

Pointless Debt



How Oregon hospitals skirt financial assistance laws to charge patients—without increasing revenue.

February 2023

DOLLAR FOR
We crush medical bills.



Acknowledgements

This report could not have come to fruition without the incredible work of Dollar For's patient advocacy team and the patients we serve. Dollar For patient advocates work side-by-side with patients to advocate on their behalf or help them advocate for themselves when dealing with the hospital billing system. The first-hand experiences of advocates and patients are invaluable insight into the behavior and practices of hospital billing and financial assistance departments.

Dollar For also wants to thank and acknowledge SEIU Local 49 for its help in preparing this report. SEIU 49 is a leader in Oregon healthcare policy and has done amazing work for its members and the community at large in the space of healthcare advocacy. Their research and expertise was vital and appreciated.

About Dollar For

Dollar For is a national nonprofit that eliminates medical debt by empowering patients and advocating on their behalf. We support patients dealing with medical debt by leveraging hospital charity care policies. Guided by section 501(r) of the Affordable Care Act, nonprofit hospitals are required to offer financial assistance to patients under a certain income limit, as determined by the hospital. Unfortunately, these programs are little known and hard to access.

Dollar For makes charity care known, easy, and fair. We help patients check if they are eligible for financial assistance at their hospital, prepare and submit applications, and eliminate medical bills. Our services are completely free – no strings attached. Since 2019, Dollar For has worked with patients to complete and submit over 4,300 financial assistance applications, which has led to over \$23 million in debt cancellation. Dollar For's advocacy team works with hospitals, regulators, and community partners to improve financial assistance policies and practices, and to encourage better compliance and enforcement of charity care laws.

About the authors



Jared Walker founded Dollar For in 2012 in Portland, Oregon. Dollar For was born out of a desire to help folks in medical crisis after watching his own family's experience. Dollar For started as a crowd-funding organization that recruited donors to pay one family's hospital expenses per month. Since then, Jared has led Dollar For through transformative growth, building Dollar For into a fully-staffed, sustainable organization, crushing millions of dollars of medical bills each year.



Eli Rushbanks serves as the Dollar For general counsel and director of policy. Eli joined Dollar For as a member of the Board of Directors in 2018. At the time he was an attorney at a law firm in Clark County, Washington defending patients sued for medical debt. Eli was familiar with hospital financial assistance programs from this work and helped Jared transform Dollar For from a crowd-funding non-profit to a patient advocacy organization. In 2019 the two launched a pilot Debt Forgiveness Program, an early iteration of Dollar For's current programming. After the program proved successful, Eli was elected Chairman of the Board of Directors and helped Jared scale to more states. As the organization grew to a national presence, Eli joined Dollar For's staff in 2022 and has become recognized as an expert on hospital financial assistance policy.

Table of Contents

Executive Summary	3
Introduction	5
History and structure of Oregon’s financial assistance policy	6
Findings	9
The overwhelming majority of Oregonians sued for debt do not have a lawyer and do not have the means or ability to defend themselves	9
The vast majority of hospitals grant less financial assistance than before HB 3076 became law	10
Placing the burden on patients to apply for financial assistance does not work	13
Case Study: Evaluation of St. Charles Cases	15
By their own reporting, Oregon hospitals do not screen many eligible patients for financial assistance	16
Increasing financial assistance lowers bad debt but does not meaningfully impact net patient revenue	18
Presumptive eligibility grants increase financial assistance	21
Recommendations	22
Appendices	23
Sample of Oregon debt collection cases	23
Study of relationships between financial assistance, bad debt and net revenue	27
Endnotes	31

Executive Summary

In 2019, Oregon passed [House Bill \(“HB”\) 3076](#), which set out a comprehensive plan to get financial assistance into the hands of patients. The law initially gives patients the responsibility of requesting financial assistance from the hospital by submitting the relevant documentation. However, the burden is then on the hospital to screen the patient, regardless of whether or not they’ve applied, to determine eligibility. This screening must take place before the hospital can refer the patient’s debt to a debt collector and before interest can be charged to the account.

Dollar For conducted a data-driven evaluation of the Oregon case filing system (OJCIN), public hospital financial data, and federal hospital tax filings. It found that Oregon hospitals have not adequately implemented HB 3076 and are pointlessly suing thousands of patients. Out of 60 Oregon hospitals, 42 of them granted less financial assistance the year after HB 3076 went into effect than the year before. Many Oregonians meant to be protected by HB 3076 were sent to debt collectors and sued in Oregon small claims courts, a venue where the overwhelming majority of defendants do not have lawyers and lack the means to defend themselves. To add insult to injury, this practice does not appear to have increased hospital revenue.

Dollar For examined the relationship between financial assistance, bad debt, and net patient revenue for the top five hospitals that increased their financial assistance giving the most after HB 3076 became law. It found that over an 11-year period, increases in financial assistance reduced hospital bad debt but had no meaningful effect on net patient revenue. In other words, when hospitals increase their financial assistance they reduce bad debt, but their overall profitability seems unaffected.

Quick Facts

- 42 out of 60 Oregon hospitals gave less financial assistance after HB 3076 went into effect
- An estimated 4 in 9 patients sued for medical debt is entitled to have their bill written off
- Patient self pay amounts only account for 1.6% of hospital revenue
- Hospital data show that increased financial assistance giving reduces bad debt but has no meaningful effect on profitability

This report concludes that most Oregon hospital financial assistance programs are not compliant with the law, fail to bring in hospital revenue, and leave thousands of patients with court judgments for medical debt they cannot and should not have to pay.

Dollar For recommends that hospitals screen patients for financial assistance far earlier in the treatment process. It also recommends hospitals adopt modern submission technology such as secure online portals and move away from requiring patients to fax or hand-deliver applications. Finally, Dollar For urges hospitals to stop considering it the patient's responsibility to ask for financial assistance. Instead, hospitals should recognize that their profitability is unaffected by granting financial assistance and, for the good of their community, they should take it upon themselves to screen as many patients as they can.



Introduction

Unpaid medical bills are the most prevalent and devastating debt affecting Oregonians. Credit records show that Oregonians carry at least \$390 million in medical debt.¹ Nationally that figure climbs to \$88 billion.² Medical debt is consistently more than half of all debt handled by debt collectors.³ For example, in the second quarter of 2021, 58% of all allegedly overdue account balances recorded in the CFPB's Consumer Credit Panel were for medical debt.⁴

Medical debt is universal, regardless of insurance status. Uninsured patients are charged approximately 2.5 times more than insured patients.⁵ Yet, according to a 2016 study by the Kaiser Family Foundation, over 60% of people with medical debt have health insurance.⁶

Healthcare costs are rarely determined according to a uniform set of standards, which encourages hospitals to take advantage of consumers in vulnerable circumstances. For example, a 2021 study conducted by Axios and Johns Hopkins University found that the top 100 hospitals in the country, on average, charge patients seven times what it costs a hospital to deliver a service.⁷

Medical debt can seriously impact an individual's life. Medical debt affects the ability to access credit,⁸ insurance, or housing;⁹ can result in higher interest rates on loans;¹⁰ and increase the likelihood of bankruptcy.¹¹ Many researchers and hospitals have also recognized medical debt as a social health risk that can endanger the physical and mental health of the debt holder.¹² Studies have also found that patients with medical debt will avoid seeking care in the future. One Stanford study found that 46% of patients who already had medical debt avoided future care.¹³ Virtually all of these burdens are disproportionately felt by low-income individuals, people of color, veterans, young adults, and the elderly.¹⁴

History and structure of Oregon's financial assistance policy

The Affordable Care Act added a section to the federal tax code, 26 USC 501(r), which requires all 501(c)(3) tax-exempt hospitals to have a Financial Assistance Policy (FAP) for tax years starting after December 29, 2015.¹⁵

While a good start, 501(r) left much to be desired. For example, 501(r) does not establish a mandatory income cut-off whereby all individuals who make under a fixed amount are automatically eligible for financial assistance. In addition, the section has lax notice requirements (meaning there are few rules when it comes to informing patients about available assistance programs), and always puts the burden on the patient to learn about the program and apply instead of requiring hospitals to seek out eligible patients.

In 2019, Oregon passed HB 3076, which added several complimentary requirements to 501(r). For example, it extended financial assistance requirements beyond hospitals to include care provided by associated clinics. It also set a floor for how much financial assistance a nonprofit hospital must give patients within certain income ranges. All patients at or below 200% of the federal poverty level ("FPL") are entitled to have 100% of their out of pocket costs eliminated, and patients between 200 and 400% are eligible for a discount based on their ability to pay.

Excerpted Text from HB 3076

ORS 442.614

(a) Provide for adjusting a patient's costs as follows:

(A) For a patient whose household income is not more than 200 percent of the federal poverty guidelines, by 100 percent;

(B) For a patient whose household income is more than 200 percent of the federal poverty guidelines and not more than 300 percent of the federal poverty guidelines, by a minimum of 75 percent;

(C) For a patient whose household income is more than 300 percent of the federal poverty guidelines and not more than 350 percent of the federal poverty guidelines, by a minimum of 50 percent; and

(D) For a patient whose household income is more than 350 percent of the federal poverty guidelines and not more than 400 percent of the federal poverty guidelines, by a minimum of 25 percent

HB 3076 also requires all hospitals and affiliated clinics to screen patients for financial assistance eligibility before referring them to a debt collector. It prohibits hospitals and debt collectors from charging interest on any account of an eligible patient.

The structure of Oregon’s financial assistance laws attempts to strike a balance between ensuring hospitals don’t have to guess at patient eligibility and protecting the patient from the consequences of debt they legally should not have to pay. At first, the burden is on the patient to apply for financial assistance through the hospital’s process. However, if the hospital wishes to send the debt to a third-party collector, the burden shifts to the hospital to determine if the patient is at or below 200% FPL. With the requirement that hospitals screen patients for financial assistance eligibility before referring them to a debt collector, one would expect hospitals to report an increase in financial assistance.

Goals of this Report

Dollar For conducted a data-driven evaluation of the Oregon case filing system (OJCIN), public hospital financial data, and federal hospital tax filings to determine if hospitals were screening patients for financial assistance before sending them to debt collectors. Dollar For evaluated large public data sets to assess hospital compliance (or lack thereof) as a whole.

Excerpted Text from HB 3076

ORS 646A.677

(4) Before transferring an unpaid charge for services to a debt collector or referring an unpaid charge for collection, a hospital or hospital-affiliated clinic shall:

(a) Conduct a screening to determine if the patient qualifies for financial assistance as described in ORS 442.614(Requirements for financial assistance policies) (1)(a), if applicable; and

(b) Provide a copy of its financial assistance policy to the patient along with an application for financial assistance.

(5) A hospital or nonprofit hospital-affiliated clinic may conduct the screening described in subsection (3) and (4) of this section using commercially available services, software or online tools.

...

(7) If a patient qualifies for financial assistance under ORS 442.614 (Requirements for financial assistance policies) (1)(a), a hospital, nonprofit hospital-affiliated clinic or other debt collector may not charge interest on the patient’s medical debt.

This report then narrows the scope of its evaluation to ultimately review individual medical debt collection lawsuits and hospital financial assistance training materials. Dollar For found that many Oregonians meant to be protected by HB 3076 were sent to debt collectors and sued in Oregon small claims courts, a venue where the overwhelming majority of defendants do not have lawyers and lack the means to defend themselves.

This report also evaluates the relationship between financial assistance, bad debt, and total patient revenue and concludes that hospitals are not even helping their profit margin by falling short of the screening requirements. The result is a program that fails to bring in hospital revenue, yet leaves thousands of patients with unfavorable court judgments for medical debt they cannot and should not have to pay.



Findings

The overwhelming majority of Oregonians sued for debt do not have a lawyer and do not have the means or ability to defend themselves

Before most of the negative consequences of medical debt occur, such as bankruptcy and poor credit, medical debt must often be sent to a third-party debt collector. As most court records are available to the public, Oregon debt collection lawsuits are a fruitful data source on the scope and state of medical debt in Oregon.

As the majority of Oregon debt collection cases are filed in small claims court, Dollar For reviewed publicly available data on every small claims court case filed in 2022 in Oregon. The data Dollar For accessed for each case typically included the case number, case type, case sub-type, date filed, county, the first named defendant, the plaintiff, the defendant's attorney, the plaintiff's attorney, the total amount awarded at the end of the suit, and the list of pleadings and other documents filed in each case.

This data made clear that in the overwhelming majority of debt collection cases the debtor is not represented by a lawyer, never responds to the suit or appears in court, and ends up losing the case by default for lack of participation. The data show that:

- There were 34,157 small claims court cases filed in Oregon in 2022.
- Of those, 27,133 were consumer debt collection or debt buyer cases.
- Of the 27,133 debt collection and debt buyer cases, the debtor had a lawyer in only 19 cases.
- Of the debt collection and debt buyer cases, 5,390 have resulted in the collector trying to withhold funds from the debtor's bank account or wages.
- Of the debt collection and debt buyer cases, defendants filed a response to the suit in only 697 cases. That means that as many as 25,116 cases were lost by default by patients who may not have even known about the suits against them.¹⁶

Given that medical debt makes up more than half of all recorded debt on credit reports, it is highly likely that the majority of these small claims collection lawsuits are for medical debt. That means that tens of thousands of Oregonians are being sued for medical debt and nearly all of them are without lawyers, resources, or knowledge to defend themselves.

The vast majority of hospitals grant less financial assistance than before HB 3076 became law

The Oregon Health Authority's Hospital Reporting Program collects and [reports data](#) about hospital financials and community benefit.¹⁷ The data show that the vast majority of Oregon hospitals actually grant less financial assistance since HB 3076 went into effect. Excluding Oregon Health & Science University (OHSU), which is an extreme outlier, all Oregon hospitals combined granted over \$33.6 million more financial assistance in 2019, the year before HB 3076 went into effect, than they did in 2021, the year following. Interestingly, OHSU increased its amount of financial assistance awards so much between 2019 and 2021 that it reversed the trend for the entire state. See figures 1 and 2 for representations of total reported hospital assistance in Oregon both including and excluding OHSU over the years before and after the implementation of HB 3076

As shown in Figure 3, out of Oregon's 60 hospitals, 42 granted less financial assistance in 2021 than in 2019. Out of the remaining 18 hospitals, most increases in financial assistance were marginal at best. This is the opposite result one would expect after the implementation of HB 3076. Further, hospitals have admitted to the Oregon Health Authority that they are not screening many patients who are otherwise eligible for financial assistance.

Financial assistance increases statewide with OHSU included

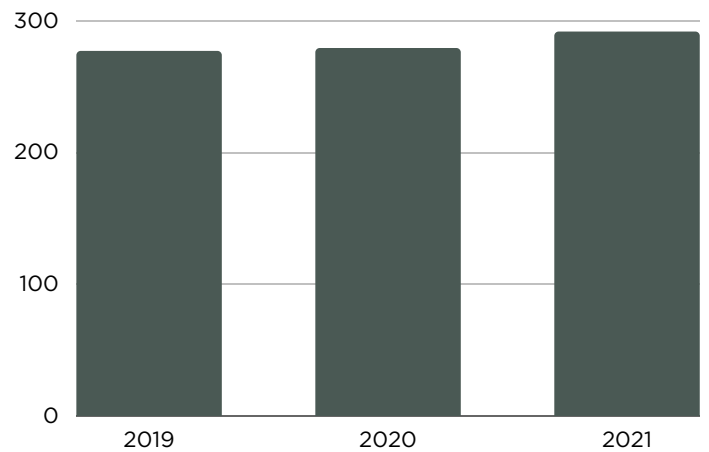


Figure 1: All OR Hospital Financial Assistance in Millions

When OHSU is excluded financial assistance sharply declines

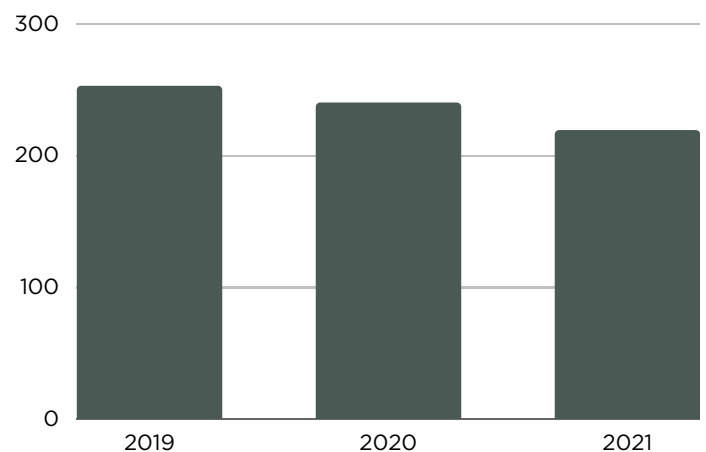


Figure 2: Hospital assistance excluding OHSU in Millions

42 out of 60 hospitals gave less financial assistance in 2021 than 2019

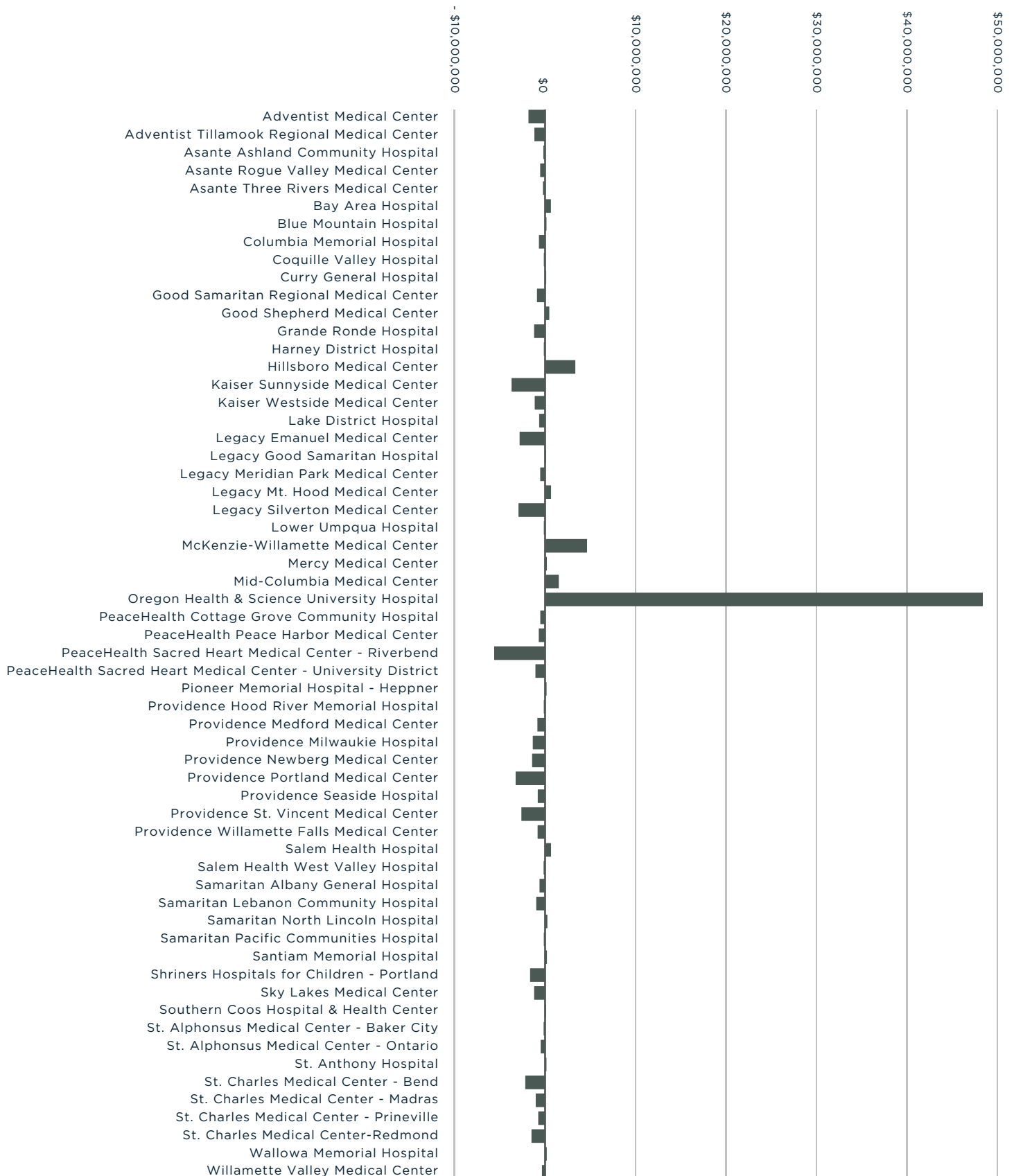


Figure 3: Change in Financial Assistance in 2021 Compared to 2019

An [Oregon Health Authority report](#) from December 2022 on the state of HB 3076 noted that one hospital spent \$7,000 per month mailing financial assistance applications to potentially eligible patients, yet fewer than 1% of patients responded.¹⁸ This implies that the other 99% of likely eligible patients were ultimately sent to collections. The report also noted that “several” hospitals were unsure how long they had to wait after a patient is sent a financial assistance application before it is appropriate to send the patient to collections.¹⁹ This is despite the clear mandate in the law that a patient with income below 200% of FPL must be screened before being sent to collections. The law at no point allows for a scenario where a patient below 200% of FPL can be sent to collections without first being screened.

The OHA report also discussed statements from hospital staff that they use different vendors for billing, debt collection, and processing financial assistance applications and approvals. Staff reported poor communication between these entities, and added that relevant patient financial data is not always shared.²⁰



Placing the burden on patients to apply for financial assistance does not work

Shifting the burden onto the hospital to screen patients before sending their account to a debt collector is a critical component of Oregon's financial assistance law. Whereas hospitals are large organizations with a variety of resources and personnel, individual patients are comparatively limited in their ability to access financial assistance. The Hospital billing systems are one of the most complex systems in the healthcare space, and patients are asked to navigate this system when dealing with illness, recovering from surgery, beginning parenthood, or experiencing one of the many other life-altering events that causes one to accumulate medical debt in the first place. With that in mind, the burden-shifting provision should act as a safety net to ensure overwhelmed patients are screened before they are subjected to the most devastating consequences of debt possession.

SEIU Local 49, the largest union in Oregon, examined the implementation of HB 3076 and [published its findings](#) in October 2022.²¹ One such finding was that hospital financial assistance application processes are unnecessarily complex. The report looked at Oregon's ten largest healthcare systems and found that the majority of policies were still requiring financial assistance applications to be submitted by fax, mail, or in person, despite the availability of established and efficient electronic alternatives.²²

Some hospital applications are very long and ask for irrelevant information. For example, Asante's application asks a patient to fill out 16 different fields with a slew of information about credit cards, property taxes, homeowners insurance, telephone bills, automobile gas, etc²³ - which are all irrelevant to calculating a patient's FPL.

On top of the difficulties of filling out and submitting applications, many hospital departments are not properly trained on financial assistance issues and are unhelpful when patients call for help. However, even if hospitals made applying for financial assistance easy, the mental strain of poverty makes everything more difficult. According to research from Princeton University, the difference in brain function for those facing money problems is equivalent to operating on a full night without sleep.²⁴

Dollar For sees patients struggle with getting through the financial assistance application process every day. Dollar For has a database of most hospital financial assistance policies in the United States that links to a single screening intake form on its website. Patients can be screened for eligibility and provide Dollar For all necessary information to submit an application with the assistance of a trained patient advocate in a matter of minutes. To date, over 22,000 people have filled out Dollar For's financial assistance eligibility screener. However, of those who are eligible, only 30% actually submitted applications to hospitals. This is in spite of multiple email and text message follow-ups and reminders by Dollar For nudging them to move forward with the process.

Further, when patients are left to navigate the system without a group like Dollar For, the chances of getting help drop even lower. The previously-mentioned hospital that spent \$7,000/month on mailing applications to likely eligible patients with a response rate lower than 1% was far less effective at getting eligible patients to apply for financial assistance.²⁵

Given how many patients either never learn of financial assistance options or lack the capacity to get through the application process, the safety net of ORS 646A.677 is all the more important. Yet many low-income patients are “slipping through the cracks” and ending up on the debt collection court dockets throughout Oregon.

Case Study: Evaluation of St. Charles Health System Cases

To get a sense of the number of patients with incomes at or below 200% of FPL referred from hospitals to debt collectors, Dollar For looked at a court list of all small claims cases for 2022 in Oregon. This review did indeed turn up several cases of patients who are likely below 200% FPL. Finding every instance of a low-income patient being sued by a debt collector is difficult, as the patient's income is only listed in select court files where the patient's wages were withheld, or, "garnished." Determining whether a patient's income appeared in the court file requires opening each filing individually to review a series of .pdf or .tif documents. Given that there were 34,157 small claims court cases filed in 2022, Dollar For did not have the resources to evaluate the entire database.

Instead, Dollar For reviewed every file where a garnishment was attempted in cases filed in Deschutes County by the debt collector Ray Klein, Inc. dba Professional Credit Service for the first three months of 2022. A review of the cases made clear that the majority of court filings by Professional Credit Service in Deschutes County are on behalf of the St. Charles Health System. The search yielded a sufficient density of hospital debt collection cases in a sample size that was large enough to be relevant but small enough to allow Dollar For to review every file.

In the first three months of 2022, Professional Credit Service filed 313 debt collection cases in Deschutes County. In 15% (47) of those cases, Professional Credit Service pursued some form of garnishment. In only 55% (26) of those cases did the entity that received the garnishment order (whether an employer or bank) file a response. 34% (9) of those garnishment responses contained the patient's income. As shown in Figure 4, in 44% (4) of those cases where the patient's income was visible, the patient was below 200% FPL assuming a household size of one.²⁶ In this instance, of the cases where Dollar For can see the patient's income, nearly half of patients sued were likely at or below 200% FPL. These patients should never have had their debt referred to a collector without a financial assistance screening.

4 in 9 patients in debt collection are likely entitled to 100% discount on out-of-pocket costs

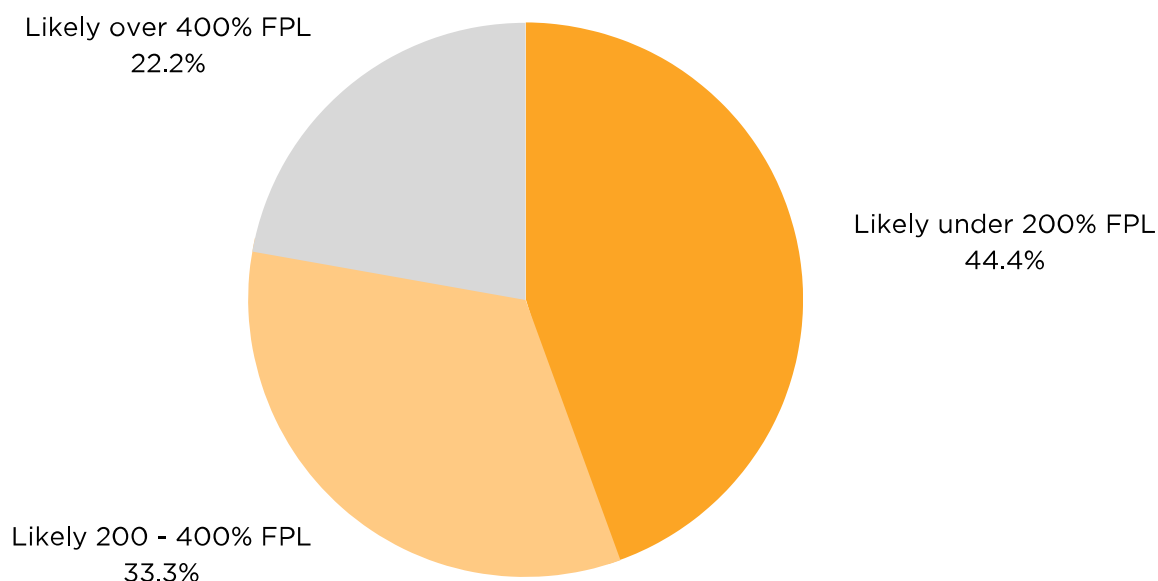


Figure 4: Estimated defendant FPL in St. Charles garnishment cases Q1 2022

By their own reporting, Oregon hospitals do not screen many eligible patients for financial assistance

Many hospitals also report to the IRS on their 990 Schedule H form that large swaths of their bad debt is likely eligible for financial assistance. In some instances, hospitals report carrying more debt that is eligible for financial assistance as “bad debt” than they actually granted in financial assistance for the year.

Legacy Emanuel in Portland, for example, reported that it accrued over \$28.1 million in bad debt for the fiscal year ending March 2021.²⁷ In its Schedule H, however, the hospital estimated that over \$20 million — over two-thirds of its total bad debt — was actually eligible for financial assistance. It is also worth noting that the hospital granted over \$16.5 million in financial assistance during that time.²⁸ Not only is most of Legacy Emanuel’s bad debt likely eligible for financial assistance, the amount of debt eligible for but not granted relief is more than the hospital granted in financial assistance for that year. Legacy Emanuel calculates the amount of bad debt likely eligible for financial assistance by calculating the number of people who would be eligible for financial assistance in Legacy Emanuel’s service area using census data.²⁹

Financial assistance-eligible bad debt is visible throughout Oregon:

- Asante estimates that, for the fiscal year ending in September 2022, over \$2.8 million of the total \$21.1 million in bad debt is eligible for financial assistance. However, in calculating that figure, Asante states that only 13.7% of people in their service area are eligible for financial assistance. According to Census data, 13.7% correlates to approximately the number of people with incomes at or below 100% of FPL in Jackson County, OR.³⁰ Oregon law requires financial assistance screening for anyone at or below 200% FPL, and financial assistance must be available for patients up to 400% FPL, thus Asante's calculation is extraordinarily low.
- Salem Hospital estimates that for the fiscal year ending in June of 2020, of its over \$11.7 million in bad debt, over \$7.1 million was eligible for financial assistance. It calculated that number by evaluating the data in its patient accounting system against census data for its service area.³¹
- Portland Adventist Medical Center estimates that for the fiscal year ending Dec. 2020, of the over \$3.6 million in bad debt, \$956,882 is eligible for financial assistance. However, it did not state how it calculated that figure.³²

Failing to screen so many patients for financial assistance is devastating for patients and largely irrelevant to hospitals. According to the figures above, hospitals estimate that large amounts of money going uncollected are eligible for financial assistance. Grants of financial assistance could be increased by tens of millions of dollars a year, while only impacting bad debt, not net patient revenue. Historic data on the relationship between financial assistance, bad debt, and net patient revenue further supports this reality.

Increasing financial assistance lowers bad debt but does not meaningfully impact net patient revenue

When tracking revenue and profitability, most businesses separately account for bad debt. While bad debt is a somewhat subjective concept, at its core it is the amount of money an organization has billed for services or products but believes it is very unlikely to collect. Hospitals often argue that expanded financial assistance would only worsen the already poor financial health of hospitals. Yet data on hospital bad debt, financial assistance, and net patient revenues indicate that an increase in financial assistance reduces bad debt and has no effect on net patient revenue.

The accounting definition of “bad debt” changed at the end of 2018 for most organizations. Before the change, hospitals would report any difference between their chargemaster price (the “sticker price”) and the amount paid as “bad debt.” This number was always inflated because the chargemaster rate is widely known to be artificially high — its real purpose is to serve as a starting point in insurance reimbursement negotiations.³³

The Financial Accounting Standards Board (FASB), which has authority to establish generally accepted accounting principles (GAAP), changed what hospitals may consider “bad debt,” a change that went into effect at the end of 2018.³⁴ The new definition tightens the way organizations may calculate revenue or expected revenue. Before the change, if a hospital’s chargemaster rate was \$1,000, but they negotiated an insurance payment rate of \$600, the hospital would often claim \$400 as so-called “bad debt.” The 2018 change by FASB means that organizations, including hospitals, cannot consider the difference between the paid price and the chargemaster price as “bad debt” if they never reasonably expected to be paid the chargemaster price. The rule change included an example of how a hospital may use this rule.

In the FASB update, the Board imagined a hypothetical hospital providing emergency services to a patient as follows. The chargemaster price for the services is \$10,000. The hospital in the example then evaluates the patient and their financial situation to determine if they are eligible for financial assistance or government subsidies. After the evaluation and a review of historical collection rates from patients in similar circumstances, the hospital expects to collect \$1,000 from the patient. Under the new FASB rule, this hospital could only report up to \$1,000 in bad debt if the patient did not pay. The remaining \$9,000 between the amount the hospital expects to collect and the chargemaster price is considered an implicit price concession.³⁵

The [data](#) on hospital financial assistance, bad debt, and net patient revenue suggests that when hospitals offer more financial assistance, they reduce bad debt rather than net patient revenue. This makes sense given that financial assistance only applies to emergency or medically necessary services that would otherwise be paid directly by the patient. Such scenarios occur either in the form of an uninsured patient without government coverage who is charged the entirety of their bill, or an insured patient who is asked to pay some form of co-payment or deductible. As shown in Figure 5, this category of self pay revenue only accounts for 1.6% of all hospital revenue in Oregon.³⁶

Only 1.6% of net patient revenue was from self-pay sources from Q1 2021 - Q2 2022

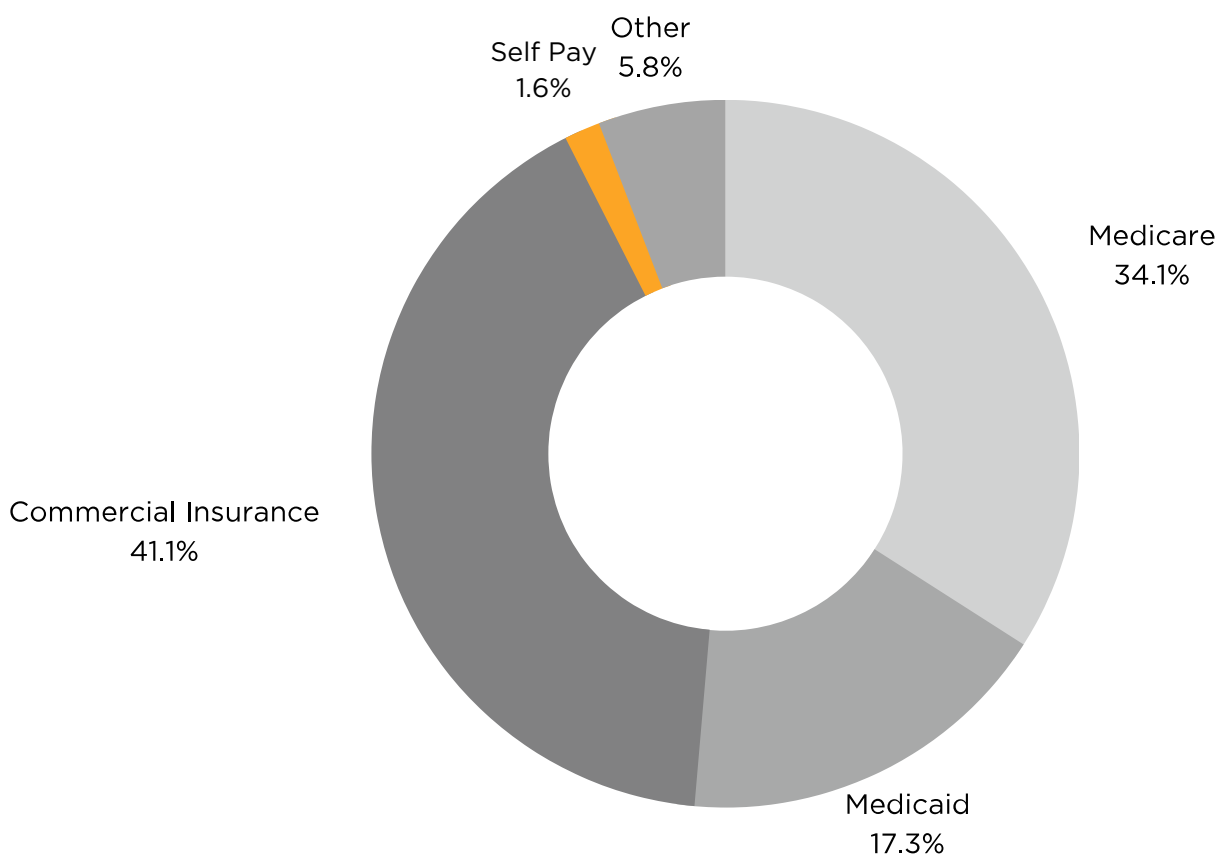


Figure 5: Net Patient Revenue Sources OR hospitals

Dollar For graphed the net patient revenue, bad debt, and financial assistance from 2010 to 2021 for the five hospitals in Oregon that had the greatest increase in financial assistance granted from 2019 to 2021.³⁷ Some interesting trends appear.

First, the data show that there is no clear correlation between how much financial assistance is allotted by a hospital and the hospital's net patient revenue. In the example of OHSU in Figure 6, net patient revenue increased significantly even while financial assistance also went up. See Appendix B for similar charts for other hospitals.

Second, there is a clear inverse relationship between how much financial assistance is awarded and how much bad debt a hospital carries starting in calendar year 2019, which is the first full year that the new method of calculating bad debt was required by FASB (which excludes financial assistance from bad debt). From 2019 on, the more financial assistance awarded the less hospitals accumulate bad debt — all while patient net revenue remains the same or increases. Accordingly, it would appear that hospitals sending financial assistance-eligible patients to third-party debt collectors instead of granting them assistance accomplish nothing but keeping their bad debt numbers artificially inflated.

As financial assistance giving increases it only decreases bad debt. Net patient revenue continues to go up.

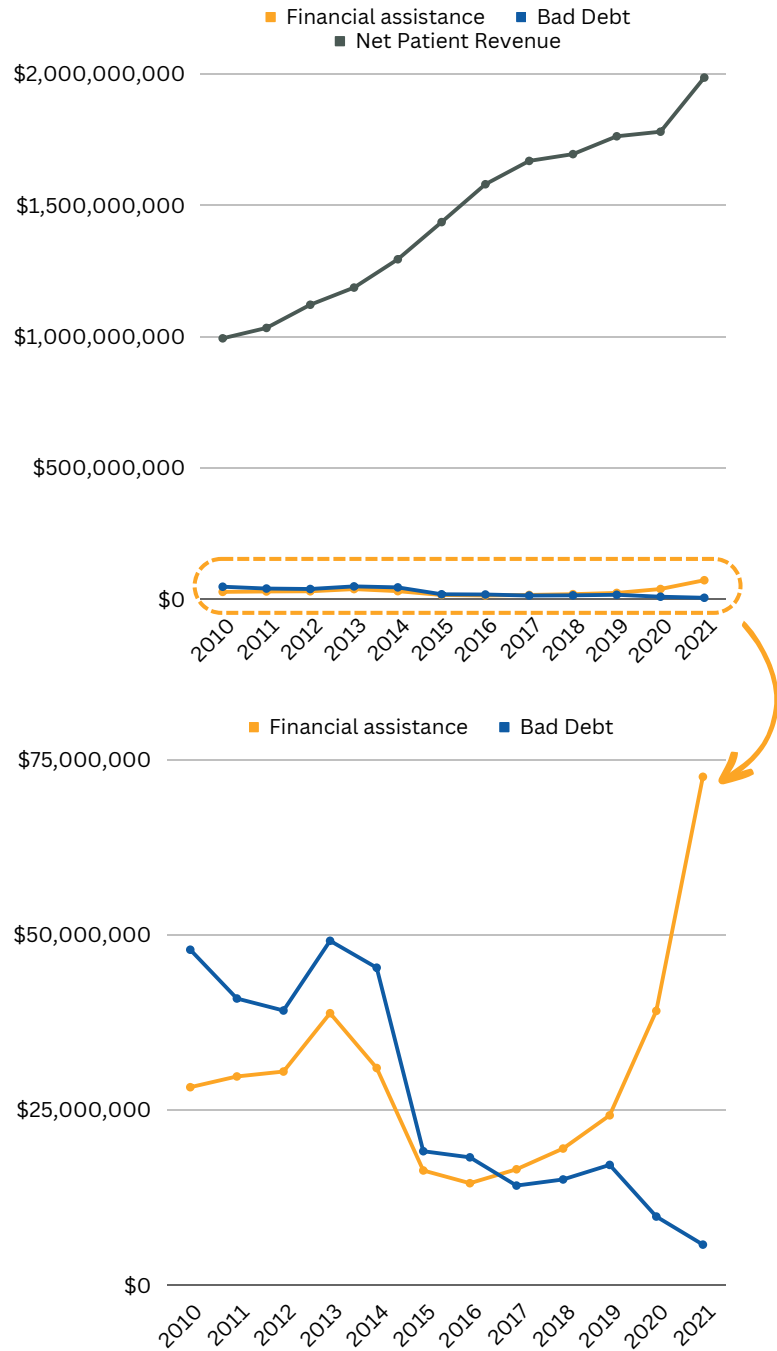


Figure 6: OHSU Financial Assistance, Bad Debt & Net Patient Revenue

Presumptive eligibility grants increase financial assistance

The vast majority of financial assistance policies allow hospitals to grant financial assistance via “presumptive eligibility.” In other words, if the hospital has reason to believe a person is at or below a certain FPL threshold, the hospital will grant assistance without requiring the patient to apply. Sometimes these policies require some other prerequisite; for example, that the patient be receiving government benefits such as food stamps, un-housed status, etc. Sometimes these policies simply allow a hospital to grant assistance if it suits them to do so. A public record request to OHSU revealed that it has a robust presumptive eligibility system baked into its financial assistance program.

OHSU provided Dollar For with its training handbook entitled “Medicaid/Financial Assistance Screening Training.” It discusses in depth how staff should handle patient financial assistance. According to the manual, OHSU utilizes at least one commercially available software product sold by a credit reporting agency. It accumulates data from credit bureaus, the Social Security Administration, the Census Bureau, and other data warehouses. OHSU uses the tool to run an informal inquiry on a patient’s credit report and the software returns an estimated FPL percentage for the patient. If the software indicates a patient is at or below 300% FPL, then financial assistance is automatically applied to the patient’s account without the need for the patient to apply. If the patient is over 300% FPL, they are required to go through the hospital’s application process.

While a tool like this may be helpful in the right hands, the manual indicates that this system returns some results that could be counterproductive in less friendly hands. For example, the software returns a ranking for “Propensity to Pay” and a “Propensity to Pay Score.” While the OHSU manual explicitly instructs employees not to use that information, it could be used by a less than well-meaning organization to pursue collection from patients regardless of their estimated FPL if their propensity to pay score is high. While commercial tools for granting presumptive eligibility may be useful, they are not yet a silver bullet.

Overall, OHSU increased its financial assistance giving after HB 3076 went into effect far more than any other hospital in Oregon. In 2019, the year before HB 3076 went into effect, OHSU granted \$24.3 million in financial assistance. In 2020 it granted \$39.2 million. In 2021 that number jumped to \$72.6 million. That is a 298% increase in financial assistance grants in two years, all while net patient revenue at OHSU continued to climb. It seems likely that OHSU’s robust presumptive eligibility system in its financial assistance department is at least somewhat responsible for the increase in financial assistance without impacting net revenue.

Recommendations

Hospitals should take seriously their legal obligation to screen all patients for financial assistance before sending them to collections. The simple act of being referred to collections can have serious consequences to a patient's life. Collecting or attempting to collect a bill without screening patients for 200% FPL or below is also an unlawful collection practice in Oregon, and opens both the hospital and debt collector up to liability.³⁸ Further, the data shows that saddling patients with medical debt affects their health and causes many patients to avoid care. This coupled with the data that suggests increasing grants of financial assistance does not affect patient net revenue means that not screening patients is a lose-lose. Patients are losing in obvious ways and hospitals are negatively affecting patient health for no financial gain. The only entities coming out ahead in the current environment are third party debt collection agencies.

Hospitals should bake financial assistance screening into their procedures at intake or discharge with every patient. Hospitals are caught in an old paradigm that places too much responsibility on the patient to the detriment of all. By the time a patient has received services and moved on to recovery, it's too late. Hospitals always manage to get insurance information before a patient is discharged — they should be able to get a patient's household size and income to calculate their FPL as well.

Hospitals should modernize their communication methods surrounding financial assistance. Many hospitals require patients to fax or hand-deliver applications or proof of finances. This is somewhat understandable given other regulatory requirements for patient data privacy such as the Health Insurance Portability and Accountability Act (HIPAA). However, these methods are outdated and often nearly impossible for many patients to utilize. Specifically, hospitals should have secure online portals as options for communication and document retention.

Dollar For calls on all hospitals to think about financial assistance and patient self pay revenue differently. Self pay revenue is a marginal line item on hospital income statements—but is the leading cause of bankruptcy in the United States. The mental and physical anguish of medical debt directly works against the crucial and heroic service hospitals provide their communities: keeping them well and saving their lives. The sheer pointlessness of medical debt in Oregon shows that it is not the result of hospital greed or malice, but inertia and context. Hospitals can better serve the health of the communities they serve by striving to forgive as much financial assistance as possible instead of meeting their minimum obligation.

Appendices

Sample of Oregon debt collection cases

Case No. 22SC01464

In Case No. 22SC01464 Professional Credit Service sued a defendant for \$1,457.61 in principal and \$27.68 in interest in charges from St. Charles Medical Group Redmond, Mosaic Medical, and St. Charles Redmond. After obtaining a default judgment against the defendant, Ray Klein garnished the defendant's wages. The garnishment filings show that the defendant worked at Wal-Mart earning \$948.06 bi-weekly. For a household of one this would put them at 181% FPL.

Case No. 22SC01988

In Case No. 22SC01988 Professional Credit Service sued a defendant for \$576.02 in principal and \$175.96 in interest. They listed the creditors as St. Charles Redmond and St. Charles Medical Group Redmond. After obtaining a default judgment against the defendant, Professional Credit Service garnished the defendant's wages. The garnishment filings show that the defendant averaged \$1,032.02 paid bi-weekly. As a household of one, this would put the defendant at 197% FPL.

Case No. 22SC01992

In Case No. 22SC01992 Professional Credit Service sued a defendant for \$3,537.99 in principal and \$75.49 in interest. It listed the creditors as St. Charles Medical Center Bend and NW Brain & Spine. After receiving a default judgment, it garnished the defendant's wages from the bank Washington Federal. The garnishment filings indicate the defendant was paid \$1,326 paid every two weeks. This would put the defendant at 234% FPL for a household of 1.

Case No. 22SC02597

In Case No. 22SC02597 Professional Credit Service sued a defendant for \$557.43 in principal and \$28.41 in interest. It listed the creditors as St. Charles Medical Center Bend, Mosaic Medical, and St. Charles Redmond. After receiving a default judgment, Professional Credit Service garnished the defendant's wages from Wal-Mart. Their average pay was \$1,009.02 bi-weekly. For a household of 1 that puts the defendant at 193% FPL.

Case No. 22SC03424

In Case No. 22SC03424 Professional Credit Service sued a defendant for \$1,250.04 in principal and \$28.08 in interest. It listed the creditors as St. Charles Medical Group Bend, St. Charles Medical Center Bend, and Ortho&Neurosrg CTR-HRO/PCS AS. After receiving a default judgment, Professional Credit Service garnished the defendant's wages. The garnishment filings indicate the defendant made \$3,006.71 bi-weekly. For a household of 1 this defendant would be 575% FPL.

Case No. 22SC03999

In Case No. 22SC03999 Professional Credit Service sued a defendant for \$1,154.54 in principal and \$128.75 in interest. It listed the creditors as St. Charles Medical Center Bend and Salem Clinic. After obtaining a default judgment, Professional Credit Service garnished the defendant's wages. The garnishment filings indicate the defendant made \$3,003.80 in gross wages bi-weekly. For a household of 1 this would put the defendant at 574% FPL.

Case No. 22SC04612

In Case No. 22SC04612 Professional Credit Service sued a defendant for \$1,383.26 in principal and \$142.95 in interest. It listed the creditors as St. Charles Medical Center Bend and Mosaic Medical. After obtaining a default judgment, Professional Credit Service garnished the defendant's wages from Fred Meyer. The garnishment filings indicate they made, on average, \$440/week. For a household of 1 this would put them at 168% FPL.

Case No. 22SC07867

In Case No. 22SC07867 Professional Credit Service sued a defendant for \$2,156.69 in principal and \$104.43 in interest. It listed the creditors as St. Charles Medical Center Bend and St. Charles Medical Group Bend. After obtaining a default judgment, Professional Credit Service garnished the defendant's wages from Rent-A-Center. The garnishment filings indicate the defendant's gross wages were \$800/week. For a household of 1 that would put the defendant at 306% FPL.

Case No. 22SC07869

In Case No. 22SC07869 Professional Credit Service sued a defendant for \$692.28 in principal and \$57.18 in interest. It listed the creditors as St. Charles Redmond, Bend Surgery, and Desert Orthopedics. After obtaining a default judgment, Professional Credit Service garnished the defendant's wages. The garnishment filings indicate the defendant's gross wages were \$5,188.25 bi-weekly. For a household of 1 that would put the defendant at 992.55% FPL.

It should be stressed that this issue persists across Oregon and is not simply an issue at St. Charles. For example, the following cases were found without difficulty:

Case No. 22SC00233

In Case No. 22SC00233 General Credit Service, Inc. sued on behalf of Asante for \$1,690.23. After receiving a default judgment, they successfully garnished the defendant's wages. According to the garnishment response the defendant's gross income was \$2,233.78. If this defendant is a household of one, they are at 197% FPL and eligible for 100% financial assistance.

Case No. 22SC01177

In Case No. 22SC01177 General Credit Service, Inc. sued on behalf of Asante for \$1,284.65. After receiving a default judgment, they garnished the defendant's military benefits pay from the Defense Finance and Account Service. The defendant made \$1,715.20 per pay period, which based on the Defense Finance and Accounting Service website, a pay-period is likely 1 month. If the defendant is a household of one, they are at 151.43% FPL and eligible for 100% financial assistance.

Case No. 22SC10158

In Case No. 22SC10158 General Credit Service Inc. sued on behalf of Asante for \$605.54. After receiving a judgment, Asante garnished the defendant's wages from Asante, where he was also employed. The court filing does not list the defendant's wages or job title, but an internet search suggests he works as a Patient Access Rep. The starting wage for that job at Asante is \$16.66/hr, or \$33,320/year. That would make the defendant at 182.09% FPL for a household of 1 and eligible for 100% assistance.

Case No. 22SC11075

In Case No. 22SC11075 General Credit Service Inc. sued on behalf of Asante for \$595.83. After receiving a default judgment, Asante garnished the defendant's wages. The defendant's pay in the court file averages \$1,363.92 biweekly. That would make the defendant at 193.54% FPL for a household of 1 and eligible for 100% assistance.

Case No. 22SC00397

In Case No. 22SC00397 Western Mercantile Agency Inc. sued the defendant on behalf of Bay Area Hospital for \$1,522.40. After receiving a default judgment, it garnished the defendant's wages from the Oregon Department of Human Services. The defendant makes \$1,939.23 gross per month. If they have a household of 1 they are at 171.21% FPL and eligible for 100% financial assistance.

Case No. 21SC24526

In Case No. 21SC24526 Western Mercantile Agency Inc. sued the defendant on behalf of Bay Area Hospital for \$1,288.83. After receiving a default judgment, it garnished the defendant's bank account and then garnished their wages. The wage garnishment filings indicate the defendant made about \$470/week. For a household size of 1 that puts them at 179.84% of FPL and eligible for 100% financial assistance.

Case No. 22SC00397

In Case No. 22SC00397 Western Mercantile Agency Inc. sued the defendant on behalf of Bay Area Hospital for \$4,619.66. After receiving a default judgment, it garnished the defendant's wages. The wage garnishment filings indicate the defendant made \$1,939.23/month. For a household size of 1 that puts them at 171.21% of FPL and eligible for 100% financial assistance.

Case No. 22SC10366

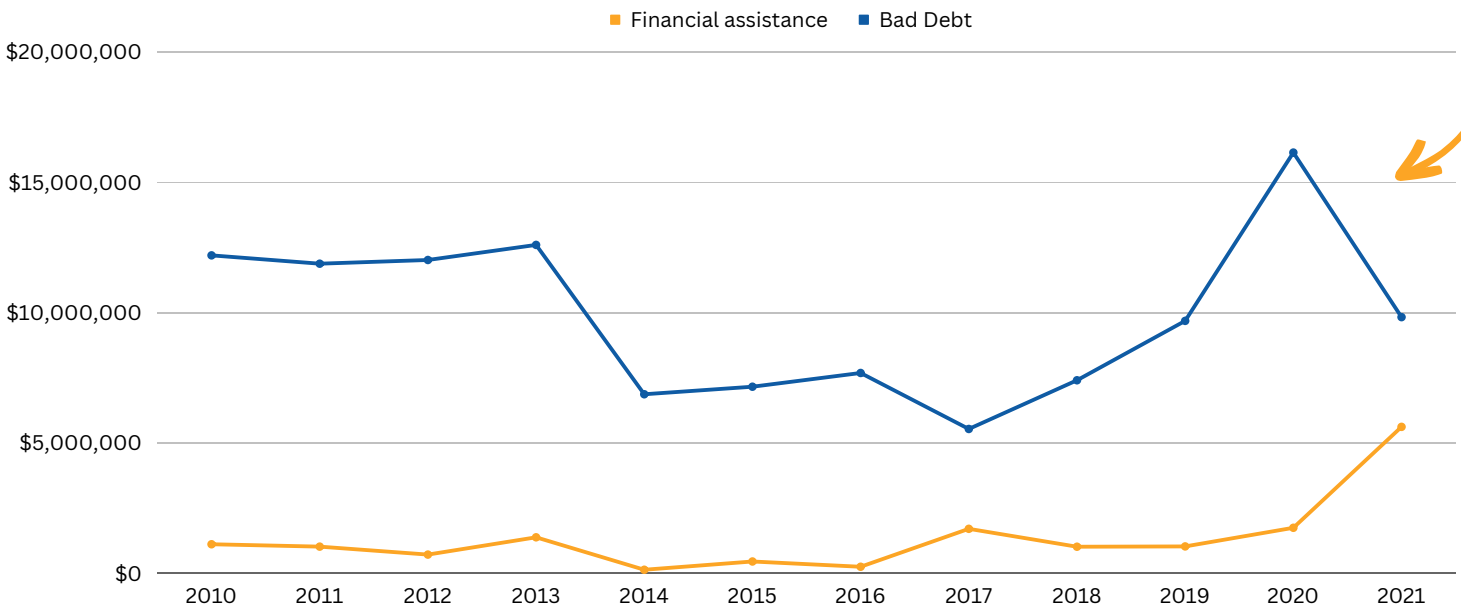
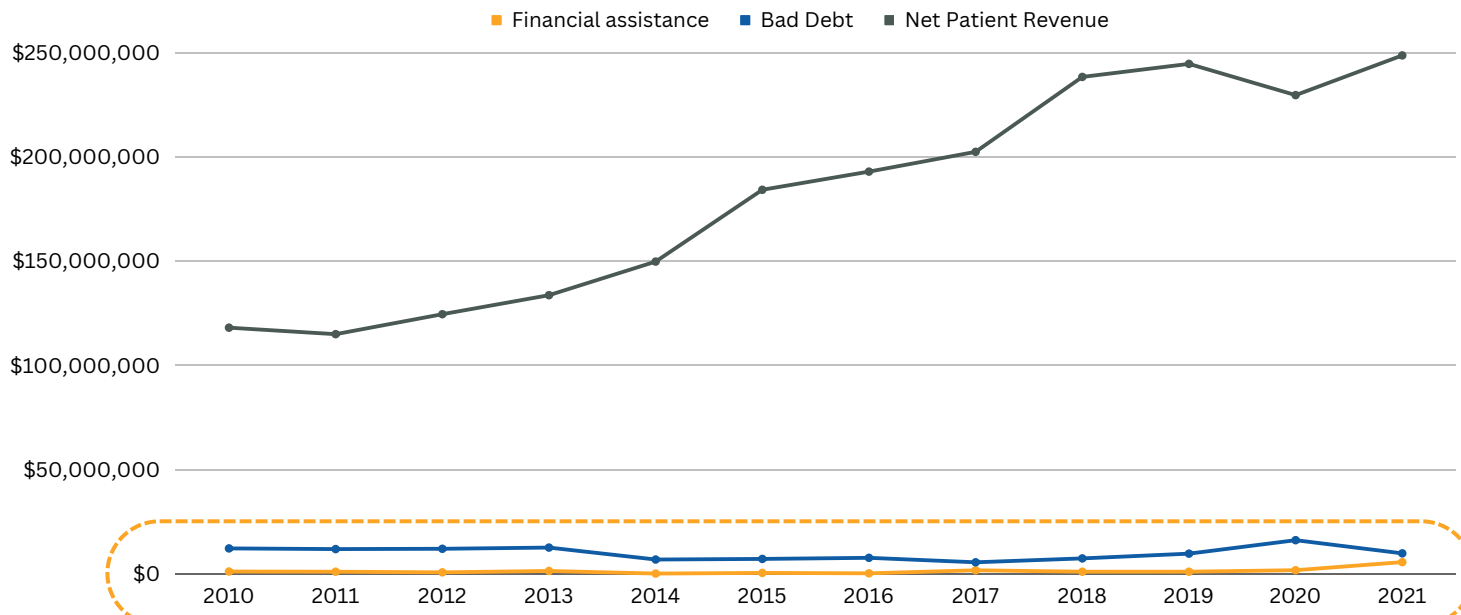
In Case No. 22SC10366 Western Mercantile Agency Inc. sued the defendant on behalf of Bay Area Hospital for \$1,918.80. After receiving a default judgment, it garnished the defendant's wages. The wage garnishment filings indicate the defendant averaged \$714.30 in bi-weekly pay. For a household size of 1 that puts them at 136.60% of FPL and eligible for 100% financial assistance.

The Oregon small claims dockets are filled with similar cases.

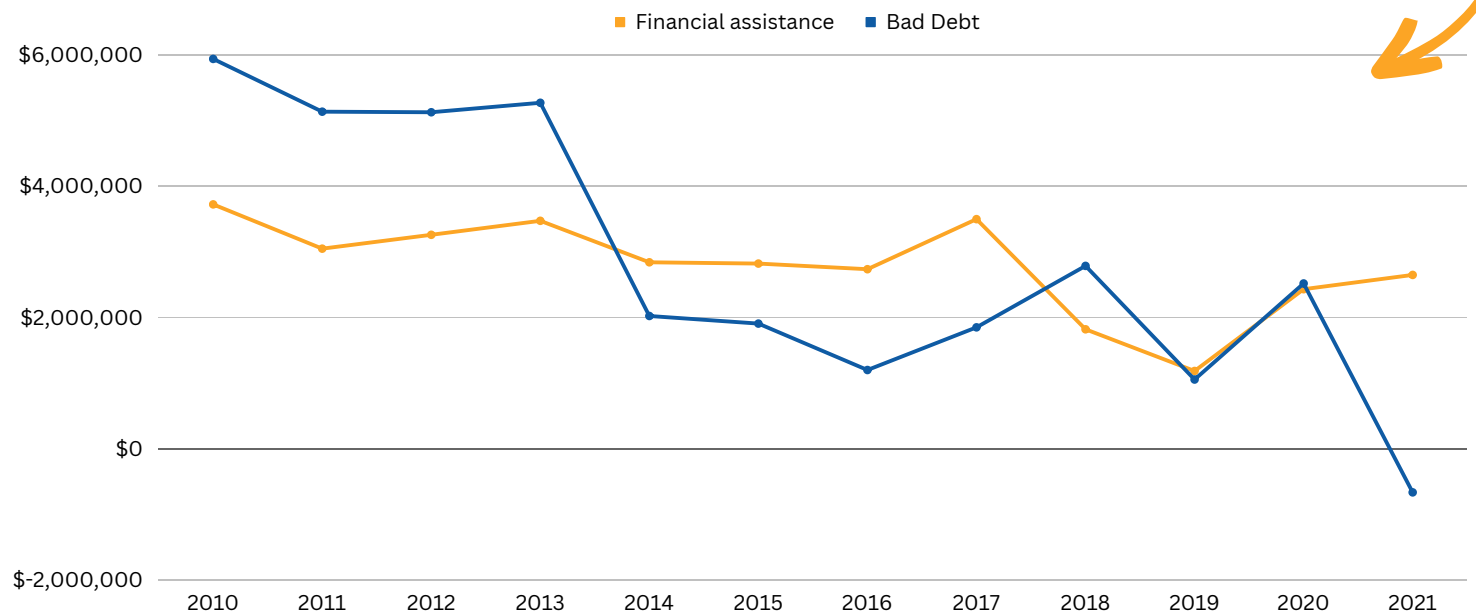
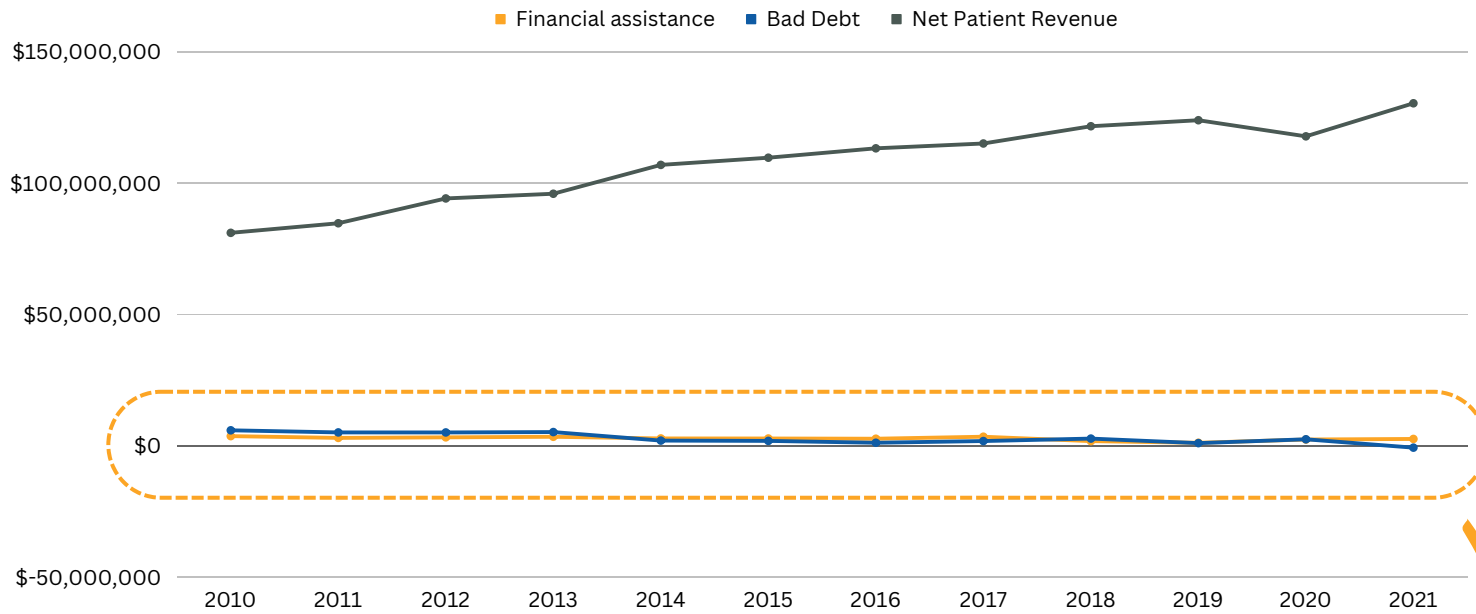
Study of relationships between financial assistance, bad debt and net revenue

When financial assistance increases, bad debt decreases, but net patient revenue is unaffected.

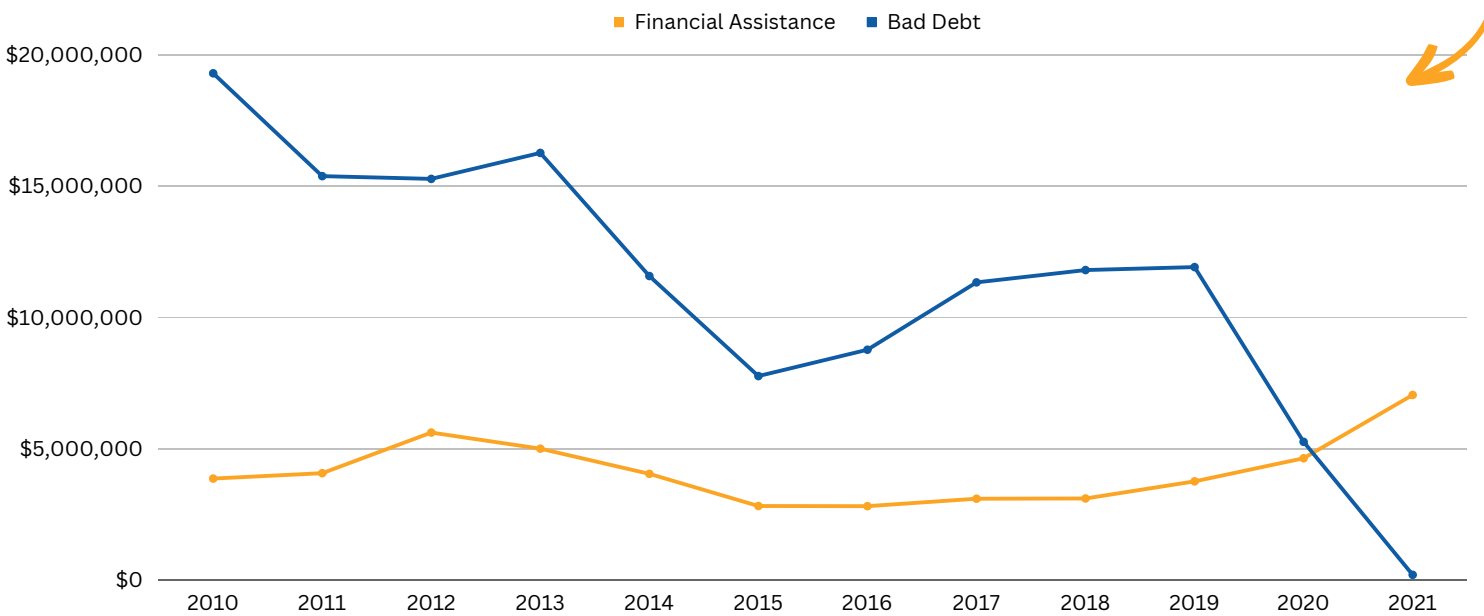
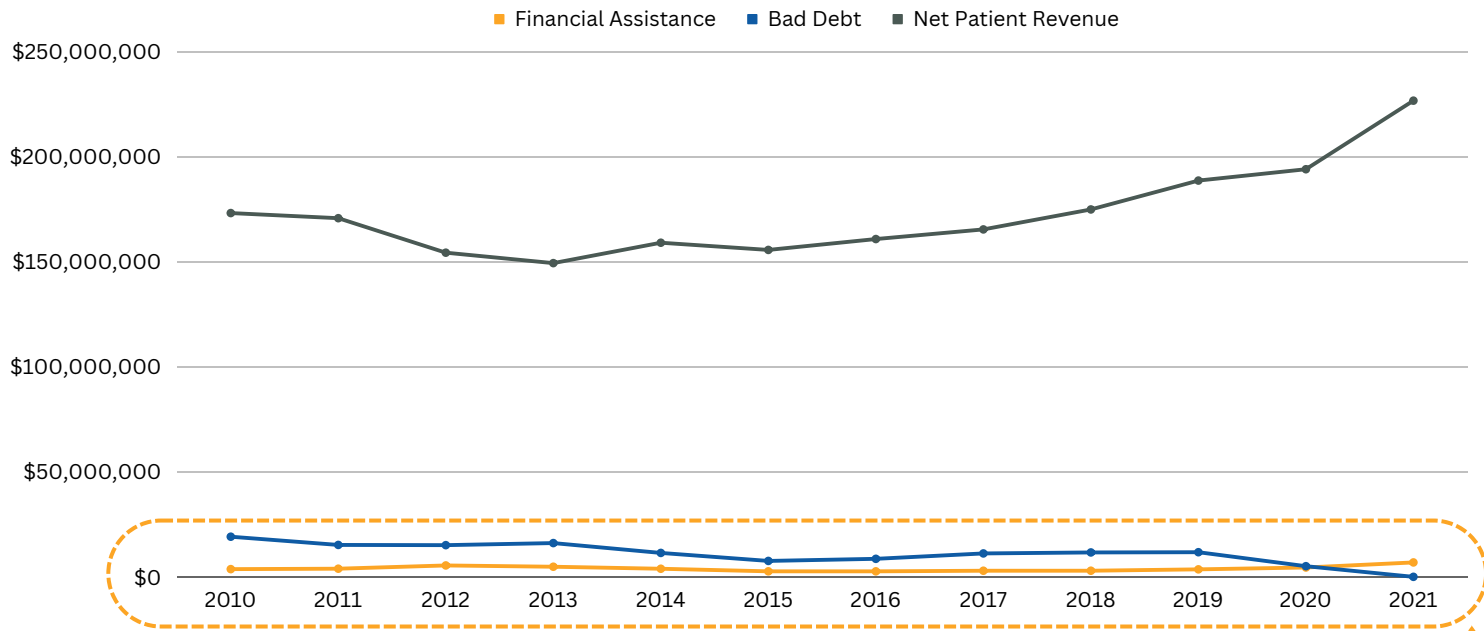
McKenzie-Willamette Medical Center



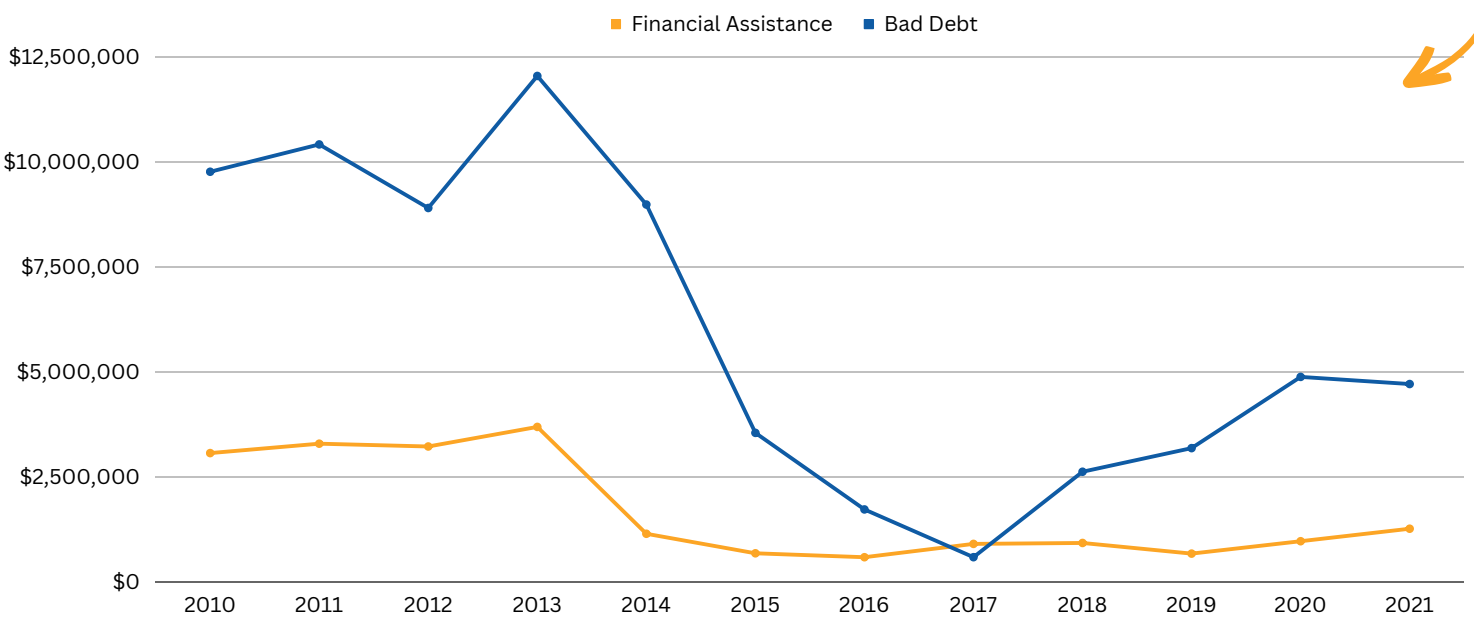
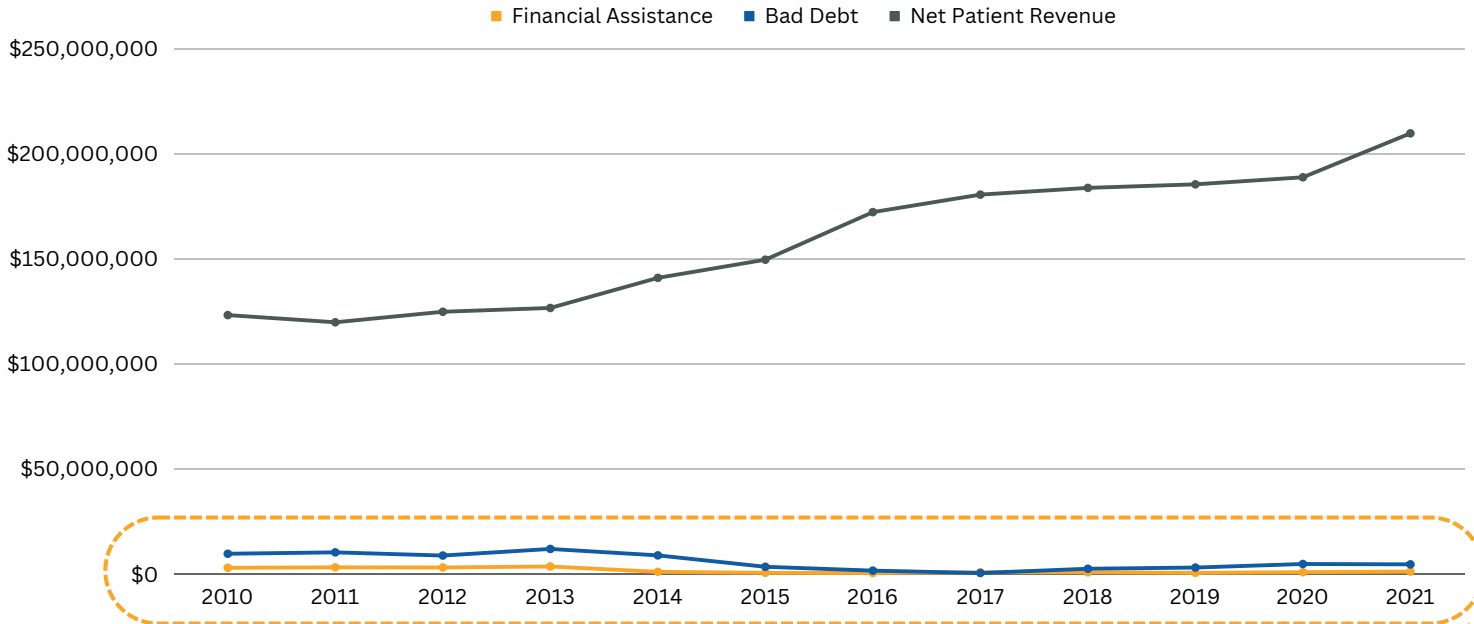
Mid-Columbia Medical Center



Hillsboro Medical Center



Bay Area Health



Endnotes

1. *Medical Debt Burden in the United States*, Consumer Financial Protection Bureau (Feb. 2022), available at, https://files.consumerfinance.gov/f/documents/cfpb_medical-debt-burden-in-the-united-states_report_2022-03.pdf [hereinafter CFPB Report].
2. Id.
3. Id.
4. Id.
5. Id.
6. Id.
7. *How America's top hospitals hound patients with predatory billing*, Axios.com, <https://www.axios.com/hospital-billing#interactive> (last visited Feb. 20, 2023).
8. Id.
9. CFPB Report, *supra* note 1 at 27.
10. Id.
11. CFPB Report, *supra* note 1 at 4.
12. Id. at 32.
13. Id. at 32 (citing Adams, Alyce et al. "The Impact of Financial Assistance Programs on Health Care Utilization." National Bureau of Economic Research. August 31, 2021)
14. Id. at 15-23; Urban Institute, <https://apps.urban.org/features/debt-interactive-map/?type=overall&variable=totcoll&state=41> (last visited Feb 23, 2023).
15. IRS, <https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r> (last visited Feb 20, 2023).
16. However many cases are still open so that may increase.
17. Oregon Health Authority, <https://www.oregon.gov/oha/hpa/analytics/pages/hospital-reporting.aspx> (last visited Feb. 20, 2023)
18. HB 3076 Implementation Report, Oregon Health Authority (December, 2022), available at https://www.oregon.gov/oha/HPA/ANALYTICS/HospitalReporting/HB-3076-Comm-Benefit-Leg-Report.pdf?utm_medium=email&utm_source=govdelivery [hereafter HB 3076 Implementation Report].
19. HB 3076 Implementation Report, *supra* note 17 at 20.
20. Id. at 21.
21. *Shortchanged: How hospital financial assistance practices and policies fail oregon patients with the greatest need*, SEIU Local 49 (October, 2022), available at https://static1.squarespace.com/static/5c410100cc8fed8a660f968c/t/6340a82e876a152fbb205782/1665181742724/Shortchanged_final.pdfhttps://static1.squarespace.com/static/5c410100cc8fed8a660f968c/t/6340a82e876a152fbb205782/1665181742724/Shortchanged_final.pdf [hereafter Shortchanged].
22. Id. at 9.
23. Id. at 10.
24. *Poor concentration: Poverty reduces brainpower needed for navigating other areas of life*, Princeton University (Aug. 29, 2013), available at <https://www.princeton.edu/news/2013/08/29/poor-concentration-poverty-reduces-brainpower-needed-navigating-other-areas-life>
25. HB 3076 Implementation Report, *supra* note 17 at 20.

26. Neither the household size nor income of any other household members of the patient is known. These are both relevant factors to calculating FPL.
27. Pro Publica Nonprofit Explorer, *available at* <https://projects.propublica.org/nonprofits/organizations/930386823/202230469349302823/IRS990ScheduleH>
28. Pro Publica Nonprofit Explorer, *available at* <https://projects.propublica.org/nonprofits/organizations/930386823/202230469349302823/IRS990ScheduleH>
29. Pro Publica Nonprofit Explorer, *available at* <https://projects.propublica.org/nonprofits/organizations/930386823/202230469349302823/IRS990ScheduleH>
30. US Census Data, available at <https://www.census.gov/quickfacts/medfordcityoregon?>
31. Pro Publica Nonprofit Explorer, *available at* <https://projects.propublica.org/nonprofits/organizations/930579722/202121359349302322/IRS990ScheduleH>
32. Pro Publica Nonprofit Explorer, *available at* <https://projects.propublica.org/nonprofits/organizations/930429015/202133149349306683/IRS990ScheduleH>
33. The New York Times, <https://www.nytimes.com/interactive/2021/08/22/upshot/hospital-prices.html> (last visited Feb 20, 2023)
34. *Revenue from Contracts with Customers (Topic 606)*, https://www.fasb.org/Page/ShowPdf?path=ASU+2014-09_Section+A.pdf&title=UPDATE+NO.+2014-09%E2%80%94REVENUE+FROM+CONTRACTS+WITH+CUSTOMERS+%28TOPIC+606%29+SECTION+A%E2%80%944SUMMARY+AND+AMENDMENTS+THAT+CREATE+REVENUE+FROM+CONTRACTS+WITH+CUSTOMERS+%28TOPIC+606%29+AND+OTHER+ASSETS+AND+DEFERRED+COSTS%E2%80%94CONTRACTS+WITH+CUSTOMERS+%28SUBTOPIC+340-40%29&acceptedDisclaimer=true&Submit= (last visited Feb 20, 2023)
35. Id. at 73-74
36. Oregon Health Authority Databank dataset for the year of 2021 and first two quarters of 2022. The Databank is accessed at <https://www.oregon.gov/oha/hpa/analytics/pages/hospital-reporting.aspx>
37. See Appendix B.
38. ORS 646.639(10).