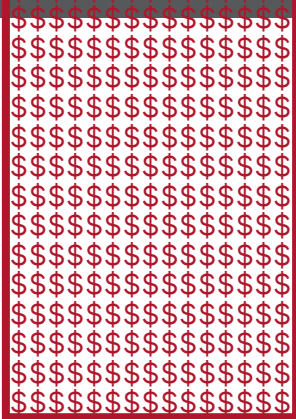




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Washington's Charity Care System, its Shortfalls,  
and the Effect on Low-Income Patients





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# Executive Summary

**Hospital debt is one of the leading reasons why low-income families and individuals remain trapped in poverty in the United States.**<sup>1</sup> A single injury or medical issue requiring hospital care can trigger devastating financial consequences such as housing instability, loss of savings, additional debt by borrowing from others, wage garnishment, deprivation of necessities, and bankruptcy.<sup>2</sup> Individuals with hospital debt are far more likely to deny themselves further hospital care or other medical treatment such as follow-up visits or prescriptions.<sup>3</sup> Washington State's charity care law should help prevent some of these consequences, but hospitals are implementing their charity care policies in ways that create barriers for patients and deny access to needed assistance.

Charity care is hospital care provided for free or at reduced cost to patients whose income falls below 200% of the federal poverty line.<sup>4</sup> Hospital charity care laws have been in place in Washington since 1989, and are meant to ensure that health care is not out of reach for those who cannot afford it.<sup>5</sup>

According to charity care law, hospitals have an *affirmative* duty to make an initial determination of possible charity care eligibility based on information from or about the patient.<sup>6</sup> This means that hospitals should be proactive in assessing whether a patient may be eligible for free or reduced-cost care, instead of waiting for the patient to apply. Hospitals must provide written notification to patients that free or discounted care may be available.<sup>7</sup> Additionally, hospitals must interpret the information for patients who have limited English proficiency.<sup>8</sup>

Recently, evidence is mounting that patients are not receiving the charity care that they are entitled to because of improper hospital policies and practices. Two central Washington hospitals were successfully sued in a class action and have agreed to pay \$4.5 million in damages because they failed to screen patients for charity care eligibility before demanding up-front deposits or other payments.<sup>9</sup> There are other cases relating to charity care access pending.

A 2016 Washington Community Action Network (WA CAN) report found that hospital debt collectors in Pierce County were garnishing the wages of patients who should have qualified for charity care.<sup>10</sup> Many patient advocates and social service providers have similarly reported that their clients qualify for charity care, but are not receiving it.

The litigation, the stories from patients and service providers, the WA CAN report, and accounts from legal advocates across the State, led Columbia Legal Services (CLS) to investigate these reported practices. CLS conducted outreach to vulnerable low-income communities of color, gathered representative stories from over 30 patients, and interviewed advocates who work extensively with patients on charity care issues. CLS also retained a nationally recognized civil rights organization to examine how Washington hospitals responded when Spanish-speakers requested charity care information by telephone. Finally, CLS reviewed the charity care policy of every hospital in Washington to identify apparent violations of the charity care laws or barriers to patients as shown in their published documents.

The research confirmed that accessing charity care is a widespread problem. This report includes findings and recommendations designed to improve patient's access to hospital care services, and identify essential steps to ensure hospitals will fully comply with Washington's charity care law.

### **CLS identified five primary areas in which Washington hospitals are not fulfilling the promise of charity care:**

1. Hospitals are not adequately addressing language barriers.
2. Hospitals are not screening patients for charity care eligibility as legally required.
3. Hospitals do not adequately inform patients of their charity care rights.
4. Many hospitals require an application process that is difficult and demanding for patients, or refuse charity care after the account is assigned to collection.
5. Hospitals and debt collectors improperly collect on hospital debts that patients do not owe and for which they were charity care eligible.

### **To address this gap between legal policy and hospital practices, key recommendations include the following:**

- **Hospitals must affirmatively screen all patients for charity care.** Hospitals must develop and implement an affirmative screening process to evaluate all patients for charity care eligibility, and they must conduct this affirmative screening before commencing any collection efforts.
- **Effective notice of charity care availability should be required by law.** Nominal posted notices and back-of-the-bill statements are not providing adequate information about charity care to those who need it most. Charity care notice should be prominently displayed on the statements, in bold print, with greater detail about eligibility and how to apply. Hospitals should also volunteer the information in discussions with patients. All notices should be in English and other commonly spoken languages in the hospital's service area.
- **Hospitals need to eliminate language barriers.** Patients and phone testing strongly suggest that charity care is less accessible to persons who do not speak English, or who have limited English proficiency. Hospitals should eliminate these language barriers, and the Washington State Hospital Association (WSHA) should incorporate improved language access requirements in its Standard Communication Plan.

# I. Introduction

**Charity care is hospital care provided for free or at a reduced cost to low-income patients.** It is a safety net program generally unknown and unneeded in countries with universal health care coverage where hospital services are recognized as a right, not a commodity. The fee-for-service structure of hospitals in the United States creates a dangerous dynamic, whereby both access to health care and good health are based upon assumptions of insurance and ability to pay. The ease of access and favorable outcomes for persons with insurance stand in stark contrast to the health care barriers and resulting poor health of low-income communities, particularly for uninsured or underinsured persons of color, immigrants not eligible for publicly-subsidized health care insurance, and persons who have limited English proficiency (LEP). Charity care is, therefore, especially important considering these long-standing social and racial inequities in the U.S. health care system.

Washington State has determined that all hospitals have a special obligation to provide charity care. All uninsured and underinsured persons with family income below 100% of the federal poverty level (currently \$24,600 for a family of four) are “deemed charity care patients for the full amount of hospital charges.”<sup>12</sup> Persons with family income from 101% to 200% are eligible to receive hospital services on a sliding fee scale discount, and hospitals have the option to provide charity care to those with incomes above that.<sup>13</sup> As discussed below, this is an equitable and reasonable exchange in return for the many public benefits enjoyed by hospitals.

Applying for charity care should be a straight-forward process, but current hospital charity care practices and policies are failing many of those with the greatest need. CLS undertook this investigation because the need for charity care across Washington is substantial, and there are growing signs that a number of hospitals are not complying with charity care law.

## Megan<sup>11</sup>

Megan was escaping an abusive marriage, was homeless, and living on food stamps when she began experiencing pain so intense she had to gasp to breathe. She went to the hospital where she was diagnosed with pneumonia and pleurisy. Megan informed the hospital that she had no insurance and the hospital did not tell her about charity care. Because Megan had no money, her bill was sent to collections and she was sued for \$7,218.

Megan tried to represent herself in court, without success. Sometime after Megan’s loss in court, a family law attorney who was reviewing Megan’s finances realized Megan was likely eligible for charity care, and contacted a charity care law specialist at the Northwest Justice Project for advice and self-help materials. Armed with knowledge of her rights, Megan went back to the hospital and showed the hospital’s billing department that charity care is available at any time. The hospital bill was cancelled, the court case dismissed, and the money collected in violation of the law was refunded to Megan.

Information from health care advocates, litigation against hospitals for wrongful charity care policies and practices, community outreach, phone testing, and a review of charity care policies from Washington hospitals, have confirmed that eligible patients do not consistently receive charity care. Instead, hospitals have been pursuing patients for medical debt and often initiating debt collection lawsuits. Some hospitals have even actively discouraged patients from applying for charity care.

This report includes the findings from the CLS research and investigation, and provides recommendations for changes in law, policy and practice. These were written with the aim of ensuring that charity care fulfills its original purpose – guaranteeing that those in greatest need are able to obtain critical health care services.

## II. Washington’s Charity Care Law and Its Purpose

**The text and mandate of charity care law are straightforward, even though implementation can be complex for patients.** The statute provides that:

All responsible parties with family income equal to or below one hundred percent of the federal poverty standard, adjusted for family size, shall be determined to be indigent persons qualifying for charity sponsorship for the full amount of hospital charges related to appropriate hospital-based medical services that are not covered by private or public third-party sponsorship.<sup>14</sup>

Persons experiencing economic hardship (defined as income above 100% but at or below 200% of the poverty level) shall receive charity care on a sliding fee scale discount basis.<sup>15</sup> Hospitals may consider a patient’s assets if income is above 101% of poverty level.<sup>16</sup>

Hospitals must adopt policies that guarantee free care and discounts as required by the State. Hospitals submit their charity care policies to the Department of Health (DOH) for approval and annually report to the DOH the charity care amounts they provide. The DOH has oversight and responsibility to ensure compliance.<sup>17</sup>

Deciding whether a patient shall be deemed eligible for charity care requires two hospital determinations: (1) an initial determination of eligibility made at the time of admission or as soon as possible after services are provided, and (2) a final determination when patient eligibility is confirmed.<sup>18</sup>

The law states that hospitals have *an affirmative duty to make every reasonable effort to make an initial determination of charity care eligibility.*<sup>19</sup> In other words, hospitals *must* determine the patient’s family size and income upon admission, or as soon thereafter as possible. This initial determination can be based on information provided orally by the patient.<sup>20</sup> Hospitals must also explain charity care to patients and provide patients with written notice that charity care exists.<sup>21</sup>

Unless the patient fails to cooperate with the hospital, all collection efforts must be kept on

hold pending the hospital's initial determination of charity care eligibility.<sup>22</sup> Then, if the initial determination indicates that the patient may qualify for charity care, efforts to collect on the bill must remain on hold until the hospital has made a final determination of the patient's eligibility for assistance.<sup>23</sup>

The final determination and award of charity care may be based on various sources, including evidence that a patient is homeless, or has qualified for a public benefit program reserved for those with low-income, such as food benefits.<sup>24</sup> Charity care can be awarded when the patient is still at the hospital and without the need for a written application.<sup>25</sup>

Most hospitals, however, require a specific, written application for the final determination and ask patients to prove their income with multiple documents.<sup>26</sup> Patients should be able to submit a single document that shows income, such as a pay stub, income tax return, or W-2, in order for the hospital to make a final determination of charity care eligibility.<sup>27</sup> The law also provides that if the patient lacks such documentation, it is sufficient to provide a signed statement describing one's financial circumstances.<sup>28</sup> State law prevents hospitals from requiring duplicative or unnecessary documentation, and the hospital should make a final determination within 14 days of receipt of the application.<sup>29</sup> Patients then have 30 days to appeal the hospital's charity care determination if they disagree with it.<sup>30</sup>

## Celia

Celia lived south of Seattle in a six-person household that consisted of herself, her husband, and their four young children. Celia received care from a hospital in Burien for recurring health issues between 2010 and 2013. Although she had no health insurance, the hospital services should have been fully covered under the charity care law based on her family's income. The hospital never told her about charity care and she had no idea the services were covered under the law.

The hospital billed Celia for the full charges and when Celia was unable to pay, the hospital turned her account over to its collection agency. The hospital's collection agency sued her for \$11,881 plus prejudgment interest of \$1,813. When she failed to appear in the collection lawsuit, the collection agency obtained a default judgment against her in 2014 for \$15,240, including collection costs.

The debt collector then repeatedly garnished her husband's wages. This put a tremendous strain on their family, to the point where they were unable to pay electricity bills.

Two years later, in February 2016, Celia heard about Columbia Legal Services, and was able to find attorneys to assist her. With their assistance, Celia prepared a charity care application and submitted it to the hospital based on the provision in the law, which states that patients are entitled to charity care "at any time" upon proving they were eligible.

After considerable follow-up, the hospital finally agreed that Celia was entitled to charity care, and granted her a 100% write-off on her accounts. In 2017, the collection agency and the hospital refunded the money that had been collected from her.



Charity care may be granted at any time — even long after services are provided.<sup>31</sup> In the event that a patient pays charges that are later determined to have been covered by charity care at the time of service, those payments are to be refunded to the patient.<sup>32</sup>

## A. Federal Requirements for Non-Profit Hospitals

On December 31, 2014, pursuant to the Affordable Care Act (ACA), also known as Obamacare, the Internal Revenue Service (IRS) issued final rules requiring hospitals with tax exempt status to adopt additional financial assistance policies.<sup>33</sup> These regulations at least partially addressed the concern that some non-profit hospitals were generating vast revenues and paying large executive salaries, while providing only minimal financial assistance to persons who were low-income and uninsured.<sup>34</sup>

Under the federal regulations, non-profit hospitals in Washington must:

- Avoid routinely billing uninsured patients the hospital's full sticker prices, called "Charge Master" rates, which are the listed billing rates maintained by hospitals for services and supplies. These rates are negotiated sharply downward by insurance companies and governmental payors, but have been historically billed in full to those without insurance and least able to pay;
- Allow financial assistance on a presumptive basis (based on "other evidence of eligibility") or based on applicant attestations; and
- Widely publicize financial assistance policies, including financial eligibility criteria, and offer a plain language summary of the program, in various formats, and translated upon request.<sup>35</sup>

Notably, the Washington State Hospital Association (WSHA) has developed forms to help its members comply with the IRS's Section 501(r) rules and charity care requirements, including a Standard Financial Assistance/Charity Care Application, a Standard Communication Plan, and a Model Plain Language Summary of Charity Care.<sup>36</sup> Most of its members have begun to use these documents. However, some hospitals have modified the standard application to require additional or different information than recommended by WSHA, such that application is made more difficult for the patient. See Appendix A.

## B. A Fair Exchange for a Healthy Washington

Free and discounted hospital care for people who need it is good public policy and a fair exchange for the many public benefits conferred on Washington hospitals. Non-profit hospitals and public hospitals are able to provide charity care, in part, due to substantial public subsidies. These subsidies include public funds for hospital construction, federal income and state property tax exemptions, certain state business and occupation tax exemptions, the ability to issue levies or public-guarantee bonds, and favorable tax treatment that incentivizes charitable donations to hospitals or their foundations.<sup>37</sup>

Hospitals, both non-profit and for-profit, also receive substantial public monies as compensation for hospital services. This includes payments received from Medicare, Medicaid, Disproportionate Share Hospital Payments (which partially compensate hospitals with high Medicaid and indigent care rates),<sup>38</sup> insurance through the Washington Department of Labor & Industries, Affordable Care Act-subsidized insurance, Veterans insurance, and federal, state, and local government employee health insurance programs, which combine to enable small hospitals in rural areas to exist and large hospitals to thrive.<sup>39</sup>

Furthermore, Washington's Certificate of Need Program, which limits the number of beds and concentrates services at certain hospitals, protects hospitals from competition. According to a study published in 2015, hospital pricing in monopoly markets is 15.3% higher than in markets with four or more hospitals.<sup>40</sup> While there are opposing views as to whether the government should be fostering such monopolies, some have argued that monopolization allows dominant providers to receive higher revenues which can then cross-subsidize charity care.<sup>41</sup>

Significantly, the actual cost of charity care to hospitals is substantially less than the *billed charge amounts* that hospitals report to the Washington Department of Health (DOH) each year. *Billed charge amounts* are based upon each hospital's "Charge Master" rate sheet that sets the price for every treatment and item supplied by the hospital. These "Charge Master" rates are significantly higher than the amounts the hospital actually expects to be paid. As noted above, private insurers and governmental payors such as Medicaid and Medicare pay only a fraction of the hospital's "Charge Master" rates. DOH calculates that the statewide *cost of care average ratio* is approximately 35% of the *billed charge* rate.<sup>42</sup> According to the DOH Report issued in 2017, although hospitals reported \$532 million in charity care in 2015, the approximate cost of these services to hospitals was \$185 million, based on the cost of care adjustment.<sup>43</sup>

In return for the wealth of public benefits conferred on its hospitals, our communities have long expected hospitals to be accessible to the people who are most in need. Charity care for uninsured and underinsured low-income persons is a necessary and fair exchange for a healthy Washington.

### III. The Need for Charity Care

**Charity care continues to meet a significant need for those without the means to pay for necessary services.** In Washington, 13% of the population have family incomes below 100% of the poverty level,<sup>44</sup> and 28% have family incomes below 200% of the poverty level.<sup>45</sup> Based upon the current state population of just over 7 million, this means approximately 2 million Washington residents are below 200% of the poverty level. If they are also uninsured or underinsured, they essentially live on the precipice of health care-related financial catastrophe. The number of persons eligible for charity care also includes persons with incomes above 200% of the poverty level if their incomes are "otherwise not sufficient to enable them to pay" the hospital bill.<sup>46</sup>

The number of insured persons has increased over the past four years due to insurance coverage under the Affordable Care Act (ACA) and the subsequent Medicaid expansion in Washington State.<sup>47</sup> Nevertheless, the Washington Office of the Insurance Commissioner (OIC) has estimated that 522,000 individuals living in Washington remain uninsured.<sup>48</sup> In addition, because of various exclusions for Medicaid, charity care is the only way many undocumented or newly arrived immigrants in Washington can afford hospital care and the resulting hospital bills.<sup>49</sup>

Increasing enrollment in high-deductible ACA or employer-provided insurance also means charity care remains critical to underinsured persons. Underinsured individuals, including seniors on Medicare, need charity care to cover high deductibles, co-insurance, out-of-network charges, charges that exceed coverage limits, services excluded by the plan, and claim denials, both proper and improper.

Despite the promise of charity care to cover all patients who are eligible, the advocates CLS interviewed all believed that based on the volume of charity care clients in their practices, the courts are full of people who are being sued for hospital bills they should not have received.<sup>50</sup>

**Public data suggests the highest concentration of charity care need (based on poverty and lack of insurance) exists in rural areas.** Areas with robust agricultural economies are naturally tied to large farm worker and immigrant populations. Charity care access problems are exacerbated for this rural population, because individuals in this population are more likely to work strenuous, low-wage jobs without healthcare coverage and they may not speak English as their primary language.<sup>51</sup> These individuals experience long-term financial adversity, avoid necessary hospital care more often than their white counterparts in urban areas,<sup>52</sup> and are typically unfamiliar with charity care availability. Often, when they do learn

## Rafael

Rafael and his wife Camila live in a mobile home park in Eastern Washington. Rafael is 54 years old and has worked in orchards for many years. Camila works seasonally packing cherries and cares for their children. Like many other farm worker families, Rafael and Camila have very little money and no health insurance.

Both Camila and Rafael had serious health issues that even further reduced their earnings. Camila was treated for cancer, the cancer went into remission, and then it recurred. She missed long periods of work during treatment. Then, one day, Rafael had a stroke that made him unable to use his right arm and leg and he couldn't speak. Rafael required extended rehabilitation to walk and talk again.

Rafael obtained a charity care application for his medical treatment, but the hospital refused him, based on its unlawful policy which denied charity care unless the application was completed and returned within 30 days of service. Instead of helping, the hospital turned his \$10,000 bill over to collections, without even issuing a written denial or giving Rafael a chance to appeal.

Fortunately, the Volunteer Lawyer Program sent Rafael to Columbia Legal Services in Wenatchee. With an attorney to advocate for him, Rafael was able to receive charity care for the medical treatment and get the lawsuit dismissed.

about charity care, the information comes from a source other than the hospital, such as an advocate or a friend.

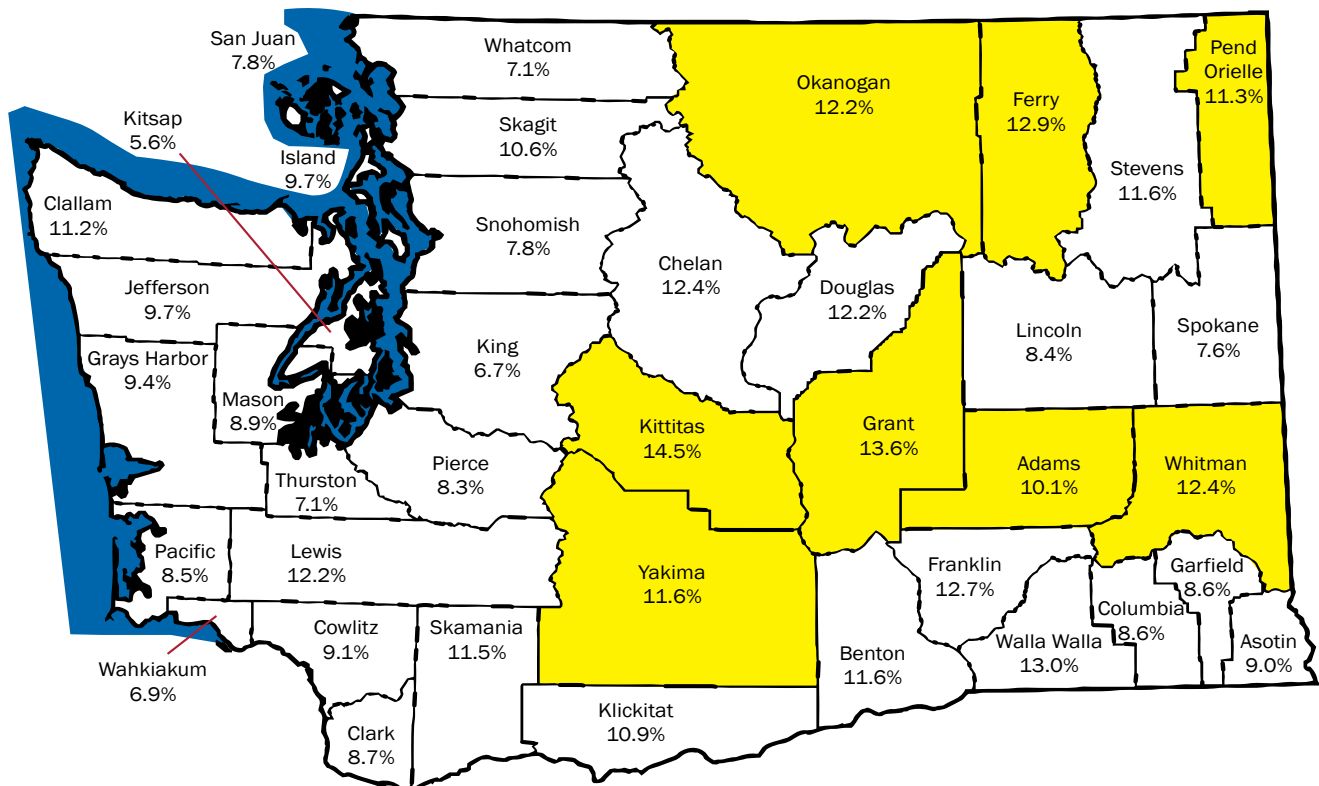
Data suggests that counties with high poverty rates also have high uninsured rates. More than one out of every five individuals living in Whitman, Adams, Ferry, Yakima, Kittitas, Pend Oreille, and Okanogan counties live below the federal poverty threshold.<sup>53</sup> Not surprisingly, all of these counties have high uninsured rates: Whitman (12.4%), Adams (10.1%), Ferry (12.9%), Yakima (11.6%), Kittitas (14.5%), Pend Oreille (11.3%), and Okanogan (12.2%).<sup>54</sup>

In comparison, the uninsured rates in Kitsap, King, and Spokane counties are 5.6%, 6.7%, and 7.6%, respectively.<sup>55</sup>

While charity care still remains essential in urban areas, the ACA has significantly shifted the relative need for charity care to rural areas, and in particular, to farm worker communities in agricultural areas. This is a key reason why CLS focused its outreach and training efforts on these communities.

### Map: Uninsured Rates By County, Compared with Poverty Rates

■ County with 20% of population or higher living below poverty level, 2010-2014



## IV. Changing Charity Care Numbers

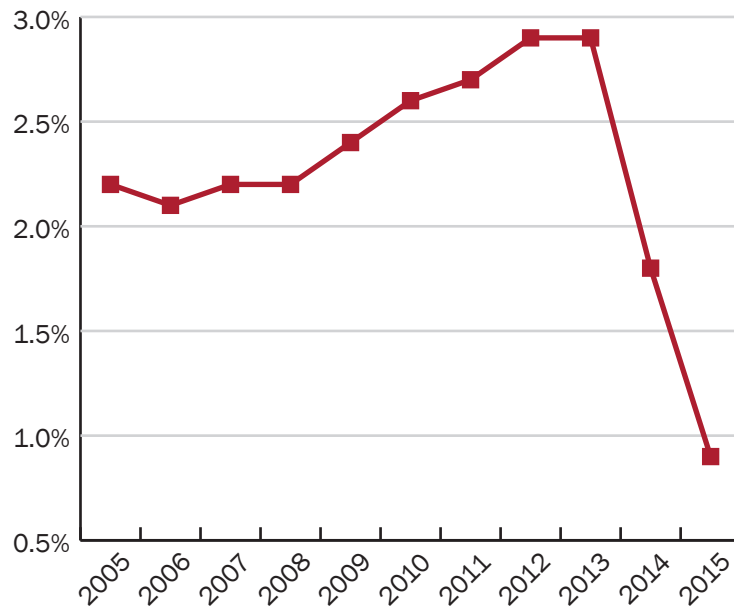
**The need for charity care across the State continues to evolve.** The ACA helped many people obtain insurance, which in turn, greatly reduced the need for charity care. The expansion of the Medicaid program to people who were previously ineligible has increased hospital utilization and revenues. Because fewer patients are uninsured, the expansion also decreased the amount of bad debt that hospitals carry.<sup>56</sup> Washington hospitals have correspondingly provided less charity care. Charity care constituted 2.9% of gross hospital revenues in 2013, and decreased to 0.9% of gross hospital revenues in 2015.<sup>57</sup>

Although the increased availability of insurance through the ACA means fewer uninsured patients, and therefore, lowers charity care costs for the hospitals, the need for charity care still remains critical. The Washington State Supreme Court's 2015 "*Civil Legal Needs Update*" report found that the two most common unmet legal needs faced by people with low income are access to health care and debt collection.<sup>58</sup> This is especially troubling given the *growing signs that hospitals might not be complying with charity care law as they should.* While the law requires that hospitals make every reasonable effort to determine charity care eligibility, some hospital policies do the opposite.

In one lawsuit, there was specific evidence that employees of the two defendant hospitals received additional compensation for minimizing charity care costs for the hospital. The hospitals also distributed talking points for employees to use with patients, designed to extract as much money as possible from low-income patients rather than providing charity care.

In addition to this litigation, patient advocates at Northwest Justice Project (NJP), Northwest Health Law Advocates (NoHLA), and other advocacy or social service organizations have informed CLS about the high volume of clients seeking help with medical debt. This was often due, at least in part, to the failure of hospitals to screen charity care eligible patients.

Graph: Changes in Charity Care as % of Total Hospital Revenues over Time



**Source:** WASH. STATE DEP'T OF HEALTH, 2015 WASHINGTON STATE CHARITY CARE IN WASHINGTON HOSPITALS 5 (Feb. 2017), <http://www.doh.wa.gov/Portals/1/Documents/2300/HospPatientData/2015CharityCareReport.pdf>.

Spokane attorney, Scott Kinkley, with NJP, summarized the experiences of his clients, as well as the patients CLS interviewed, when he said:

Hospitals are failing to adequately preliminarily screen patients. Written information explaining charity care is frequently not provided. My clients often first learn about charity care from me after receiving court papers or having their wages or bank accounts garnished. Even then, hospitals try to discourage my clients from applying by falsely stating it's too late to apply after an account is sent to a collection agency.

*Hospital debt collection data indicates that instead of receiving charity care to cover hospital bills, patients are being pursued by debt collectors. Debt collection data also suggests that hospitals are providing less charity care than they should and are engaging in harmful debt collection practices. In December 2016, the Washington Community Action Network (WA CAN) released a report documenting questionable debt collection practices by St. Joseph Hospital in Tacoma.<sup>62</sup> The report documented hospital collection agency practices such as charging high interest rates and garnishment fees, along with reporting patients to credit bureaus.<sup>63</sup> Individuals making wages as low as \$12.50 per hour were having 25% of their paychecks garnished.<sup>64</sup>*

The WA CAN report found that 54% of patients whose accounts were sent to collections were not told about charity care while they were in the hospital.<sup>65</sup>

Because it was clear to CLS from these reports that some Washington hospitals were not fully complying with charity care requirements, *CLS undertook a fuller assessment of these essential issues:*

1. Are patients accessing the charity care services they are eligible to receive and, if not, why not?
2. Which policies and practices would enable Washington's charity care program to fulfill its promise that medically necessary hospital services are accessible to all?

## Recent Case: Yakima Regional

In a 2012 lawsuit filed by CLS and co-counsel, Eleanor Hamburger of Sirianni Youtz Spoonemore Hamburger, against Yakima Regional Medical Center and Toppenish Community Hospital, hospital documents indicated that employees of both hospitals were provided with talking points, as well as incentives, to avoid offering charity care. The two hospitals directed employees to get as much money as possible from low-income patients. Employees were instructed not to mention charity care as an option unless a patient specifically asked about it.<sup>59</sup> The hospitals routinely required deposits before screening for charity care and providing services.

The Court found, "Defendants engaged in a course of conduct which violated the intent of the CCA [charity care act] as well as its mandated requirements. . . . It is likely some indigent patients were unable to pay these deposits and as a result denied access to qualified medical services. Further, Defendants sent over-billed, inflated, delinquent accounts to collection which resulted in additional collection fees and costs."<sup>60</sup> The suit settled for \$4.5 million.

## V. Methodology

To investigate these questions, CLS reviewed: state and national charity care reports and literature; state and federal charity care laws; hospital charity care data reported to the state DOH; publicly-available data quantifying uninsured and underinsured rates; and data on the correlation between the presence or absence of health insurance and poverty, race, and ethnicity.

Additionally, CLS gathered information by conducting outreach to low-income communities of color (including uninsured persons), communities with a high proportion of people who are limited-English-proficient (LEP), and immigrant communities. CLS provided charity care trainings to the non-profit agencies and churches that serve these communities in Okanogan, Chelan, Douglas, Grant, Adams, Yakima, Benton, King, Snohomish, Clallam, and Jefferson counties. See Outreach Map, page 13.

**CLS interviewed over thirty patients** who were eligible for charity care from Washington hospitals but did not receive it, carefully reviewing the circumstances in each case, consulting with each patient at length and gathering and analyzing their income, family size, other financial circumstances, and billing documentation.

To broaden the input, and to confirm that the findings were representative of common experiences, CLS interviewed five advocates working at Northwest Justice Project and Northwest Health Law Advocates who have represented clients on charity care issues throughout the state for many years. Their own work confirmed that the experiences of the

### Recent Case: Empire Health Foundation

Empire Health Foundation (EHF), through its attorneys Sirianni Youtz Spoonemore Hamburger, filed a lawsuit against Community Health Systems (CHS), a for-profit hospital chain, which bought Spokane's Deaconess and Valley hospitals.

The suit claims that CHS failed to comply with state law and its own purchase agreement with EHF, which required CHS to provide charity care in amounts that met or exceeded the regional average of eastern Washington hospitals. EHF alleges that since CHS purchased Empire Health Services entities in 2008, CHS has

withheld \$55 million in charity care that it promised but failed to provide, to as much as \$110 million when CHS's charity care figures are adjusted for its excessively inflated charges.<sup>61</sup>

In addition to this litigation, patient advocates at Northwest Justice Project (NJP), Northwest Health Law Advocates (NoHLA), and other advocacy or social service organizations have informed CLS about the high volume of clients seeking help with medical debt. This was often due, at least in part, to the failure of hospitals to screen charity care eligible patients.

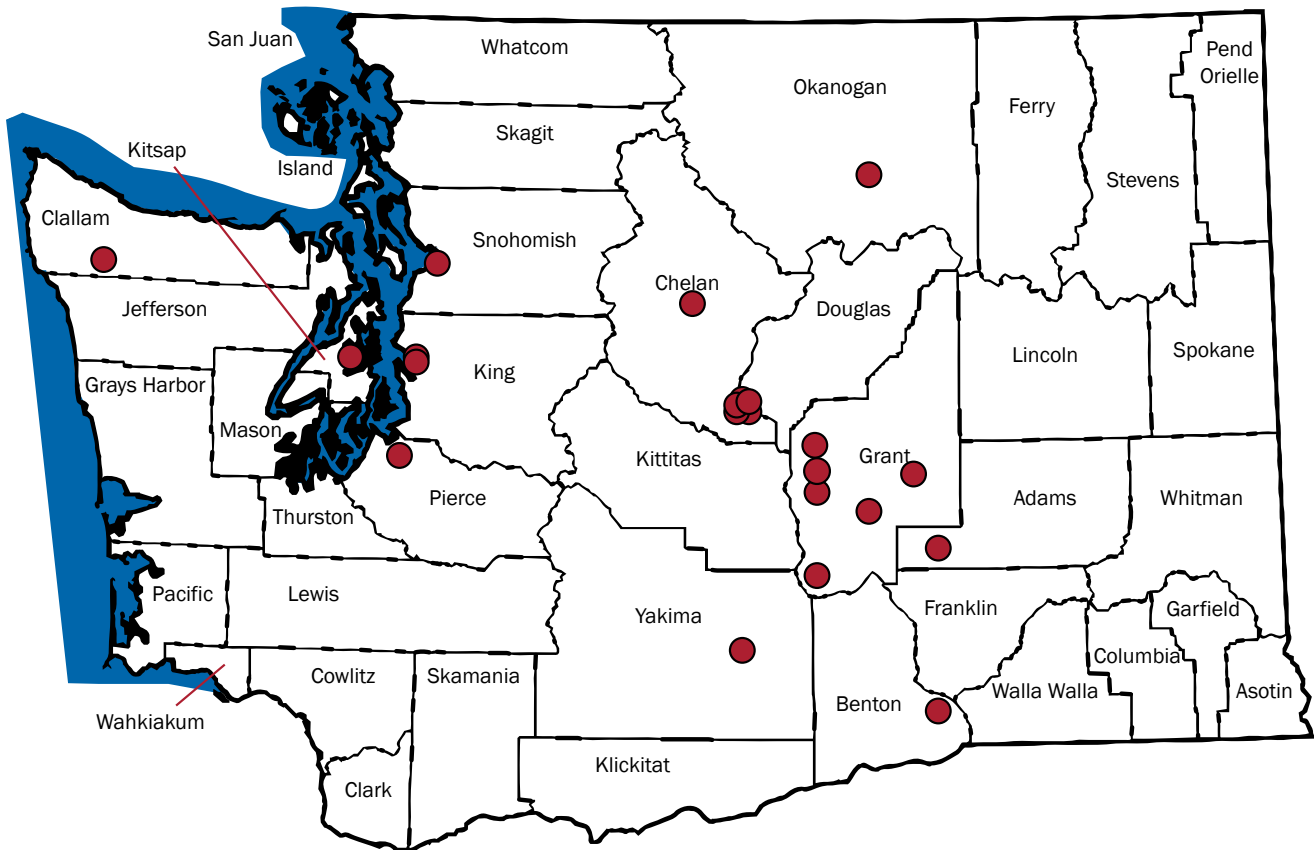
individuals CLS interviewed were typical of the patients they have represented and continue to represent in hospital debt matters.

In December 2016, CLS retained the Equal Rights Center, a non-profit training and testing organization based in Washington D.C., to conduct Spanish-English matched-pair testing. The purpose of this testing was to examine possible differences as to how hospitals respond when Spanish-speakers request charity care information, compared to how they respond when English-speakers make the same request.

Additionally, in January 2017, CLS reviewed the charity care policy of every hospital in Washington to identify potential violations of the charity care laws and barriers to charity care access. CLS also reviewed the charity care applications of many of these hospitals to see if the applications are consistent with the official hospital policies and with charity care law. CLS updated this review in June 2017 to include any policy revisions in its analysis. See Appendix A for the results of the policy review.

### Map: Outreach Locations

● Outreach Location





## VI. Findings

CLS's findings, as detailed in this report, indicate that there are significant problems with how Washington's charity care program is working:

1. **Hospitals are not doing enough to address language barriers.** Despite laws requiring that hospitals make charity care accessible to their patients who may speak a language other than English, many hospitals do not adequately meet these language needs.
2. **Hospitals are not screening patients for charity care eligibility as legally required.** In particular:
  - Some hospitals are not conducting the required initial determination to evaluate whether patients are eligible for charity care.
  - Often, hospital staff members assume patients have health insurance or that patients are able to pay the cost of hospital services, when it should be clear that the patient is eligible for charity care.
  - Some hospitals avoid screening for charity care and discourage charity care eligible patients from coming to their facilities by requiring low-income patients to pay deposits, co-pays, or deductibles up front, contrary to law.
3. **Notice practices fail to adequately inform patients of their charity care rights.** Instead, patients must actively seek out the information, learn about it from others, or obtain the help of an attorney. Even if they have information about charity care, patients are left to navigate the system without support from the hospital.
4. **Patients struggle to comply with hospital demands for documentation to establish eligibility for charity care.** These includes situations where the demands go far beyond what the law allows.
5. **Hospitals and debt collectors improperly collect on hospital bills that charity care eligible patients do not actually owe.** In particular, hospital collection agencies routinely sue indigent patients for services that should have been written off as charity care, charging billing rates higher than for those insured ("Charge Master" rates), plus 12% prejudgment and post-judgment interest, court costs, and attorney fees.

### 1. Hospitals Are Not Adequately Addressing Language Barriers

**People who have limited English proficiency face additional barriers to obtaining charity care.** The extensive outreach into farm worker communities revealed two significant factors about immigrants and persons of color who are financially eligible, who are likely most in need and who do not speak English as their primary language. First, few people in these communities are aware of Washington's charity care program and protections. Many are surprised to hear they have a right to medically necessary hospital services for free or at a

reduced cost. Second, if they had heard about discounts or free care, the information came from friends, family, or co-workers – not from the hospital. This highlights the substantial problem of language access for those most in need.

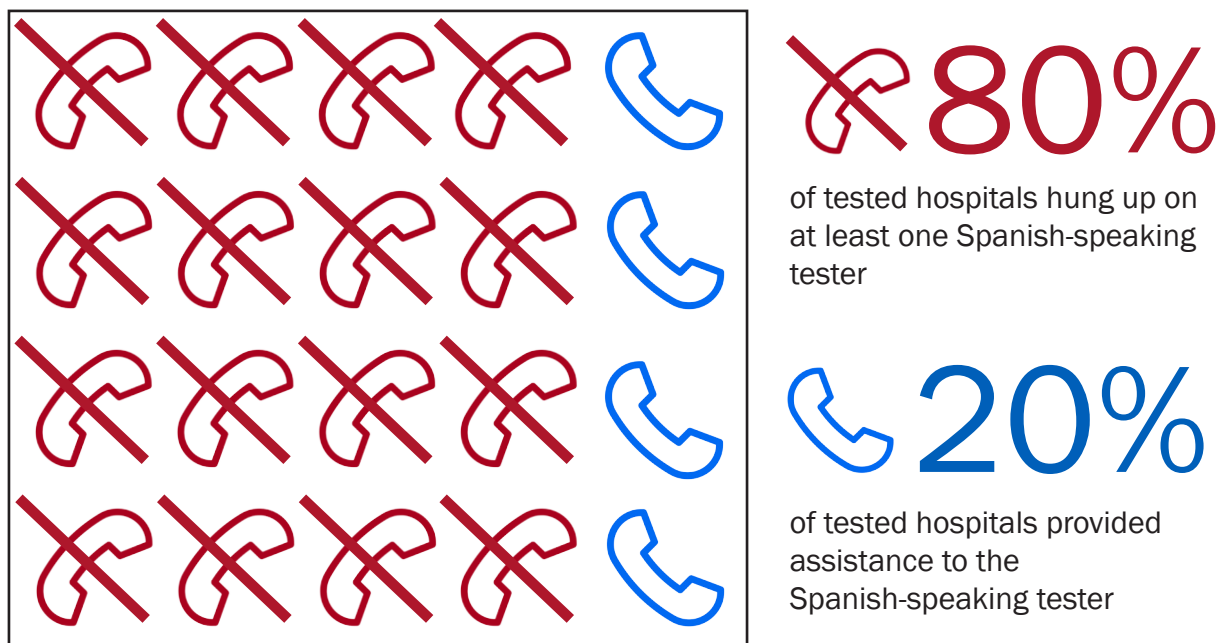
### Language Access Testing by the Equal Rights Center

In order to better research the language access issues, CLS hired the Equal Rights Center to test how prospective patients were treated and if there were differences based on whether they spoke English or Spanish. The Equal Rights Center had English-speaking and Spanish-speaking language testers place telephone calls to twenty hospitals across Washington State in December 2016. Hospitals were carefully selected to provide a representative variety of hospitals based on their geographic and demographic characteristics.

The testers were closely matched by gender and other characteristics, so the only differences between them was their apparent ability or inability to understand and speak English, and their perceived ethnicity or national origin (based on their Spanish accent or lack of accent over the phone). The testers were given identical scenarios to present to the hospitals. They were directed to inquire about health services on behalf of a low-income relative who was described as being uninsured, and having trouble paying for services.

Each English-speaking and Spanish-speaking tester called the hospital's main reception twice, and the first and second tests were then compared. In addition, testers were instructed to ask to speak with the hospital's financial office (if necessary), so a comparison could be drawn between the information provided by the main reception and the information provided by the financial office.

### Percentage of Hospitals that Hung Up on Spanish-Speaking Testers



The Equal Rights Center reported that for 80% of hospitals tested (16 of 20 total), the Spanish-speaking tester experienced at least one hang-up (in which the hospital employee simply hung up on the tester when the tester didn't speak English), from either the main reception or the financial office.

In some cases, the Spanish-speaking tester was not able to finish reciting the scenario before the hospital's employee hung up the phone without any explanation. Other times, the employee said that he/she did not understand, and specified, "English only," and then hung up when the caller did not speak English.

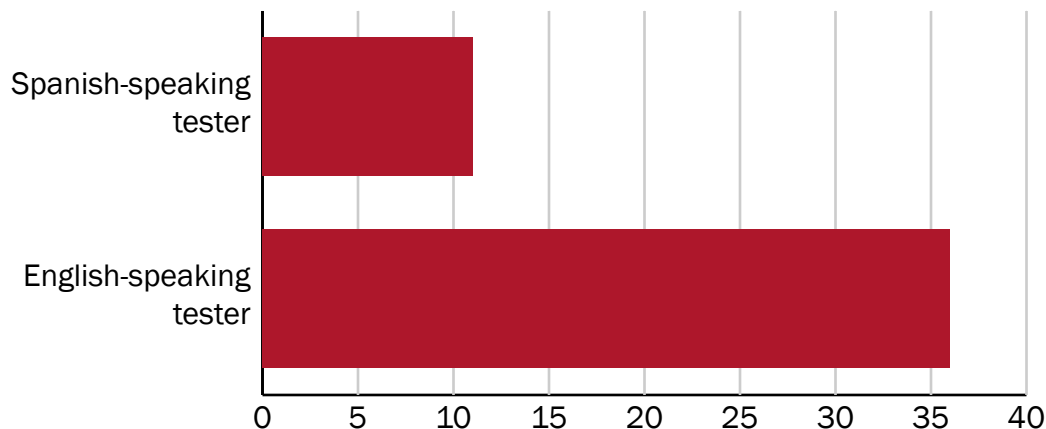
Calls to the hospitals' financial offices were somewhat more successful. Nevertheless, in 9 tests where the Spanish-speaking tester directly called the financial office, or was transferred there from the main reception, the employee who answered the call hung up the phone after the tester presented the scenario in Spanish, without providing any assistance.

When hospital employees did engage with the Spanish-speaking testers, they informed the testers that financial assistance was available in only 28% of calls (11 of 40 total) where the main hospital number was dialed. By comparison, in 90% of tests (36 of 40 total) where the main hospital number was dialed by English-speaking testers, the tester was told that financial assistance was available for their relative.

The English-speaking tester was told about the availability of charity care at least once at all 20 hospitals (100%) when the main hospital number was dialed. By comparison, the Spanish-speaking tester was told about the availability of charity care at least once at only 8 out of 20 hospitals (40%) when the main number was dialed. When the Spanish-speaking tester called the financial office directly, 5 additional hospitals (13 in total, or 65%) informed the tester that financial assistance was available.

There were three tests where Spanish-speaking testers were explicitly told that financial assistance was *not* available. In two of these three tests, the Spanish-speaking tester was simply told that financial assistance was not available at the hospital. In another instance, the

### Testers Told Financial Assistance Available - Called Main Number



hospital told the Spanish-speaking tester that they did not offer financial assistance and the tester should instead go to “Harborview” for services.

The lack of language access also occurred in regions with large populations of persons who speak Spanish. Upon calling one mid-sized Central Washington hospital, the employee hung up on the Spanish-speaking tester, who reported that, “Immediately after I finished stating my scenario, [the woman] said, ‘No Español.’ I repeated my scenario again [during the second call] but halfway through my scenario she hung up on me without saying any words.” However, the English-language tester reported the same hospital gave charity care information during both telephone calls, saying, “We have a charity application; if she’s not working they’ll pay some of the visit....”

The Equal Rights Center also reviewed the hospitals’ websites. Of the 20 websites examined, 13 provided a link to a charity care application. However, only five websites mentioned language assistance (*i.e.*, interpretation or translation services) to people who did not speak English. Many of the links provided to the various languages were written in English, as was much of the website text, even if it explained language assistance.

## Elena

Elena, a monolingual Spanish speaker, received emergency health care from a Puget Sound area hospital in December 2013 and March 2014. Although she was well below the cut-off for 100% charity care based on her income and family size, the hospital failed to screen her for charity care and made no initial determination of her eligibility. Instead, they handed her a charity care application and left her to manage on her own. A few days after her first visit, she returned with the completed application and tried to submit it, but hospital staff – who spoke only English – refused to accept it. No one was made available to speak to her in Spanish and she was never told what was wrong with her application. She was just sent away.

After her second visit in March 2014, she brought her English-speaking son, to help her in submitting her charity care application for both hospital visits. The staff told her son that she should mail the application to the hospital’s administrative office in Tacoma, but inexplicably, the

staff didn’t have the address and she was thwarted again. A year later she was sued by the hospital’s collection agency for the bills for which she had sought charity care, and a default judgment was entered against her for over \$12,000 – about 50% of her family’s total annual income.

The collection agency then began garnishing 25% of Elena’s already low wages, wages which were her family’s sole source of income because her husband was unemployed at the time. In 2017, Elena connected with Columbia Legal Services. Her attorney contacted the hospital and showed the hospital what it would have known if it had properly followed the charity care law and screened her in 2013 – that Elena was fully eligible based on her income and family size. The hospital granted her charity care for all of the hospital bills, stopped the garnishments, and restored her paycheck so her family can meet its most basic needs.

### *In-hospital interpreter services*

Separately, the patients CLS interviewed also shared experiences about whether hospitals use interpreters to discuss insurance, responsibility to make payment, payment plans, or the availability of charity care. In all but one or two instances, patients reported that hospitals do not use hospital interpreters to discuss bills or ask questions that would determine the patient's ability or inability to pay. Instead, hospitals look to family members, including minor children and visitors who may also be limited-English-proficient, to fill this void.

### *Spanish-language materials and outreach*

Many hospitals fall short in their efforts to inform Spanish-speaking patient communities that charity care exists. As noted before, posted notices instructing patients in Spanish to contact the financial office are not as effective as informing patients that free or reduced-cost care may be available.

Some hospitals provide brochures and other written materials in Spanish at their front desk or financial office. This information is only provided when Spanish-speakers know to ask for it or when hospital employees realize the information might be helpful.

Some hospitals also provide information and materials about charity care on their websites. However, materials in Spanish posted on hospital websites are not reaching their intended audience because members of the target communities may not know the materials are on a website in the first place, may not have access to the internet, and often have to navigate through English-language web pages to get to the Spanish-language link.

Hospitals across Washington engage with their communities in many different formats including offering back to school supplies, meeting with community health clinic staff, and holding Health Fair events. CLS repeatedly met the same hospital and clinic outreach workers while attending community meetings and observed that they were not providing charity care information.

The WSHA recommended practices suggest hospitals should incorporate charity care with existing community outreach work or share charity care information with other service agencies.<sup>66</sup> From the interviews we conducted with community organizations and service agencies, this does not appear to be a widespread practice. WSHA efforts to encourage this could significantly close this communications gap.

## **2. Hospitals Are Not Performing Initial Screening**

**Patients are not routinely screened at or near time of admission.** To comply with the law, hospitals must affirmatively determine the patient's income and family size. If the patient's response indicates that the patient may qualify for charity care, the hospital must suspend collection efforts pending a "final determination [of sponsorship status]."<sup>67</sup>

In patient interviews, CLS found that hospitals ask in-depth questions about public and

private insurance and third-party payment sources (such as vehicle insurance for car accidents), but not charity care eligibility. None of the low-income persons CLS interviewed were asked by the hospital about their income or how many persons live in their families, either at admission or discharge. *None were screened by the hospital for charity care eligibility in the manner required by law.*

Moreover, some hospital policies transfer the burden of identifying need for charity care onto the patient. For example, Virginia Mason Medical Center's charity care policy does not explicitly require that the hospital make an initial determination of charity care eligibility. Instead, the first step in the process – screening for eligibility – is missing from the policy. As stated in the policy, "Patient Account Specialists will determine a patient's eligibility for financial assistance based on information provided by the patient *in the form of a Financial Assistance Application and income verification.*"<sup>68</sup> In other words, rather than asking proper questions to make an initial determination or providing details about screening for charity care, it appears that Virginia Mason's patients need to know that charity care exists, obtain an application, know how to fill it out, and then submit it.

Based on CLS's patient interviews and input from other advocates, it is clear that failure to screen is a consistent problem across types of care that patients receive. In-patient, out-patient, and emergency room patients were not screened. One low-income patient described being hospitalized for three surgeries in a one-year period and not once being screened for charity care.

Many patient experiences indicate that hospitals are disregarding obvious flags that free care or reduced cost care is needed.

## Carmela

Twenty-two year old Carmela lives with her two young children and earns around \$1,000 a month working at a hotel. In 2014, Carmela was unemployed and experiencing severe abdominal pain. Carmela went to a hospital emergency room, where she was diagnosed and treated for cysts in her abdomen.

When Carmela told hospital staff that she was unemployed and did not have insurance, they did not discuss charity care, screen her for eligibility, or give her an application. Instead, the hospital billed Carmela over \$2,000 for the treatment she received. When Carmela could not pay, the hospital sent her account to a collection agency, which threatened her with legal action.

Carmela struggled to pay her debt and while the collection agency threatened her with a lawsuit, the debt was also gathering interest. Afraid of incurring even more debt that she wouldn't be able to pay, Carmela did not return for necessary follow-up care for a year. However, her health continued to be a source of stress and worry. Carmela eventually called the hospital and told them that she was afraid to come in because of the cost. A representative told her to just schedule an appointment and only when Carmela repeatedly refused to do so was she informed of charity care. Due to the lack of information, Carmela was forced to delay treatment and risk her health even further because of a bill that should have been covered by charity care.

After reaching out to Columbia Legal Services, Carmela was able to receive charity care for all of her medical costs.

For example, patients have reported to CLS and other advocates that hospitals did not screen for charity care even after the patients provided information such as that they were uninsured, didn't have sufficient income to pay, were unable to work for some time due to medical issues and other similar details. Any of these facts should have alerted hospital staff to possible charity care eligibility, yet the hospitals did not perform any screening or provide information.

Seemingly, many hospitals presume that patients know of and understand charity care and how to apply without any affirmative support. Hospital employees often ask questions about insurance, other potential sources of payment, and financial responsibility, as well as information which can be used for possible future collection action (such as place of employment for garnishment of wages). In turn, many patients without financial means attempt to explain that they are uninsured, ineligible for public insurance, and are unemployed or earn close to minimum wage. Often, even at this opportune point when ability to pay is the focus of the conversation, charity care is not discussed.

## Mateo

Fifty-eight year old Mateo is a former butcher and farm worker who has not worked for several years due to job-related injuries that have left him permanently unable to return to his former work. His adult children and their families live with him, share housing costs, and provide his daily meals. Mateo does cook special occasion food dishes for other families once or twice per month. The small sums he earns for this work are his only income.

When Mateo began experiencing pain and blood in his urine, doctors told him that he needed a CT scan at the hospital. The hospital told him that he would need to bring \$560 to his appointment, as copay, or the CT scan would not be performed. Mateo had no insurance so he asked to apply for charity care. The hospital refused to give him an application until it had received the deposit and provided care. Mateo, afraid for his health, used money he had set aside to pay next month's housing payment and borrowed the rest from his family.

After the CT scan, the hospital again refused to allow Mateo to apply for charity care. The hospital withheld the application until he returned with a Medicaid denial letter, although the hospital was already aware he would not be eligible for those benefits due to his unresolved immigration status. When Mateo returned with his denial letter, rather than being given a charity care application, he was instead questioned on how he was able to survive without any income. When Mateo mentioned free meals, the hospital refused to give him an application until his son claimed Mateo as a dependent on the son's tax return the following year.

The final bill for the hospital visit and diagnostic procedures was more than \$4,500. The process was confusing, time consuming, and created needless barriers to charity care. Until a family member contacted Columbia Legal Services for help, Mateo was forced to pay \$50 a month towards medical bills he should never have owed.

Moreover, hospitals frequently gather detailed income and family size information from patients to determine if they qualify for Medicaid under the ACA, which covers patients with income up to 138% of poverty level. However, to the extent that those patients do not qualify for Medicaid, hospitals often fail to use that same information to identify which of those patients qualify for charity care.<sup>69</sup>

**Hospitals that require deposits avoid initial screening for eligibility.** Some hospitals circumvent the duty to screen for charity care eligibility by requiring underinsured or uninsured persons to pay deposits, deductibles, or co-pays up front. The law explicitly prohibits this practice: “Hospitals may not require deposits from those responsible parties meeting ... [charity care income requirements].”<sup>70</sup>

Despite the wide publicity surrounding the lawsuit challenging Yakima Regional’s and Toppenish Hospital’s illegal deposit policies, some hospitals are still asking charity care eligible persons to pay deposits, deductibles, and co-pays up front. For example, Mason General Hospital’s website still states: “A deposit will be requested for emergency services.”<sup>71</sup> Local community health employees also confirmed that the hospital where Mateo was treated still routinely requires persons who are eligible for charity care to pay deposits (called “co-pays”) or treatment will not be provided.

The fact that there are hospitals which still do not conduct an affirmative initial screening of patients, despite the legal obligation to do so, makes notice of charity care even more important.

### 3. Notice Practices Fail to Inform Patients of Their Charity Care Rights

**Current informational poster practices are insufficient.** Washington’s charity care law requires hospitals to make notice of charity care “publicly available.”<sup>72</sup> “Publicly available” notice means a notice that is:

[P]osted or prominently displayed within public areas of the hospital, and provided to the individual in writing and explained, at the time that the hospital requests information from the responsible party with regard to the availability of any third-party coverage, in any language spoken by more than ten percent of the population in the hospital’s service area, and interpreted for other non-English speaking or limited-English speaking or other patients who cannot read or understand the writing and explanation . . .<sup>73</sup>

#### Recent Cases: Initial Determination

A number of additional cases were recently brought by CLS on the western side of the state involving hospitals’ failure to screen to make an initial determination of patient eligibility for charity care, where patients were instead pursued for collection. Three of those cases have been resolved with the hospitals agreeing to provide full charity care to the patients, and others are still ongoing.

#### More than a Sign

Even if a hospital is complying with [the posting] requirement, posting notice on the wall does not mean that patients will see the notice or understand it to mean free care or reduced cost care is available.



Even if a hospital is complying with this requirement, posting notice on the wall does not mean that patients will see the notice or understand it to mean free care or reduced cost care is available. WSHA's recommended notice poster, for example, omits useful information such as income eligibility limits and the most critical issue – that care may be free. It merely states:

**Help with Hospital Bills:** If you need help paying your bill, whether or not you have insurance, please contact our financial assistance office.<sup>74</sup>

Patients who see this notice or similarly-worded messages don't necessarily interpret this to mean they may not have to pay at all, or that they may be able to pay less. Instead, a reasonable interpretation would be that a payment plan or similar credit arrangement is available.

*Some hospitals offer payment plans, not charity care.* A number of the patients interviewed for this report, who went to the business office because they needed help paying the hospital bill, believed that this help would entail a payment plan to ameliorate the impact of one large payment. They were right. Rather than any real assistance, such as a write-off or reduction in

## Samuel

Thirty seven year old Samuel works in a packing shed in Wenatchee and speaks Spanish. In January of 2016, he was rushed to the emergency room after experiencing chest and breathing difficulties; he had surgery the following day.

Shortly after surgery, a hospital employee visited Samuel while he was recovering. The employee did not speak Spanish nor bring an interpreter and, instead, asked if one of Samuel's relatives--who spoke limited English-- could interpret. The employee asked how Samuel was going to pay the bill and became angry when he informed her that he didn't know how he could pay it. The same employee visited Samuel a week later, when he was being discharged, to ask him how he was going to pay. He could only give her the same answer – he didn't know. The employee did not ask for his income or family size and also did not tell him about charity care.

Later, the hospital billed Samuel \$50,632.22 for his treatment.

A friend told Samuel about charity care and he applied with help from his sister-in-law. In response to Samuel's attempt to apply for charity care, the hospital demanded that Samuel provide information about the relative who had helped him. They also demanded recent pay stubs for his sister-in-law, verification of other income including child support for his sister-in-law's child and a birth certificate showing Samuel was not the father of the sister-in-law's child. Samuel could not understand why the hospital required this information.

After obtaining help from Columbia Legal Services in Wenatchee, and after more than a year of back and forth with the hospital, Samuel received charity care in March of 2017.

the bill, these patients were asked to pay the bill at high “Charge Master” billing rates in monthly installments and were not offered charity care.

Patients and health care advocates also reported that some hospitals require monthly payment amounts based on the size of the bill (larger monthly amounts for larger bills) regardless of the patient’s ability to pay. Instead of receiving charity care assistance, hospital business offices threatened a number of the patients with collection actions unless they paid the unaffordable monthly amounts. One advocate reported a senior citizen going to the hospital to pay her bill, but rather than offer charity care the hospital insisted she pay more than her fixed income would allow.

*Most patients hear about charity care from their community, not the hospital.* Patients, especially those whose primary language was not English, reported first hearing about “some program that helps with the bill” long after hospital services had been provided and long after receiving a bill from the hospital. They said the large amount, encircled and in bold print (see example at right), was overwhelming and discouraging.

Patients reported their first reaction to the bill was to compare the amount to their monthly wages: “my earnings for three months, six months, or for a year, or more.” They didn’t know how they could possibly pay the bill in addition to paying rent, utilities, and feeding their children.

Even after receiving a bill they were unable to pay, patients interviewed said they did not return to the hospital to speak with the financial office, because they did not understand real assistance in terms of reduced or free care was available. One person reported going to her church for help; the hospital required the church to pay the bill at the hospital’s “Charge Master” rate. Others reported that they learned from another person, such as a friend or family member, that sometimes bills could be reduced or even completely written off. This, not information from the hospital, led patients to ask for charity care.

**The delay caused by patients searching for charity care information is counterproductive.** Hospitals communicate the amount the patient owes by prominently displaying this information in large, bold print font on the front of hospital billings. The availability of charity care should be communicated in the same manner — in large, bold print on the front of all hospital and collection agency billings. The language should make it clear that the actual assistance could be that the care is free or that the bill will be reduced, not just that there may be assistance in making payments over time.

## The First Bill in Context

Patients reported their first reaction to the bill was to compare the amount to their monthly wages: “my earnings for three months, six months, or for a year, or more.”



**BALANCE DUE \$32,035.56**

(Illustration only)

## 4. Patients Struggle to Comply With Hospital Application Demands.

Patients who learned about charity care from family or friends reported that they did not understand how the charity care process works. They often found themselves unwittingly following unreasonable and excessive hospital demands for information.

Those who speak Spanish as their primary language reported variations of the same story. From credit card bills to car values, some hospitals seem to demand as much information as possible to confirm their assumption that the patient can pay. In one case, a hospital refused to give a disabled patient with minimal income a charity care application, and said he could not apply for charity care until the following year – and then only if he was claimed as a dependent on his adult son’s income tax return. In another case, a hospital insisted a patient provide a court order showing how much child support her children’s father had to pay even after she explained no such document existed. Many patients said they felt that the hospital intended to discourage them from seeking charity care by making overly intrusive or repetitive demands and requiring repeated trips to the hospital billing department.

## 5. Hospitals and Debt Collectors Improperly Collect on Hospital Debts That Patients Do Not Owe

In the end, hospitals refer the accounts to collections, and patients are sued for amounts they should *never* have owed. Once a bill is sent to collections, additional fees begin accruing. This only gets worse if the hospital’s debt collector files a lawsuit.

### Mike

Mike and Sandra live in Central Washington. Mike has a medical condition that requires him to undergo periodic surgeries. He was hospitalized twice in early 2012, and again in December 2012. Mike and his wife told the hospital that Mike had no insurance. But the hospital did not screen him for charity care during any of his three surgeries.

Mike and Sandra worked jobs which paid just above the minimum wage, and Mike was often unable to work because of his medical condition. They were struggling to provide for themselves and their two children. The family’s 2011 gross income was \$26,000. Had the hospital screened Mike for charity care eligibility, Mike would have qualified for full coverage and would not have been billed.

Instead, the hospital sent Mike’s bill to collections. The collection agency sued Mike and Sandra, which substantially increased the amount of the illegitimate debt. Sandra’s wages were garnished to pay the debt that was charity care eligible, and the family lost 25% of the wages she earned as a hotel worker during 2014 and 2015.

Mike and Sandra received numerous eviction and utility termination notices when Sandra’s wages were being garnished, forcing the family to live in her sister’s unheated garage during the winter months of 2016 and early 2017.

## Snapshot: Mike and Sandra's Hospital Debt with Interest and Fees

Hospital Bills - February & March 2012	\$32,035.56
Pre-Judgment Interest at 12%	\$5,243.15
Court Costs/Attorney Fees	\$393
<b>First Subtotal</b>	<b>\$37,671.71</b>
Garnishment - Interest, Costs, Attorney Fees from 1/30/14 - 3/12/14: <ul style="list-style-type: none"> <li>• Interest: \$519.96</li> <li>• Costs/Attorney Fees: \$337.11 (Ex parte fee \$22.00, postage/cost of certified mail \$15.11, garnishment attorney fee \$300)</li> </ul>	\$857.07
<b>Second Subtotal</b>	<b>\$38,528.78</b>
Post-Judgment Interest at 12%: \$12.38/day Est. interest - March 13, 2014 to June 1, 2017 (1,177 days multiplied by \$12.38)	\$14,571.26
<b>Amount Owed (estimated) - June 1, 2017</b> (family has been garnished for \$3,839.36)	<b>\$53,100.04</b>

These additional fees and charges are particularly damaging for families who will not only suffer today, but also long into the future. Mike and Sandra's \$53,100.04 debt is one such example. If they are able to squeeze \$300 from their budget every month to pay the collection agency (\$3600 annually) for ten years, they will owe approximately \$164,000 in 2027 for a bill they should never have owed. This financial catastrophe was primarily caused by Washington's 12% pre-judgment and post-judgment interest rate, which is one of the highest in the country.

## VII. Recommendations

The experiences and data discussed in this report show that the goals of Washington's charity care law are not being met. Based on this analysis, CLS believes the following steps are needed to ensure that patients are afforded their charity care rights and have access to hospital services without regard to ability to pay.

### A. Recommendations for Washington Hospitals

1. Affirmatively screen all patients for eligibility, as legally required.
2. Improve charity care notices and provide notices in English and other languages commonly spoken by the patients served. Post and provide income limits by family size and discount amounts.
3. Comply with legal obligation to screen for charity care eligibility before requesting a deposit, co-pays or deductibles. Even those with insurance may be eligible for charity care to cover these costs.
4. Eliminate language barriers to charity care information. WSHA should incorporate improved language access requirements in its Standard Communication Plan.<sup>75</sup>
5. Educate communities: Hospitals should provide simple, understandable materials to staff, community health providers, and other social service agencies for distribution at health fairs, schools, church gatherings, and other events. WSHA's standard communication plan should be expanded to include this.
6. Do not require that patients known to be categorically ineligible for Medicaid apply for these benefits prior to being considered for charity care. While hospitals can and should screen for Medicaid eligibility for treatment coverage under specialized Medicaid programs, imposing unreasonably burdensome procedures is unlawful. Requiring patients to obtain a denial letter when hospitals know the patients won't qualify for Medicaid falls within this proscription.<sup>76</sup>
7. Do not treat retirement savings as an asset when assets are considered. Patients should not be required to "cash out" retirement savings and pay expenses or early withdrawal penalties to qualify for charity care. Further, many of these plans do not allow these assets to be accessed before retirement and therefore, they are not assets available to those who have not retired.
8. Use, improve, and expand upon WSHA's standard forms and communication plan.
9. Reimburse patients for any judgment proceeds received by the hospital and its debt collectors when it is later determined that the patient was eligible for charity care at the time of service.

10. Undertake legal efforts, in conjunction with the assigned hospital debt collector, to vacate judgments against patients who were eligible for charity care. These judgments have a negative impact on credit, which last long after the patient receives reimbursement.
11. Maintain lists of outside providers who are covered by the hospital's charity care policy, consistent with the requirements in Section 501(r) regulations, to provide to patients so that they can receive clinical care at discounted rates.<sup>77</sup>

## **B. Recommendations for Washington Department of Health**

1. Audit hospital records to verify patients are being screened and that initial eligibility determinations are made at or near the time of service.
2. Issue regulations requiring standardized forms, such as application and instruction forms, with translations for statewide use, and require every hospital to have a communication plan which effectively notifies patients of charity care.
3. Provide, at a minimum, the following consumer-oriented charity care information on DOH's website in English and other languages:<sup>78</sup> standard forms (as noted above); financial standards for eligibility; easily understandable instructions of the application process; and contact information for the Northwest Justice Project's Coordinated Legal Education, Advice and Referral hotline (CLEAR) (an intake line for free or low-cost civil legal aid).
4. Adopt statewide presumptive eligibility regulations for categories of persons so that they may be determined charity care eligible without filing an application. This should include those who are homeless or enrolled in a needs-based or means-tested program for which low-income status has been verified by a public or nonprofit agency, as well as other appropriate groups.
5. Require that hospitals provide more detailed charity care data to DOH, including: (a) number of patients who are screened for charity care eligibility, (b) number of patients who receive charity care by income category, (c) information explaining hospital outreach and language assistance efforts, and (d) total amount of charity care provided to patients by income category.
6. Redefine "family" so that patients have the option to exclude those persons with no obligation to support the patient in determining family income.<sup>79</sup>

## C. Recommendations for the Washington State Legislature

1. Mandate improved, visible, and language-appropriate charity care notification on hospital billing statements and collection notices and letters.
2. Require that all hospitals cease billing uninsured patients “Charge Master” rates without charity care application. Revise the charity care statute to require that: (a) uninsured patients with incomes from 101% to 200% of the federal poverty level are not charged more than the hospital’s cost-to-charges ratio multiplied by its Charge Master prices, and (b) patients with incomes from 201% to 300% of the federal poverty level are not charged more than 130% of the hospital’s cost-to-charges ratio multiplied by its Charge Master prices.<sup>80</sup>
3. Increase income ceilings for free or sliding fee scale discounts. A number of Washington hospitals recognize that Washington charity care income ceilings need to be increased. Many urban hospitals provide free care to persons with family incomes up to 300% of the poverty level and/or sliding fee scale discounts from 301% to 500% of the poverty level.<sup>81</sup> Some rural hospitals provide free care to 150% or 175% or even 200% of the poverty level.<sup>82</sup> Charity care income ceilings should be correspondingly increased statewide.
4. Reduce or eliminate exorbitant pre-judgment and post-judgment interest rates for hospital debts and other medical debts, reduce or eliminate collection fees, and impose reasonable limits on the steep court costs associated with collection of these debts.

## VIII. Conclusion

As the patient stories throughout this report show, hospital debt has devastating consequences for low-income individuals in Washington State. These patient experiences exemplify the difficulties faced by so many Washington patients who are charity care eligible. These problems would not have occurred if all Washington hospitals were affirmatively screening patients as required and consistently complying with their obligations under existing charity care law. Many hospital practices circumvent charity care obligations by imposing language barriers, assuming patients have or can obtain insurance, assuming patients will understand charity care on their own, or by imposing unreasonable and duplicative demands to verify eligibility.

Charity care’s purpose is to guarantee that those with the greatest need are able to obtain health care, regardless of their ability to pay. The findings and recommendations in this report outline ways in which hospitals can change their policies and practices to ensure that this purpose is met.

# Appendix A

## Hospital Policies – Problematic Issues in Charity Care Compliance

CLS reviewed all of the official charity care policies for hospitals in Washington, which are on file with DOH,<sup>83</sup> and all charity care policies on the hospitals' websites where available. In some cases the policies on the website differed from those filed with DOH. Below are policies that are either unlawful as written or that create unnecessary barriers for applicants, as well as examples of policies which correct these problems.

### *Excessive documentation requirements*

A number of hospital policies require patients to complete the charity care application “*in its entirety and attach appropriate documentation in order to be processed.*” As an example of this “in its entirety” barrier, Pullman Regional Hospital’s charity care application reads: “The guarantor must complete this financial statement in its entirety and attach appropriate documentation in order to be processed. Without this documentation, this financial statement will not be considered complete, your application will be denied and collection policies will be followed.”<sup>84</sup> Pullman’s application requires income tax returns, three months’ bank statements – both savings and checking, three current wage statements, and requests rental receipts, utility receipts, credit card statements, and loan or insurance statements.<sup>85</sup> Other hospital policies accommodate patients who are able to partially complete the application if eligibility can be determined. This is the better approach and consistent with the law.<sup>86</sup>

Summit Pacific Medical Center’s charity care application imposes greater requirements for Spanish speakers than for English speakers. The Spanish-language version requires 12 months’ income verification while the English version requires 3 months’ income verification.<sup>87</sup>

### *Requiring patients ineligible for Medicaid to apply for benefits*

Hospital policies that require all patients to obtain a Medicaid denial letter disproportionately impact LEP patients and patients who have unsettled immigration status that would bar them from obtaining Medicaid. WSHA’s standardized charity care application – which requires “Approval/denial of eligibility for Medicaid and/or state-funded medical assistance” in order to document “income” creates similar problems.

Other hospital policies do not create unnecessary and potentially unlawful barriers and are far more fair to patients. For example, UW Medicine’s policy states that Financial Assistance to persons who are immigrants in the U.S. will not be denied based on immigration status.<sup>88</sup> UW Medicine’s policy also says Medicaid eligibility will be determined in-house.<sup>89</sup>

Like UW Medicine, other hospital policies could state that Medicaid letters are not required if the patient is not eligible for Medicaid.



### ***Incorrect time limits to appeal charity care denials***

Charity care rules allow patients 30 days to appeal a final charity care determination. However, CLS found two hospitals with policies which state patients have 14 days to appeal: Lake Chelan Hospital<sup>90</sup> and Ocean Beach Hospital.<sup>91</sup> These policies should be corrected to allow patients 30 days to appeal as required by law.

### ***Student financial aid as “income”***

Legacy Salmon Creek Medical Center<sup>92</sup> and Skagit Valley Hospital<sup>93</sup> count various forms of educational assistance (i.e. grants, loans, scholarships) as income for purposes of charity care eligibility either in their charity care policy or application. However, needs-based educational assistance is specifically intended to provide tuition, books, or supplies. This is not income, and it is not for medical care.<sup>94</sup> Moreover, if the financial aid includes a loan, this should never be considered income as this is actually debt. Excluding student financial aid from “income” is also consistent with the ACA’s income rules which exclude scholarships, fellowship grants, and awards used for educational purposes from income.<sup>95</sup>

### ***Retirement savings treated as assets***

WSHA’s standard charity care application and many hospital policies require patients to disclose their retirement accounts as assets, presumably available to pay hospital bills. While ongoing distributions during retirement are income, federal law is clear that 401(k), 403(b), and other retirement accounts are exempt from collections to protect workers in their later years, regardless of current income. Hospital policies that require patients to “cash out” retirement savings and incur early withdrawal penalties cause severe financial loss to the patient. Some plans do not even allow such withdrawals. Hospitals should not consider the retirement savings of non-retired people, who cannot access the accounts without financial harm, as assets.

### ***Requiring social security numbers on charity care applications***

Some hospitals discourage charity care by requiring confidential information – including social security numbers. WSHA’s standardized charity care application states that social security numbers are “optional.” Yet, some WSHA members, such as Tri-State Memorial Hospital and Othello Community Hospital,<sup>96</sup> delete the word “optional” from the fill-in box on WSHA’s application form. The patient’s spouse’s SSN is required on non-WSHA applications used by Adventist Health/Walla Walla General Hospital,<sup>97</sup> Deaconess Hospital (Walla Walla),<sup>98</sup> and Cascade Valley Hospital.<sup>99</sup> Skagit Valley Hospital<sup>100</sup> and Prosser Memorial Medical Center’s non-WSHA charity care applications require the patient’s SSN.<sup>101</sup>

### ***Service area restrictions improperly limiting access to charity care***

Nearly one-third of hospital policies restrict charity care to local residents. CLS and other advocates who have looked at this issue believe this is an improper additional condition of eligibility that does not exist in state charity care law.

### ***Limits on the scope or amount of care covered***

Some hospital policies appear to limit the scope of care to provide less than the law requires. For example, Columbia Basin Hospital's policy reads, "Elective procedures and non-emergency services will be reviewed for financial assistance consideration but are generally excluded from financial assistance through the Charity Care program."<sup>102</sup> However, under the law, charity care covers all appropriate hospital-based medical services.<sup>103</sup>

### ***Refusal to consider applications for charity care after an account has been referred to collections***

Although the law says charity care is available "at any time,"<sup>104</sup> the individuals and patient advocates CLS spoke with report that many hospitals and collection agencies say that charity care is not available if the account has been referred to a collection agency. Whitman Hospital & Medical Center is one example of a hospital that engages in this practice. Their credit and collection policy brochure states: "If a person fails to apply for financial assistance prior to being sent to collection they will not be eligible for the entire amount of financial assistance available to them. They will be responsible for the collection fee charged to the hospital."<sup>105</sup>

### ***Cancelling charity care discounts because of non-payment of the remaining account***

Cascade Valley Hospital's website states, "If outstanding balance is not paid, the hospital reserves the right to cancel charity care discounts and assign unpaid balances to a collection agency."<sup>106</sup> Charity care cannot be cancelled to compel payment of the remaining bill once the patient has been found eligible and charity care is approved. There is nothing in the statutory language allowing a hospital to condition its legal obligation to provide charity care on whether the qualified patient pays or doesn't pay other sums owed to the hospital.

### ***Failure to timely report charity care to the DOH***

A number of hospitals are not reporting (or are unnecessarily delaying reporting) to DOH the amount of charity care they provide to patients. According to the annual DOH Charity Care Reports, Evergreen Health/Monroe, Confluence/Wenatchee Valley Hospital, Quincy Valley Hospital, Ferry County Memorial Hospital, Garfield County Memorial Hospital, and Othello Community Hospital, either have not reported to DOH the amount of charity care services they provided to patients, or reported so late that the numbers were not included in the DOH yearly report, for at least two years (since 2014 or 2015).<sup>107</sup>

<sup>1</sup> See, e.g., LIZ HAMEL ET AL., THE HENRY J. KAISER FAMILY FOUNDATION, THE BURDEN OF MEDICAL DEBT: RESULTS FROM THE KAISER FAMILY FOUNDATION/NEW YORK TIMES MEDICAL BILLS SURVEY (Jan. 2016), <https://kaiserfamilyfoundation.files.wordpress.com/2016/01/8806-the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey.pdf>; CONSUMER FINANCIAL PROTECTION BUREAU, CONSUMER CREDIT REPORTS: A STUDY OF MEDICAL AND NON-MEDICAL COLLECTIONS 4 (Dec. 2014), [http://files.consumerfinance.gov/f/201412\\_cfpb\\_reports\\_consumer-credit-medical-and-non-medical-collections.pdf](http://files.consumerfinance.gov/f/201412_cfpb_reports_consumer-credit-medical-and-non-medical-collections.pdf) (discussing data showing hospital and medical debt collections); Jordan Weissmann, *Census: Medical Expenses Put 10.6 Million Americans in Poverty*, THE ATLANTIC (Nov. 7, 2013), <https://www.theatlantic.com/business/archive/2013/11/census-medical-expenses-put-106-million-americans-in-poverty/281256/>.

<sup>2</sup> See KAREN POLLITZ, CYNTHIA COX, KEVIN LUCIA & KATIE KEITH, THE HENRY J. KAISER FAMILY FOUNDATION, MEDICAL DEBT AMONG PEOPLE WITH HEALTH INSURANCE (Jan. 2014), <https://kaiserfamilyfoundation.files.wordpress.com/2014/01/8537-medical-debt-among-people-with-health-insurance.pdf>; see also David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 741-46 (2009), [http://www.amjmed.com/article/S0002-9343\(09\)00404-5/pdf](http://www.amjmed.com/article/S0002-9343(09)00404-5/pdf) (finding that a majority of bankruptcies were caused by or related to medical costs).

<sup>3</sup> POLLITZ, *supra* note 2, at 15.

<sup>4</sup> See WAC 246-453-010(4)-(5); WAC 246-453-040.

<sup>5</sup> See RCW 70.170.010(2)-(3).

<sup>6</sup> RCW 70.170.060(6); WAC 246-453-020(1)(a)-(1)(b).

<sup>7</sup> See WAC 246-453-020(2) (“Notice shall be made publicly available that charges for services provided to those persons meeting the criteria established within WAC 246-453-040 may be waived or reduced.”); WAC 246-453-010(16) (defining publicly available notice for charity care as “posted or prominently displayed within public areas of the hospital, and provided to the individual in writing and explained, at the time that the hospital requests information from the responsible party with regard to the availability of any third-party coverage, in any language spoken by more than ten percent of the population in the hospital’s service area, and interpreted for other non-English speaking or limited-English speaking or other patients who cannot read or understand the writing and explanation.”); see also WAC 246-453-020(5) (“Hospitals may not impose application procedures for charity care sponsorship which place an unreasonable burden upon the responsible party, taking into account any physical, mental, intellectual, or sensory deficiencies or language barriers which may hinder the responsible party’s capability of complying with the application procedures.”).

<sup>8</sup> See WAC 246-453-010(16).

<sup>9</sup> *Judge Rules that Two Hospitals Broke Law by Not Offering Charity Care to Patients, Hospitals Agree to \$4.5M Settlement*, HEALTH WATCHED (Feb. 19, 2017), <https://healthwatched.org/2017/02/19/judge-rules-that-2-central-wa-hospitals-broke-law-on-offering-charity-care-to-patients/>.

<sup>10</sup> WASH. COMMUNITY ACTION NETWORK, INDENTURED SERVITUDE: WAGE AND BANK ACCOUNT GARNISHMENT FOR MEDICAL DEBT AT CHI FRANCISCAN ST. JOSEPH HOSPITAL 8 (2016), [http://washingtoncan.org/wordpress/wp-content/uploads/2011/01/Medical-Debt-Report-11-1-16PM-\\_FINAL.pdf](http://washingtoncan.org/wordpress/wp-content/uploads/2011/01/Medical-Debt-Report-11-1-16PM-_FINAL.pdf).

<sup>11</sup> Pseudonyms are used throughout this report to protect patient confidentiality.

<sup>12</sup> RCW 70.170.060(5). Federal poverty guidelines are issued each year by the U.S. Department of Health and Human Services and may be accessed here: <https://aspe.hhs.gov/poverty-guidelines>.

<sup>13</sup> WAC 246-453-040(2)-(3).

<sup>14</sup> WAC 246-453-040(1).

<sup>15</sup> WAC 246-453-040(2).

<sup>16</sup> See WAC 246-453-050(1)(d)(ii).

<sup>17</sup> See RCW 70.170.060(3)-(8) (outlining how the Department shall monitor and report hospital compliance of charity care); WAC 246-453-080 (each hospital must report charity care data to the Department); see also *Patient Information and Charity Care*, WASH. STATE DEP'T OF HEALTH, <http://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalPatientInformationandCharityCare/CharityCareinWashingtonHospitals> (last visited June 15, 2017) (stating Department of Health responsibilities and providing links to annual charity care reports).

<sup>18</sup> See WAC 246-453-020 (1)(b)-(c) (outlining procedures for initial and final determination of charity care status).

<sup>19</sup> RCW 70.170.060(6); WAC 246-453-020(1).

<sup>20</sup> See WAC 246-453-030(1) (“For the purpose of reaching an initial determination of sponsorship status, hospitals shall rely upon information provided orally by the responsible party.”).

<sup>21</sup> See WAC 246-453-020(2) (requirement of publicly available notice); WAC 246-453-010(16) (defining publicly available notice).

<sup>22</sup> WAC 246-453-020(1).

<sup>23</sup> WAC 246-453-020(1)(c).

<sup>24</sup> See WAC 246-453-030(1)-(4).

<sup>25</sup> WAC 246-453-020(5) (“hospitals *may* require potential indigent persons to use an application process ... hospitals may not impose application procedures for charity care sponsorship which place an unreasonable burden upon the responsible party, taking into account any physical, mental, intellectual, or sensory deficiencies or language barriers which may hinder the responsible party’s capability of complying with the application procedures”) (emphasis added). The “may require” here means applications are optional.

<sup>26</sup> See Appendix A for examples.

<sup>27</sup> See WAC 246-453-030(2) (“any one of the following documents shall be considered sufficient evidence upon which to base the final determination of charity care sponsorship status, when the income information is annualized as may be appropriate”... then listing “pay stubs,” etc.).

<sup>28</sup> See WAC 246-453-030(4) (if “the responsible party is not able to provide any of the documentation described above, the hospital shall rely upon written and signed statements from the responsible party . . .”).

<sup>29</sup> See WAC 246-453-020(5) (“Hospitals may not impose application procedures for charity care sponsorship which place an unreasonable burden upon the responsible party...”); WAC 246-453-020(7) (must be notified of determination of charity care status within 14 days).

<sup>30</sup> See WAC 246-453-020(9)(a) (responsible party shall have thirty calendar days to appeal).

<sup>31</sup> See WAC 246-453-020(10) (“Hospitals should make every reasonable effort to reach initial and final determinations of charity care designation in a timely manner; however, hospitals shall make those designations at any time upon learning of facts or receiving documentation...”).

<sup>32</sup> See WAC 246-453-020(11).

<sup>33</sup> Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return; Final Rule, 79 Fed. Reg. 78954-79016 (Dec. 31, 2014) (codified at 26 C.F.R. § 1.501(r)-1-1.501(r)-7).

<sup>34</sup> See Laura Sesana, *Why Nonprofits are the Most Profitable Hospitals in the US*, ARBITER NEWS (updated May 3, 2016), <http://www.arbiternews.com/2014/04/08/why-nonprofits-are-the-most-profitable-hospitals-in-the-us/> (discussing the lucrative nature of nonprofit hospitals and the debate over tax breaks).

<sup>35</sup> See 26 CFR § 1.501(r)-4 (outlining requirements for determining eligibility, publicizing the financial assistance policy, and accommodating limited English proficient individuals); 26 CFR § 1.501(r)-5 (limitation on charges).

<sup>36</sup> *Financial Assistance Information for Hospitals*, WASH. STATE HOSP. ASS’N, <http://www.wsha.org/our-members/resources-for-hospitals/financial-assistance-information-for-hospitals/> (last visited June 17, 2017).

<sup>37</sup> See, e.g., Elisabeth Rosenthal, *Benefits Questioned in Tax Breaks for Nonprofit Hospitals*, N.Y. TIMES (Dec. 16, 2013), <http://www.nytimes.com/2013/12/17/us/benefits-questioned-in-tax-breaks-for-nonprofit-hospitals.html>; INST. FOR HEALTH & SOCIO-ECONOMIC POLICY, *BENEFITING FROM CHARITY CARE: CALIFORNIA NOT-FOR-PROFIT HOSPITALS* (Aug. 15, 2012), [http://nurses.3cdn.net/2c18b9633089481d2c\\_qrm6yn2ci.pdf](http://nurses.3cdn.net/2c18b9633089481d2c_qrm6yn2ci.pdf). See also WAC 458-20-168 (discussing Washington hospital business and operations tax requirements and exemptions).

<sup>38</sup> THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUNDATION, *How Do Medicaid Disproportionate Share Hospital (DSH) Payments Change Under the ACA?* (2013), <https://kaiserfamilyfoundation.files.wordpress.com/2013/11/8513-how-do-medicaid-dsh-payments-change-under-the-aca.pdf> (finding that Disproportionate Share Hospital (DSH) payments substantially declined in January 2014 when the Affordable Care Act went into effect).

<sup>39</sup> See generally, Daniel B. Rubin, Simone R. Singh, Peter D. Jacobson, *Evaluating Hospitals’ Provision of Community Benefit: An Argument for an Outcome-Based Approach to Nonprofit Hospital Tax Exemption*, AM. J. OF PUBLIC HEALTH 612, 612-616 (Apr. 2013), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3673262/> (discussing tax-exempt status of non-profit hospitals and policymakers’ questioning of community benefits that nonprofit hospitals provide).

<sup>40</sup> ZACK COOPER, STUART CRAIG, MARTIN GAYNOR & JOHN VAN REENAN, *THE PRICE AIN’T RIGHT? HOSPITAL PRICES AND HEALTH SPENDING ON THE PRIVATELY INSURED 3* (Dec. 2015), [http://www.healthcarepricingproject.org/sites/default/files/pricing\\_variation\\_manuscript\\_0.pdf](http://www.healthcarepricingproject.org/sites/default/files/pricing_variation_manuscript_0.pdf)

<sup>41</sup> See, e.g., Dep’t of Justice, *Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice on Certificate-of-Need Laws and South Carolina House Bill 3250* 16-17 (Jan. 11, 2016), [https://www.ftc.gov/system/files/documents/advocacy\\_documents/joint-statement-federal-trade-commission-antitrust-division-u.s.department-justice-certificate-need-laws-south-carolina-house-bill-3250/160111ftc-doj-sclaw.pdf](https://www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-u.s.department-justice-certificate-need-laws-south-carolina-house-bill-3250/160111ftc-doj-sclaw.pdf) (discussing arguments about monopolization in the healthcare context in South Carolina and research about markets and cross-subsidization of charity care).

<sup>42</sup> WASH. STATE DEP’T OF HEALTH, *2015 WASHINGTON STATE CHARITY CARE IN WASHINGTON HOSPITALS 8* (Feb. 2017), <http://www.doh.wa.gov/Portals/1/Documents/2300/HospPatientData/2015CharityCareReport.pdf>.

<sup>43</sup> *Id.* at 16.

<sup>44</sup> WASH. STATE DEP'T OF HEALTH, HEALTH OF WASHINGTON STATE: SOCIOECONOMIC POSITION IN WASHINGTON 1 (updated Dec. 19, 2016), <http://www.doh.wa.gov/Portals/1/Documents/1500/Context-SEP2016-DU.pdf>.

<sup>45</sup> *Distribution of the Total Population by Federal Poverty Level (above and below 200% FPL), Timeframe: 2015*, KAISER FAMILY FOUNDATION, <http://kff.org/other/state-indicator/population-up-to-200-fpl/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>.

<sup>46</sup> See WAC 246-453-010(4).

<sup>47</sup> See Wei Yen & Thea Mounts, Second Year Impact of ACA on Washington State's Health Coverage, OFFICE OF FINANCIAL MANAGEMENT HEALTH CARE RESEARCH CENTER, Research Brief No. 80 (Dec. 2016), <http://www.ofm.wa.gov/researchbriefs/2016/brief080.pdf>.

<sup>48</sup> *Uninsured Rate in Washington State Drops by Half to 7.3 Percent*, WASH. STATE OFFICE OF INSURANCE COMM'R (Feb. 3, 2016), <https://www.insurance.wa.gov/about-oic/newsroom/news/2016/02-02-2016.html>. Based on data samples, The Washington Office of Financial Management estimates the uninsured rate in Washington has declined to 5.8%, or 406,000 persons. Either number is large. See also Wei Yen, *Trends in County Uninsured Rates in Washington: 2013-15*, OFFICE OF FINANCIAL MANAGEMENT HEALTH CARE RESEARCH CENTER, Research Brief. No. 81 (Mar. 2017), <http://www.ofm.wa.gov/researchbriefs/2017/brief081.pdf>.

<sup>49</sup> Immigration status is irrelevant to charity care. See *Ensuring Immigrant Access to Healthcare*, COLUMBIA LEGAL SERVICES, <http://www.columbialegal.org/ensuring-immigrant-access-healthcare> (describing CLS's advocacy that resulted in DOH's decision and directive to all Washington hospitals that immigration status may not be considered for charity care eligibility). DOH's November 2013 decision letter states that hospitals "may not adopt policies that exclude undocumented patients from eligibility for charity care" and "may not require a valid Social Security number to establish eligibility for charity care."

<sup>50</sup> See Paul Kiel & Chris Arnold, *From the E.R. to the Courtroom: How Nonprofit Hospitals Are Seizing Patients' Wages*, PROPUBLICA (Dec. 19, 2014, 6:00 AM), <https://www.propublica.org/article/how-nonprofit-hospitals-are-seizing-patients-wages>. This conclusion is supported by the CLS review of King, Chelan, Douglas, Whatcom, Skagit, and Island County District Court case filings.

<sup>51</sup> See, e.g., WASH. HEALTH ALLIANCE, DISPARITIES IN CARE 2014 REPORT 1, 16, 19-20 (2014), [www.commonwealthfund.org/usr\\_doc/837\\_Doty\\_seeing\\_red\\_medical\\_debt.pdf](http://www.commonwealthfund.org/usr_doc/837_Doty_seeing_red_medical_debt.pdf) (discussing disparities in care in Washington between racial and ethnic groups and disparities in care between rural and urban regions).

<sup>52</sup> See, e.g., WASH. STATE DEP'T OF HEALTH, *supra* note 44, at 1-3 (discussing poverty rates in rural areas of Washington).

<sup>53</sup> WASH. STATE DEP'T OF HEALTH, *supra* note 44, at 2 (from American Community Survey Public Use Microdata Sample, 2010-2014) (Whitman County has the highest poverty rate in the State due to its large student population).

<sup>54</sup> *Uninsured Rate in Washington State Drops by Half to 7.3 Percent*, WASH. STATE OFFICE OF INSURANCE COMM'R (Feb. 3, 2016), <https://www.insurance.wa.gov/about-oic/newsroom/news/2016/02-02-2016.html>.

<sup>55</sup> *Id.*

<sup>56</sup> See Beth Kutscher, *Without Medicaid Expansion, Some Hospitals Suffer*, MODERN HEALTHCARE (Aug. 16, 2014), <http://www.modernhealthcare.com/article/20140816/MAGAZINE/308169979>. The benefit to hospitals has

been partially offset by the reduction of Disproportionate Share Payments to hospitals with high Medicaid and uninsured rates. See also WASHINGTON OFFICE OF THE INSURANCE COMMISSIONER, THE STATE OF WASHINGTON'S UNINSURED 2014-2015 - AN EXAMINATION OF THE HEALTH INSURANCE MARKET BEFORE AND AFTER THE AFFORDABLE CARE ACT (2016), <https://www.insurance.wa.gov/sites/default/files/documents/2014-2015-state-of-uninsured.pdf> (discussing reduction of uninsured rate of persons at or below 200% of poverty level).

<sup>57</sup> WASH. STATE DEP'T OF HEALTH, *supra* note 42, at 5.

<sup>58</sup> See CIVIL LEGAL NEEDS STUDY UPDATE COMMITTEE-OFFICE OF CIVIL LEGAL AID, 2015 WASHINGTON CIVIL LEGAL NEEDS STUDY UPDATE 7-8 (Oct. 2015), [http://ocla.wa.gov/wp-content/uploads/2015/10/CivilLegalNeedsStudy\\_October2015\\_V21\\_Final10\\_14\\_15.pdf](http://ocla.wa.gov/wp-content/uploads/2015/10/CivilLegalNeedsStudy_October2015_V21_Final10_14_15.pdf). The Civil Legal Needs Study Update may reflect pre-ACA hospital debt to some extent, since the ACA was implemented on January 1, 2014, and it takes time for hospital debt to become a legal issue.

<sup>59</sup> *Judge Rules that Two Hospitals Broke Law by Not Offering Charity Care to Patients, Hospitals Agree to \$4.5M Settlement*, HEALTH WATCHED (Feb. 19, 2017), <https://healthwatched.org/2017/02/19/judge-rules-that-2-central-wa-hospitals-broke-law-on-offering-charity-care-to-patients/>.

<sup>60</sup> *Lopez v. Health Management Associates*, Yakima Co. Sup. Ct. No. 13-53508-03, "Order Granting Motions for Partial Summary Judgment Re: Charity Care Act and Breach Of Contract Claim," January 27, 2016. See [http://columbialegal.org/sites/default/files/Yakima-County-Case\\_Lopez-HMA-Charity-Care.pdf](http://columbialegal.org/sites/default/files/Yakima-County-Case_Lopez-HMA-Charity-Care.pdf) to view the letter constituting the oral ruling in this case.

<sup>61</sup> See Becky Kramer, *Lawsuit Alleges Deaconess, Valley Hospital Owner Shorted Community Millions in Charity Care*, THE SPOKESMAN-REVIEW (June 13, 2017), <http://www.spokesman.com/stories/2017/jun/12/for-profit-owner-of-deaconess-valley-hospitals-sti/>.

<sup>62</sup> WASH. COMMUNITY ACTION NETWORK, *INDENTURED SERVITUDE: WAGE AND BANK ACCOUNT GARNISHMENT FOR MEDICAL DEBT AT CHI FRANCISCAN ST. JOSEPH HOSPITAL* (2016), [http://washingtoncan.org/wordpress/wp-content/uploads/2011/01/Medical-Debt-Report-11-1-16PM-\\_FINAL.pdf](http://washingtoncan.org/wordpress/wp-content/uploads/2011/01/Medical-Debt-Report-11-1-16PM-_FINAL.pdf).

<sup>63</sup> *Id.* at 1.

<sup>64</sup> *Id.*

<sup>65</sup> *Id.*

<sup>66</sup> The Washington State Hospital Association has adopted a recommended "WSHA Standard Communication Plan: Minimum Recommendations for Communicating About Financial Assistance/Charity Care" available online at <http://wsha.wpengine.com/wp-content/uploads/WSHA-Standard-Financial-Assistance-Communication-Plan.pdf>. We do not know the extent of its current implementation.

<sup>67</sup> See WAC 246-453-020(1)(c).

<sup>68</sup> See *Virginia Mason Medical Center, Policy: Financial Assistance*, VIRGINIA MASON 1-2(Effective January 1, 2016), <https://www.virginiamason.org/workfiles/billing/Financial-Assistance-Policy-English.pdf>.

<sup>69</sup> See WAC 246-453-030(3) ("In the event that the responsible party's identification as an indigent person is obvious to hospital personnel, and the hospital personnel are able to establish the position of the income level within the broad criteria described in WAC 246-453-040 or within income ranges included in the hospital's sliding fee schedule, the hospital is not obligated to establish the exact income level or to request the aforementioned documentation from the responsible party, unless the responsible party requests further

review”).

<sup>70</sup> See WAC 246-453-020(6).

<sup>71</sup> *Pay Your Bill: Financial Assistance/Uncompensated Care*, MASON GENERAL HOSPITAL & FAMILY OF CLINICS, <https://www.masongeneral.com/payyourbill> (last visited May 16, 2017). The same website does have “uncompensated care” information but does not indicate that this applies to deposits. The charity care policy on the DOH does state that “pending financial eligibility, the District will not initiate collection efforts or requests for deposits” but it is unclear how this actually works in practice, given the above and that the policy contains no presumptive eligibility standards, unlike a number of other hospitals.

<sup>72</sup> See WAC 246-453-020(2).

<sup>73</sup> See WAC 246-453-010(16).

<sup>74</sup> *Financial Assistance Sign: English/Spanish*, Online Bookstore of the WASHINGTON STATE HOSPITAL ASSOCIATION, <https://washington-state-hospital-association.myshopify.com/collections/financial-assistance/products/financial-assistance-sign-english-spanish> (last visited June 18, 2017).

<sup>75</sup> See *WSHA Standard Communication Plan: Minimum Recommendations for Communicating About Financial Assistance/Charity Care*, WASH. STATE HOSP. ASS’N (April 2016), <http://wsha.wpengine.com/wp-content/uploads/WSHA-Standard-Financial-Assistance-Communication-Plan.pdf>. Requiring written information to be in multiple languages under this plan is insufficient. WSHA should adopt written standards regarding non-written communications and affirmative screening of LEP persons (telephone, intake, discharge, hospital training on use of interpreters).

<sup>76</sup> See WAC 246-453-020(5) (hospitals may not impose application procedures that are an unreasonable burden).

<sup>77</sup> Non-profit hospitals are required by Section 501(c)(3) regulations to maintain a list of outside providers (other than the hospital itself) delivering medically necessary care in the hospital’s service area who are covered by the hospital’s Charity Care plan and to supply the list to patients upon request. Similar lists should be created and made available at all Washington hospitals, so indigent patients may know which providers provide financial assistance. See 26 C.F.R. § 1.501(r)-4(b)(1)(iii)(F).

<sup>78</sup>The DOH has taken a positive step forward by adding a Spanish-language link to its website. However, the DOH should include consumer-oriented Charity Care information in various languages on its website as well.

<sup>79</sup> DOH regulations define “family” as “a group of two or more persons related by birth, marriage, or adoption who live together; all such related persons are considered as members of one family.” WAC 246-453-010(18). Unlike the existing definition, the more modern and accepted definition of “family” recognizes concepts of tax dependency and obligation to support. The ACA and Medicaid use the “Modified Adjusted Gross Income” (MAGI) standard where “family income” includes the income of the taxpayer, spouse, and all claimed tax dependents, and the tax dependent’s MAGI. Under this method, the income of elderly parents, adult siblings, cousins, in-laws, and other extended family members is excluded unless they are tax dependents.

<sup>80</sup> The Washington State Hospital Association recommends this practice and has proposed a standard which states: “No uninsured patient with an annual income under 300 percent of the federal poverty level is required to pay more than 130 percent of the estimated cost of their care. (Cost is the charge multiplied by the hospital’s average cost-to-charge ratio).” *Hospital Voluntary Pledge Billing to the Uninsured*, WASH. STATE HOSP. ASS’N, <http://www.wsha.org/our-members/resources-for-hospitals/financial-assistance-information-for-hospitals/hospital-voluntary-pledge-billing-to-the-uninsured/> (last visited June 22, 2017).



<sup>81</sup> Examples of urban hospitals with this policy include UW Medicine which includes Harborview Hospital; Kadlec Hospital; and Multicare Systems which includes Good Samaritan, Swedish, and Kennewick General. See, e.g., *Financial Assistance Policy*, UW MEDICINE, <http://www.uwmedicine.org/patient-care/billing/financial-assistance/policy> (last visited May 16, 2017) (financial assistance for full charges at 300% FPL); Kadlec Regional Medical Center Financial Assistance Policy, KADLEC REGIONAL MEDICAL CENTER 4 (effective date Jan. 2016), [https://www.kadlec.org/uploads/Patient\\_Financial\\_Services\\_Financial\\_Assistance\\_Policy-Kadlec-Dec-2015.pdf](https://www.kadlec.org/uploads/Patient_Financial_Services_Financial_Assistance_Policy-Kadlec-Dec-2015.pdf) (free care at or below 300% FPL, 75% discount between 301-350% FPL, and financial assistance above that level in certain cases); *MultiCare Systems: Financial Assistance*, MULTICARE, <https://www.multicare.org/financial-assistance/> (last visited May 16, 2017) (bill fully reduced at or below 300% FPL and some reductions for 301%-500% FPL).

<sup>82</sup> Examples of this include North Valley Hospital up to 150% FPL; Confluence HealthCare up to 300% FPL; and Island Hospital up to 200% FPL. See Charity Care Policy Document, NORTH VALLEY HOSPITAL 2 (last revised Feb. 2016), <http://www.doh.wa.gov/Portals/1/Documents/2300/HospPatientData/CCP107-2016.pdf>; Compassionate Care Program, CONFLUENCE HEALTH, <https://www.confluencehealth.org/patient-information/financial-assistance/compassionate-care-program/> (last visited June 18, 2017); Financial Assistance Program Policy Document, ISLAND HOSPITAL 4 (Dec. 22, 2016), <http://www.doh.wa.gov/Portals/1/Documents/2300/HospPatientData/CCP134b-2016.pdf>.

<sup>83</sup> See *Hospital Policies*, WASH. STATE DEP'T OF HEALTH, <http://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalPolicies> (last accessed June 16, 2017).

<sup>84</sup> *Pullman Regional Hospital Assistance Program – Financial Statement (2016)*, PULLMAN REGIONAL HOSPITAL 1, <http://www.pullmanregional.org/sites/default/files/PRH-Charity-Care-Application-2016.pdf> (last visited June 16, 2017).

<sup>85</sup> *Id.*

<sup>86</sup> In addition, as noted earlier, if the patient lacks such income documentation it is sufficient for the patient to provide a signed statement describing the patient's financial circumstances. See WAC 246-453-030(4).

<sup>87</sup> *Billing Information*, SUMMIT PACIFIC MEDICAL CENTER, <https://summitpacificmedicalcenter.org/wordpress/billing-information/> (last visited June 16, 2017) (contains links to Spanish and English language financial assistance applications).

<sup>88</sup> See *UW Medicine Administrative Policies and Procedures: Financial Assistance*, UW MEDICINE 2, <http://www.doh.wa.gov/Portals/1/Documents/5300/CCPuwmc-2016.pdf> (last accessed June 16, 2017).

<sup>89</sup> *Id.* at 3.

<sup>90</sup> See *Lake Chelan Community Hospital Policies and Procedures: Charity Care*, LAKE CHELAN COMMUNITY HOSPITAL 4 (May 1991), <http://www.doh.wa.gov/Portals/1/Documents/5300/CCP1651991.pdf> (last accessed from DOH website on June 16, 2017).

<sup>91</sup> See *Charity Care*, PACIFIC COUNTY HOSPITAL DISTRICT #3 OCEAN BEACH HOSPITAL AND CLINICS FINANCE DEPARTMENT 3, <http://www.doh.wa.gov/Portals/1/Documents/5300/CCP079-2007.pdf> (last accessed from DOH website June 16, 2017).

<sup>92</sup> See *Financial Assistance: Charity Care*, LEGACY HEALTH 1 (March 2016), <http://www.doh.wa.gov/Portals/1/Documents/5300/CCP208-2016.pdf>.

<sup>93</sup> See *Skagit Regional Health Financial Assistance/Sliding Fee Scale Policy*, SKAGIT REGIONAL HEALTH 5 (Oct.

2012), <https://www.skagitregionalhealth.org/SVH/media/documents/foundation/Charity-Application-SRH-Revised-2012-0612.pdf>.

<sup>94</sup> See WAC 246-453-010(17) (“‘Income’ means total cash receipts before taxes derived from wages and salaries, welfare payments, Social Security payments, strike benefits, unemployment or disability benefits, child support, alimony, and net earnings from business and investment activities paid to the individual.”). Loans and educational assistance are certainly not “income” as they are not wages or salaries received.

<sup>95</sup> See 42 C.F.R. 435.603(e)(2) (“Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income.”).

<sup>96</sup> See *Financial Assistance Application*, TRI-STATE MEMORIAL HOSPITAL & MEDICAL CAMPUS, <http://tristatehospital.org/media/downloads/Financial-Assistance-Application.pdf> (last accessed June 16, 2017). See also, *Summary of Financial Assistance/Charity Care Policy*, OTHELLO COMMUNITY HOSPITAL, [https://www.othellocommunityhospital.org/uploadedFiles/Policies/English%20Handout%20Policy-English%20Charity%20Application\(1\).pdf](https://www.othellocommunityhospital.org/uploadedFiles/Policies/English%20Handout%20Policy-English%20Charity%20Application(1).pdf) (last accessed June 16, 2017). While Othello Community Hospital’s Application Instructions state, “Note: You do not have to provide a SSN to apply for financial assistance,” the word optional is deleted in the application itself.

<sup>97</sup> See *Policy: Patient Billing: Financial Assistance*, ADVENTIST HEALTH 11, [https://www.adventisthealth.org/Documents/Financial-Assistance-Policies/ENG\\_PFS-112\\_Financial-Assistance-Policy.pdf](https://www.adventisthealth.org/Documents/Financial-Assistance-Policies/ENG_PFS-112_Financial-Assistance-Policy.pdf) (last accessed June 16, 2017).

<sup>98</sup> See *Charity Care Policy Exhibit C – Financial Assistance Form*, DEACONESS HOSPITAL / ROCKWOOD HEALTH SYSTEM 9 (Jan. 2017), <http://www.doh.wa.gov/Portals/1/Documents/2300/HospPatientData/CCP037-2017.pdf>.

<sup>99</sup> See *Patient Financial Assistance Application*, CASCADE VALLEY HOSPITAL AND CLINICS, <http://www.cascadevalley.org/wp-content/uploads/2013/12/Charity-Application.pdf> (last accessed June 16, 2017).

<sup>100</sup> See *Financial Assistance/Sliding Fee Scale Form*, SKAGIT REGIONAL HEALTH, <http://www.skagitregionalhealth.org/SVH/media/documents/foundation/Charity-Application-SRH-Revised-2012-0612.pdf> (last accessed June 16, 2017).

<sup>101</sup> See *Charity Care*, PMH MEDICAL CENTER’S MANAGEMENT GUIDELINE 8, <http://www.doh.wa.gov/Portals/1/Documents/5300/CCP046-1991.pdf> (last accessed June 16, 2017).

<sup>102</sup> See *Financial Assistance / Charity Care Policy*, COLUMBIA BASIN HOSPITAL POLICY AND PROCEDURE POLICY 4 (March 2016), <http://www.doh.wa.gov/Portals/1/Documents/5300/CCP045-2016.pdf>.

<sup>103</sup> See WAC 246-453-010(5), (7).

<sup>104</sup> See WAC 246-453-020(10).

<sup>105</sup> See 2016 Credit and Collection Policy Brochure, Whitman Hospital & Medical Center (obtained by CLS through a public records request). According to its credit and collection policy, the hospital provides this brochure to patients during the admission process when it asks if they might need assistance paying the bill. See *Credit and Collection Policy & Procedure*, WHITMAN HOSPITAL & MEDICAL CENTER 6 (approved Oct. 4, 2016), <https://www.whitmanhospital.org/media/1246/credit-and-collection-policy-procedure.pdf> (explaining when patients receive the brochure).

<sup>106</sup> See *Understanding Charity Care--What Happens if I am Eligible?* CASCADE VALLEY HOSPITAL, <http://www.cascadevalley.org/charitycare/> (last accessed June 16, 2017).

<sup>107</sup> See WASH. STATE DEP'T OF HEALTH, 2014 WASHINGTON STATE CHARITY CARE IN WASHINGTON HOSPITALS 12-16 (Jan. 2016), <http://www.doh.wa.gov/Portals/1/Documents/5300/2014CharityCareReport.pdf>; see also WASH. STATE DEP'T OF HEALTH, 2015 WASHINGTON STATE CHARITY CARE IN WASHINGTON HOSPITALS 12-16 (Feb. 2017), <http://www.doh.wa.gov/Portals/1/Documents/2300/HospPatientData/2015CharityCareReport.pdf>.



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