational material. At the system level, Dollar For identifies hospitals not following federal or state charity care law and works to bring them into compliance through advocacy, enforcement, or both.

To get help or learn more, visit www.dollarfor.org.

Conclusions

Oregon is a leader in advancing requirements around hospital financial assistance, but statutes that live only on paper fail to protect Oregonians. Neighboring states are taking action to ensure nonprofit hospitals are held accountable for failing to give back to their communities. Washington's Attorney General is aggressively pursuing this issue, and California's Attorney General recently put hospitals on notice for withholding financial assistance after receiving consumer complaints.^{xvii} At the federal level, the Biden Administration has made the issue of medical debt and hospital financial assistance a priority, recently directing the Health and Human Services Administration to launch an investigation into how hospital billing practices impact patient access and affordability.^{xviii}

Simply by examining publicly available documents, our analysis has made it clear that there are significant issues with health systems' adherence to state and federal law. A thorough audit of internal practices is necessary to fully document the scope of this problem, particularly given that all but two of Oregon's 60 hospitals are nonprofits. That audit should include key questions, such as:

- *When and how are patients made aware of financial assistance programs?*
- *Are hospitals supporting non-English speaking patients, and how have they been treated?*
- *Are patients being misled to believe that assets influence eligibility determination? And relatedly, are health systems in fact using assets to determine eligibility?*
- *How are patients screened for eligibility and when? Are previously paid bills refunded if eligibility is granted?*
- *How are systems using data they have about patients' ability to pay to grant financial assistance?*

Oregon leaders should take immediate action to enforce requirements around hospital financial assistance and consumer protections in ORS Chapters 442 and 646A. Our analysis of just ten health systems makes it clear that health systems are blatantly violating federal and state guidance and ruining the financial well-being of families as a result. If we don't act, we could see even further devastation as the limits on debt collection practices put in place during the COVID-19 federal health emergency expire.

Citations

- i** Oregon Health Authority. [Oregon Health Care Cost Trends: State and Market-Level Cost Growth in Oregon, 2013-2019](#). July 2022.
- ii** Many health systems have begun moving away from calling these programs “charity care,” because the term “charity” can be stigmatizing and lead patients to believe these programs are only available to people who are indigent or uninsured. For example, one of PeaceHealth’s [Frequently Asked Financial Assistance Questions](#) is: “Why is it called Financial Assistance instead of charity care? In the spirit of our core value, Respecting Individual Human Dignity and Worth, PeaceHealth avoids using the term charity, which can carry negative connotations.”
- iii** Oregon Health Authority. [Oregon Health Care Cost Trends: State and Market-Level Cost Growth in Oregon, 2013-2019](#). July 2022.
- iv** Ibid.
- v** Oregon Health Authority. [Impact of Health Care Costs on People in Oregon, 2019](#). April 2022.
- vi** Kaiser Family Foundation. [Health Care Debt In The U.S.: The Broad Consequences Of Medical And Dental Bills](#). June 2022.
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- viii** National Consumer Law Center. [The Racial Health and Wealth Gap](#). March 2022.
- ix** The documents and website content reviewed for this analysis were current as of September 1, 2022. When finalizing citations, we noticed that PeaceHealth was in the process of updating its financial assistance materials. We included PeaceHealth’s updated materials in our final analysis; these data are current as of September 23, 2022.
- x** [Financial Assistance Policies \(FAPs\) | Internal Revenue Service \(irs.gov\)](#)
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- xii** Ibid.
- xiii** California Policy Lab. [Pushed out by paperwork: Why eligible Californians leave CalFresh](#). January 2021.
- xiv** *Tradeoffs*. [Forms and Phone Calls and Faxes, Oh My! Measuring Patients’ Admin Burden](#). September 2021.
- xv** Ibid.
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- xviii** *Healthcare Dive*. [HHS to request provider data on billing practices under new White House plan to ease medical debt](#). April 2022.