

# HB 3076

## Implementation Report

Status of the new hospital community benefit program, expanded financial assistance, and new medical debt protections

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December 2022



# Executive Summary

The Oregon Legislature made several significant changes to Oregon's laws governing hospital charity care during the 2019 session. House Bill (HB) 3076 charges the Oregon Health Authority (OHA) with administering a new hospital community benefit program that sets minimum spending floors for nonprofit hospitals; expands hospital financial assistance requirements; and creates new medical debt protections for patients.

HB 3076 directs OHA to launch a new hospital community benefit program with minimum spending floors in order to encourage hospital spending on patient financial assistance and equity-related investments at a community level. The bill directs OHA to establish a spending floor for each non-profit hospital in the state. Individual hospital floors are to be based on several criteria, including the hospital's previous spending history, the hospital's financials, and the hospital's community needs assessments.

HB 3076 also expands hospital financial assistance requirements in two ways. First, it requires hospitals to provide financial assistance to more patients, including those with income up to 400% of the federal poverty level (FPL). Second, it specifies the minimum adjustment hospitals must make to amounts charged to patients, at each of four different levels of income.

Finally, HB 3076 provides new medical debt protections. Hospitals are prohibited from referring patients to collections prior to screening them for financial assistance eligibility. If patients qualify for financial assistance, hospitals cannot charge interest on amounts still owed to the hospital. HB 3076 also provides a private right of action under the federal Unfair Debt Collection Act to patients who do not receive financial assistance and/or protection from debt collection and interest charges as specified in the bill.

HB 3076 charges OHA with reporting on its implementation of the new community benefit program, as well as the bill's provisions regarding financial assistance and medical debt, by Dec. 30, 2022. The following report contains a description of OHA's implementation of the new community benefit program, including partner engagement in the program design and hospital compliance with the new reporting requirements. The report also reviews relevant hospital policies, data on Oregon-specific medical debt trends, and findings from numerous interviews OHA conducted with representatives from both hospitals and patient advocacy groups.

## What is Community Benefit Spending?

Non-profit hospitals have an obligation to provide charitable services to their local communities in lieu of paying taxes.

Community benefit spending is comprised of unreimbursed care, such as charity care and Medicaid losses, and proactive, direct spending on services, such as supporting community health improvement projects or donating money or equipment to community groups.

Annually, 75% of all community benefit spending is on unreimbursed care.

Two general conclusions emerge from the report:

**I. OHA has successfully launched the new community benefit program as directed in HB 3076 and hospitals are complying with the program's new reporting requirements.**

Oregon's new Community Benefit Program was developed in partnership with Oregon's non-profit hospitals and other partners. Many different organizations and provider entities collaborated throughout OHA's policy development and rule-making processes, which has contributed to a relatively smooth program launch.

On Jan. 1, 2021, following a robust Rules Advisory Committee process, OHA formally established the community benefit program and assigned all Oregon non-profit hospitals their initial minimum spending floors. OHA used a separate Rules Advisory Committee process to focus on reporting and issued the official hospital affiliated clinic reporting form that same year.

In July 2022, OHA convened the first annual community benefit summit, focused on providing support to hospitals during the transition to the new minimum spending floor program. Hospitals have complied with reporting requirements for the new program and OHA will receive complete data for the first year of implementation in September 2023.

OHA will publish annual reports on hospitals performance relative to the spending floors, as well as more detailed reports about individual hospital community benefit spending and how hospitals are addressing needs identified in their communities.

**II. Hospital financial assistance policies are largely in alignment with the new legal requirements for patient financial assistance and medical debt. However, patients continue to experience challenges with accessing financial assistance and hospital billing practices remain an area of concern.**

Hospitals have updated their financial assistance policies (FAP) to be in alignment with statutory requirements for minimum levels of financial assistance at different income tiers. Most hospital policies pertaining to medical debt have also been updated to incorporate the added protections against referrals to collection and interest charges.

However, patients and patient advocates report that financial assistance information remains difficult to find and understand at some hospitals, and application processes are complex and difficult to navigate. Some hospital staff struggle to understand and apply eligibility criteria that aligns to HB 3076, and report barriers to effectively screening and notifying potentially eligible patients of financial assistance prior to moving debts to collection.

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# Introduction

In 2019, House Bill (HB) 3076 charged the Oregon Health Authority (OHA) with administering a new hospital community benefit program and setting spending floors for each non-profit hospital in the state. The bill makes significant changes to reporting requirements and adds a new definition for spending on “Social Determinants of Health”.

HB 3076 also requires hospitals to provide financial assistance to patients with income up to 400% of the federal poverty level (FPL), with minimum reductions in charges set by household income level. Hospitals are required to post their FAP within their facilities in a place visible to patients.

Hospitals and their clinics are required to conduct financial assistance screening at the patient’s request and before transferring their medical debt to collections. Hospitals are prohibited from charging interest on medical debt of patients who do qualify for financial assistance and interest charged on the debt of patients who do not qualify for financial assistance is tied to a specified amount. Medical debt cannot be collected from designated family members of the patient.

HB 3076 called for a report on implementation of these new provisions by December 30, 2022.

OHA is well-positioned to report on implementation of the new hospital community benefit program, which it developed in partnership with the primary architects of HB 3076: Service Employees International Union (SEIU) Local 49 and the Oregon Association of Hospitals and Health Systems (OAHHS) as well as other interested parties. OHA consulted with national experts on criteria and methodology for setting minimum spending floors, and conducted a robust Rules Advisory Committee, which attracted over 40 participants in a three-part series of regulatory meetings. Further detail is provided in the body of this report.

In contrast, OHA was not charged with implementation of the expansion of hospital financial assistance and has no role to play in oversight or enforcement of new provisions on financial assistance and medical debt. In order to provide a report on hospital implementation of provisions related to hospital financial assistance, OHA reviewed hospital FAP and conducted

interviews with hospital staff representing 37 hospitals as well as patient advocates. SEIU's recent report, "Shortchanged: How hospital financial assistance practices and policies fail Oregon patients with the greatest need"<sup>1</sup> is cited for findings related to patient experience with hospital financial assistance in Oregon as well as interviews with a national nonprofit, Dollar For, who assists patients in obtaining financial assistance. OHA also reviewed recent data from the 2021 Oregon Health Insurance Survey (OHIS) on medical debt trends in Oregon and complaint data available to OHA's Ombuds office.

Taken together, the information in this report provides a detailed picture of implementation of the new community benefit program and reveals both progress and continued challenges with hospital financial assistance and medical billing practices in Oregon. The community benefit minimum spending floor program and changes to the hospital financial assistance and medical debt policies are found in the following Oregon Revised Statutes (ORS) and Oregon Administrative Rules (OAR):

- [ORS 442.601 to ORS 442.630](#)
- [ORS 646A.677](#)
- [OAR 409-023-0100 to 0115](#)

## Implementation of a New Hospital Community Benefit Program

HB 3076 required OHA to establish a methodology to assign minimum community benefit spending floors to hospitals every two years no later than January 1<sup>st</sup>, 2021. The bill provided a range of criteria OHA was to base the spending floor on, and requirement for consultation, outreach, and engagement with community partners.

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<sup>1</sup> <https://www.actheathyoregon.org/news-reports-1/2022/10/4/shortchanged-how-hospital-financial-assistance-practices-and-policies-fail-oregon-patients-with-the-greatest-need>

HB 3076 required OHA to consider multiple factors in establishing the spending floor:

1. Historic and current expenditures on community benefits.
2. Community needs identified in the community needs assessment conducted by the hospital.
3. The hospital's need to expand the health care workforce.
4. The overall financial position of the hospital and affiliated clinics based on financial statements and other objective data.
5. The demographics of the population in the area served by the hospital and affiliated clinics.
6. The spending on the social determinants of health by the hospital and affiliated clinics.
7. Taxes paid by the hospital and the hospitals payments, in lieu of taxes, made to a local government, the state, or the federal government.

OHA developed a spending floor methodology and filed final rules in December of 2020. Throughout 2021, OHA assigned the first spending floors to all fifty-eight of Oregon's non-profit hospitals. Community benefit spending floor rules are found in OAR 409-023-0110.

As of December 2022, all hospitals have accepted their spending floors. One health system and one independent hospital made informal contact with OHA to discuss possible options to modify their spending floors. In both cases the hospitals declined to formally request a modification.

The current cycle of spending floors is effective for hospital fiscal years of 2022 and 2023. Data related to performance against the first year of the spending floor will be available in the fall of 2023. More detail on the implementation process follows.

### **Methodology Development**

In developing the minimum spending floor methodology, OHA adopted several guiding principles, which were informed by conversations with partners and legal analysis from Oregon's Department of Justice (DOJ).

The most fundamental principle is that “minimum” really means “minimum.” All hospitals should exceed their minimum spending floor, and the spending floor should not be a disincentive for hospitals with robust spending to maintain those levels. OHA expressed an intention to link spending minimums to the hospital operating margins. Hospitals in robust financial health have their spending floor adjusted upward, even if they are already making strong community benefit investments. Hospitals that are financially struggling will have their spending floor adjusted downward.

Additional principles established for the program are set forth in the text box to the right – the principles call on the methodology to be comprehensive, prospective, efficient, and flexible.

While OHA does not explicitly include or exclude any specific community benefit categories (per DOJ guidance) from allowable spending, the agency did differentiate historical spending in the different community benefit categories when developing the formula. Unreimbursed care, such as charity care and unreimbursed Medicaid, usually trend with utilization. Due to the codification of minimum financial assistance levels, charity care is highly regulated in Oregon. Because of the strong correlation to utilization, OHA built part of the methodology’s formula on utilization trend forecasts, and part of the formula on patient revenue. This resulted in a formula that is responsive to changes in both hospital revenue and patient mix.

The proposed formula was modelled against historic data. Data for 2015-2017 was used to assign a test floor to compare with actual spending in 2018. The formula assigned a spending floor that was an average of 90% of actual 2018 community benefit spending, and a median of 81% of actual

#### Guiding principles for development of the minimum community benefit spending floors

- Minimum means minimum. All hospitals should exceed their floors
- Comprehensive. All community benefit spending is captured
- Prospective. All hospitals know their floors in advance.
- Efficient. Existing data systems should be used.
- Simple and scalable.
- Flexible.
- Avoids negative trends.



spending. In 2018, 13 hospitals (22%) had actual spending lower than the test floor.

The COVID pandemic was immediately recognized as a concern for the spending floor. The key limitation of the formula is it relies on historic trend data for spending that lags by two years. As a result, the formula cannot account for sudden spikes in spending either up or down. OHA introduced specific guidance related to how it would handle the impact of the COVID pandemic in its guidance for spending floor adjustments.

### **Partner & Expert Engagement**

Oregon's work to develop a minimum spending floor for hospital community benefit is first in the nation. Hospitals, patient advocates and other interested parties expressed appreciation and gratitude for the level of transparency OHA brought to its work developing a methodology, and the agency's willingness to incorporate feedback in developing the program's regulatory framework.

While the COVID pandemic necessitated a pause in face-to-face engagement, OHA used the spring and early summer months of 2020 to consult with national experts and explore methodology options. OHA consulted with two notable experts in health care economics and law to help guide development of the minimum spending floor methodology.

**Ge Bai, PhD, CPA** is a Professor of Accounting at Johns Hopkins Carey Business School and Professor of Health Policy & Management (joint) at Johns Hopkins Bloomberg School of Public Health. She is currently a visiting scholar at the Health Analysis Division of the Congressional Budget Office.

**Sara Rosenbaum, JD** is the Harold and Jane Hirsh Professor of Health Law and Policy and Founding Chair of the Department of Health Policy, George Washington University School of Public Health and Health Services. She also holds a Professorship by Courtesy in the law school and is a member of the faculty of the School of Medicine and Health Sciences.

The agency's initial direction for methodology was outlined in a document posted for comment in the summer of 2020. OHA kept interested parties updated in meetings requested by OAHHS, SEIU, Representative Andrea

Salinas (the legislative sponsor), the Northwest Health Foundation, and several individual hospitals.

OHA began formal rulemaking in September of 2020, conducting broad outreach across all Oregon counties to solicit member applications for the Rules Advisory Committee (RAC). The RAC held three meetings throughout September, each of which were well attended by a variety of interested parties as well as the RAC members. Legislators were notified of the proposed rules in October of 2020, and the proposed rules were posted in the Secretary of State bulletin in the beginning of November. A rules hearing was held on November 17<sup>th</sup>, 2020, to collect final comments. Final rules were sent to the Secretary of State on the first of December, becoming effective on the legislative mandated date of January 1<sup>st</sup>, 2021.

Starting in 2023, OHA will use spending floor data to publish an annual report on the impact of hospital community benefit dollars, highlighting real changes that have followed in Oregon's communities.

### **Hospital Concerns with the Methodology**

Community benefit in Oregon has traditionally been made up of around 75% unreimbursed care, or losses hospitals took providing care to those who are low-income or cannot pay, and 25% proactive direct spending dollars the hospital spent on programs that meet the health needs of the community, especially in SDOH. Hospitals have calculated unreimbursed care retrospectively, often through their finance departments, using the previous year's spending on financial assistance for individual patients as a guide.

The new program's focus on proactive community benefit activities and programming shifts the emphasis to future planning – including dollar amounts and programs hospitals can invest in to improve the health of their service area.

Interviews with hospitals indicate that some have found forecasting for the new, proactive community benefit spending to be a challenge. Many facilities expressed a lack of confidence in their ability to forecast utilization for the coming years and concern that financial challenges stemming from COVID will persist at least through 2023. Several commented on the shift in thinking the proactive focus has called for, concluding that while the first

year or two have been difficult, the benefit of proactive community benefit planning has been significant.

It is worth noting here that OHA has the ability to address individual hospital financial distress and other scenarios through the community benefit minimum spending floor modification policy.

### **Public Reporting Requirements – Posting to Hospital Websites**

Although HB 3076 does not specifically require hospitals to post their FAP on their websites, section five of the bill does mandate that non-profit hospitals post community benefit documents to their website, in accordance with section 501(c)(3) of the Internal Revenue Code.


Federal regulations already required hospitals to post triennial community health needs assessments and implementation strategies. The new posting requirements add annual updates on progress as well as information on opportunities for public engagement in the assessment and strategy development. The requirement to publicly share annual updates on progress gives hospitals the opportunity to better measure and demonstrate the impact of their investments on the assessed health needs of their communities. The opportunity for public engagement reaffirms the focus of each hospital's community benefit work in what their community wants and needs.

OHA found that all hospitals follow HB 3076's requirements for posting community needs assessments. OHA collects and posts these documents on the Hospital Reporting Program webpage, under Hospital Profiles.

### **OHA Reporting Requirements and Definitional Changes**

Section seven of HB 3076 creates the requirement for hospital to report all affiliated clinics operating in Oregon that the hospital owns or controls in whole or in part, or any clinic operating under the same brand as the hospital to OHA on an annual basis. OHA introduced administrative rules governing health care facility and affiliated clinic reporting along with the rules for the minimum spending floor program in September 2020, with final rules effective on January 1, 2021. Hospitals made their first annual report on June 30, 2021.

All hospitals in Oregon have submitted required reports by June 30 for both 2021 and 2022 as of the writing of this report. OHA review of submitted



OHA ESTABLISHED AN ANNUAL COMMUNITY BENEFIT SUMMIT FOR THE PURPOSE OF HOSPITAL AND COMMUNITY PARTNER ENGAGEMENT ON COMMUNITY BENEFIT MINIMUM SPENDING FLOOR PROGRAM AND OTHER TOPICS RELATED TO COMMUNITY BENEFIT.

forms generally show a high level of accuracy, though some hospitals have been notified there may be incomplete or missing data in their submissions. Administrative rules governing reporting health care facilities and

affiliated clinics are found in OAR 409-023-0115. All health care facility reporting forms are posted to OHA's website.

Section 10 of HB 3076 provides two key definition changes to community benefit reporting. The first definitional change expands the definition of community benefit to include programs or activities that address health disparities *or* SDOH in response to an identified community need. Community benefit has always been focused on improving health and access for those who need it most. This expanded definition puts the focus of the work front and center, with more clarity than before. The definition now also mirrors OHA's goal of eliminating health disparities by 2030.

The second definitional change aligns Oregon state law with federal policy for community benefit reporting by excluding unreimbursed Medicare costs from state community benefit spending starting January 1, 2020. This change means the Oregon community benefit reporting form now matches the federal hospital financial reporting form, eliminating reporting differences between state and federal forms.

To implement the new definition of SDOH, OHA took a multipronged approach. Starting in fiscal year 2022 OHA added a narrative report to capture community benefit activities in SDOH. The new narrative requires hospitals to report on how their investments address identified health needs, efforts to collaborate and partner with community-based organizations and other entities, and measurements of the impact of their investments. This gives hospitals the opportunity to share about their investments and activities focused on the bigger, more long-term efforts whose impacts in their communities often go beyond what can be conveyed through numbers.

In 2021, hospital community benefit direct spending accounted for almost 22% of all spending, or \$426 million. Only two percent of all community benefit spending is specifically directed towards SDOH – when hospital partnerships with community-based and other philanthropic organizations fund programs in identified areas of need such as housing, education, and economic stability. The changes made in HB 3076 incentivize spending in SDOH through the new community benefit definition including SDOH and the addition of narrative reporting with newly required outcomes reporting. These changes have the potential to increase hospital direct spending in SDOH and make big impacts on the health and wellbeing of Oregon communities.

OHA's Hospital Reporting Program also worked with the OHA Transformation Center to promote alignment between hospital community benefit SDOH spending and Coordinated Care Organization (CCO) Health Related Spending. While there is no regulatory requirement for alignment, these two spending areas focus on the same SDOH efforts in similar populations across the state. Thus, there is great opportunity for hospitals and CCOs to collaborate on SDOH investments with community-based organizations or other interventions in their shared service areas. OHA invited all Oregon hospitals to the first of an annual community benefit summit meeting in July 2022 and presented this topic to hospitals for discussion.

OHA engaged with hospitals to help smooth the transition to removing Medicare unreimbursed amounts from community benefit reporting. OHA established a reporting deadline for the exclusion, updated reporting forms, and removed Medicare amounts from historic reports, so as to maintain consistent trend reporting for hospital community benefit amounts.

It is worth noting that although the new law excluded Medicare losses from the charity care portion of community benefit, hospitals have been able to include some Medicare related costs that meet specified criteria as part of their losses attributed to Subsidized Health Services (SHS), a federal category of community benefit that must be included in Oregon's community benefit reporting. Medicare losses that qualify as SHS would then count toward establishment of hospital minimum spending floors. Medicare losses did not previously qualify as SHS because they were costs

potentially counted as charitable expenses and thus expressly excluded from SHS.

OHA identified that after the change in law that allowed hospitals to shift costs to SHS, some hospitals may have inappropriately attributed unreimbursed Medicare costs to SHS that did not meet all specified criteria for SHS. After an initial review of fiscal year 2021 compliance, OHA engaged hospitals in discussion around how to properly calculate new SHS amounts. In March 2022, OHA shared guidance on proper accounting for unreimbursed Medicare.

As was written into rule, OHA held the first annual community benefit summit for all interested parties in July 2022 to discuss the implementation of the community benefit minimum spending floor program and changes to reporting requirements. OHA specifically spoke to the importance of correctly reporting Medicare loss calculations as SHS and shared a graphic to breakdown the formula. Hospitals indicated comprehension of the breakdown.

Following the methodology review of federal SHS calculations, OHA asked for hospitals' input towards crafting an Oregon-specific definition of SHS to better capture services that provide access specific to local community needs. OHA received feedback from multiple hospitals, including a joint 12-hospital letter requesting no state definition be established so that multi-state health systems can have standardized reporting across states.

## **Implementation of HB 3076 Financial Assistance and Medical Debt Provisions**

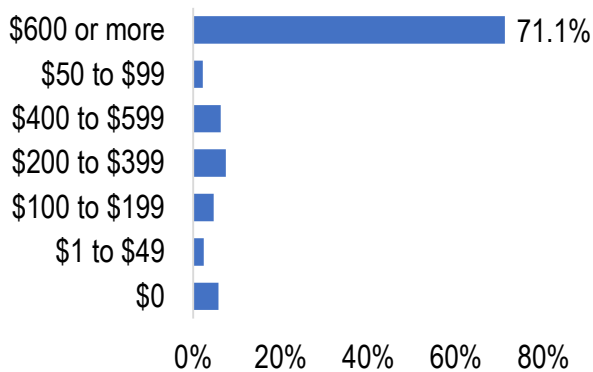
HB 3076 targets the burden of ever-increasing health care costs and medical debt through expansion of hospital financial assistance and new protections against medical debt. OHA was not charged with an oversight or monitoring function related to these new provisions, and therefore cannot report on hospital implementation in detail. In order to provide this

implementation report, OHA reviewed hospital FAP and conducted interviews with hospital staff representing 37 hospitals and health systems, as well as patient advocates. The recent SEIU report “Shortchanged” and national nonprofit Dollar For are cited for perspectives related to patient experience with hospital financial assistance in Oregon. OHA consulted with the agency’s Ombuds office, and reviewed available data related to state trends in medical debt, delayed care, and medical bankruptcies.

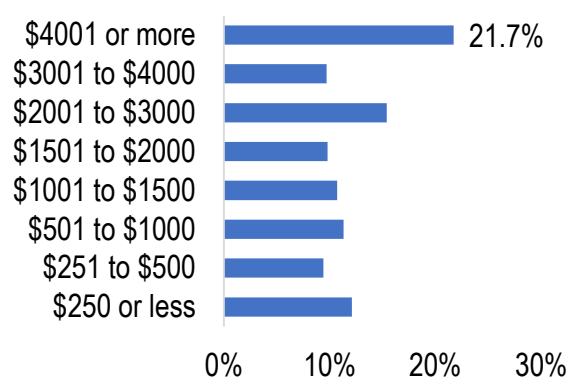
In 2019, at least 60 percent of Chapter seven and Chapter 13 bankruptcy filings in Oregon included medical debt<sup>2</sup>. Of those bankruptcy filers who had medical debt, 15 percent report having more than \$10,000 in medical debt.

Even patients covered by insurance are exposed to significant medical costs, according to 2021 OHIS data.

71% of Oregonians spent \$600 or more in out-of-pocket medical expenses in the last year



Among Oregonians with private insurance, 22% have annual deductibles of \$4000 or more

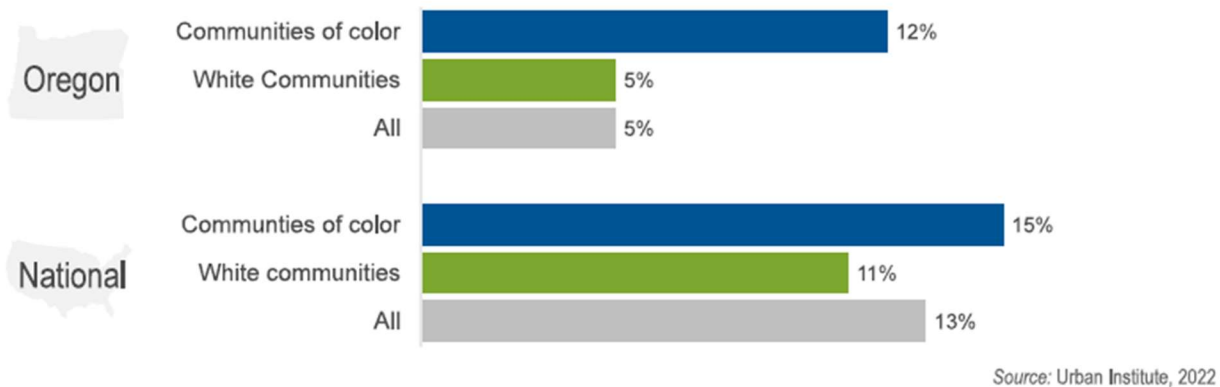


Data provided by the Urban Institute regarding the amount of medical debt owned by collection agencies demonstrates a relatively low rate for Oregon compared to national averages, but stark racial inequities within Oregon’s communities. As of February 2022, 5% of white Oregonians had medical debt in collections compared to 12% of Oregonians from communities of

<sup>2</sup> OSPiRG, "Unhealthy Debt: Medical costs and bankruptcies in Oregon," 2021. <https://ospirg.org/reports/orp/unhealthy-debt-medical-costs-and-bankruptcies-oregon>

color with medical debt in collections. As the graphic below illustrates, while Oregon's overall rate of medical debt in collections is low compared to national averages, the gap between Oregon's white communities and communities of color is much larger than the national gap (Oregon's gap is seven percentage points, nationally the gap is four percentage points).

The gap between Oregon's white communities and communities of color is much larger than national averages for medical debt in collections



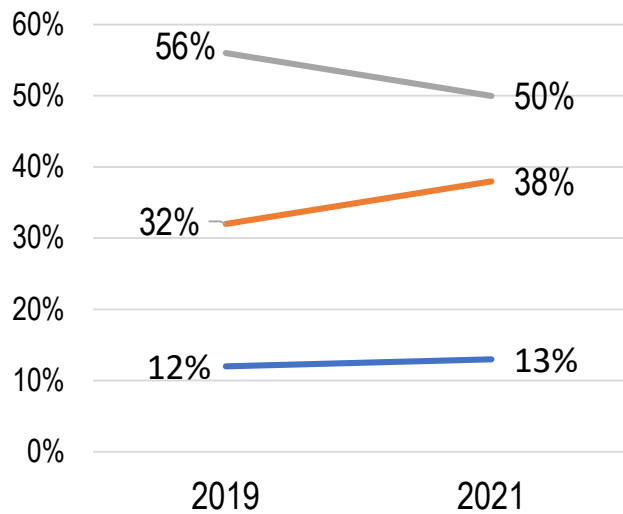
OHIS data from the 2021 survey indicates that the number of people delaying medical care due to cost has fallen from 9% in 2019 to 4% in 2021<sup>3</sup>. This compares favorably to Kaiser Family Foundation national data that indicates upwards of 40% of adults nationally delay health care due to cost<sup>4</sup>. Further, the number of all Oregonians that reported needing to make payments on medical bills in the past year fell from 10% in 2019 to 8% in 2021.

<sup>3</sup> Oregon Health Insurance Survey 2021 (OHIS) available at: <UPDATE WHEN LIVE>

<sup>4</sup> <https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-march-2022/>



### Amounts owed in medical bills have increased



General trends continue to mask inequities, however. Even as fewer Oregonians report owing medical debt, the amounts they owe have increased as indicated in the chart to the left. OHIS reports that 17% of Hispanic or Latinx survey respondents and 18% of two or more races respondents reported using up all or most of their savings on medical bills, an increase from 10% in 2019 for both groups. This compares to 9% rate for white survey respondents. Likewise, 10% of Hispanic or Latinx respondent report being unable to pay for food, rent, or utilities due to medical bills compared to a 2% rate for whites. This is also an increase from 2019, where 6% of Hispanic or Latinx respondents reported being unable to pay other bills due to medical expenses.

What is hospital financial assistance?

As a part of non-profit hospital community benefit obligations, hospitals are required to provide free and reduced care to low-income patients. HB 3076 created minimum standards for the amount a hospital is required to reduce their bill.

FPL	Amount Bill is Reduced
0-200%	100%
200-300%	75%
300-350%	50%
350-400%	25%

## Implementation Status

As of December 2022, all posted hospital FAP reflected the income-based tiers of assistance called for in HB 3076. Review of hospital FAP interviews with stakeholders indicate that hospital policies are largely compliant with medical debt protections as well.

However, information on financial assistance is not easy for patients to find on hospital websites, and some postings indicate eligibility is limited to Oregon residents, sometimes county residents, which is not an eligibility requirement for hospital financial assistance.

A review of financial assistance applications forms indicates that most ask

for asset information even though eligibility for financial assistance is based on income, not assets. OHA continues to receive questions and reports of hospitals using assets in determining eligibility, despite state issued guidance that only household income may be considered.

In addition, there is evidence that not all hospitals are appropriately screening patients for eligibility for financial assistance or Medicaid and complying with the IRS required 120 day waiting period prior to initiating collection action.<sup>5</sup> A review of the OHA Ombuds office reports from calendar year 2019 to 2022, revealed 418 complaints of illegal billing of Medicaid members by Oregon providers<sup>6</sup>. Billing complaints made up 7% to 12% of all complaints and in most cases, the provider failed to determine eligibility prior to sending a bill.

<sup>5</sup> Interviews with hospital staff also indicate that lack of compliance with IRS required 120 waiting periods prior to referral of medical debt to collection. Internal Revenue Service regulations section 501(r)(6): <https://www.irs.gov/charities-non-profits/billing-and-collections-section-501r6>.

<sup>6</sup> Oregon Health Authority Ombuds Program Quarter 2&3 Report, 2022 available at: <https://www.oregon.gov/oha/ERD/OmbudsProgram/>

## Patient Advocate Perspectives

SEIU published a review<sup>7</sup> of hospital FAP statewide in October 2022. In the report, SEIU found that while many Oregon hospitals are in alignment with the letter of the law, some hospitals may be adding unwarranted complexity to the financial assistance process. Examples include requiring patients to fill out multiple, similar forms, and provide multiple pieces of financial information, including pay stubs, tax returns and bank statements going back several years. Requiring this level of document is not warranted for a program whose eligibility criteria is based on **income** rather than **assets**.

Eligibility criteria also appear to have been inappropriately applied by some hospitals. Even though Oregon law specifies that eligibility decisions are to be made on the basis of household **income**, some patients have faced questioning from hospital staff about assets and expenditures on bank statements. OHA released a memo<sup>8</sup> to all hospitals in October 2021 clarifying that only income can be considered for financial assistance determination. Yet, OHA continues to receive questions from hospital around what types of assets they are allowed to consider as income. In addition, SEIU reports that at least five of Oregon's largest health systems restrict their financial assistance to Oregon residents, or in some cases, specific Oregon counties, even though HB 3076 does not reference residency as an eligibility factor.

SEIU also reported that patients often cannot locate information on hospital financial assistance policies, particularly when searching on a facility's website. Oregon statute (442.610) requires non-profit facilities to post their financial assistance policies in their facilities, however, there are no requirements regarding website access or visibility.

Dollar For cites Oregon as a national leader in terms of state policy on financial assistance and Dollar For data indicates that Oregon hospitals are providing more financial assistance than other states.

Interviews with Dollar For staff echo many of the findings of the SEIU reports. Dollar for cites examples of complex processes and excessive

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<sup>7</sup> SEIU, "Shortchanged: How hospital financial assistance practices and policies fail Oregon patients with the greatest need", 2022.

<sup>8</sup><https://www.oregon.gov/oha/HPA/ANALYTICS/HospitalReporting/Financial%20assistance%20guidance%20Oct%202021.pdf>

eligibility criteria, including examples of hospitals limiting financial assistance to residents of specific Oregon counties.

Dollar For cites lack of awareness of financial assistance as a barrier to access for patients, despite favorable state policies. Dollar For also indicates compliance with both federal and state laws is an issue. While performing research using the Oregon Judicial Case Informant Network<sup>9</sup> (OJCIN) to evaluate debt collection lawsuits and judgements in Oregon, *Dollar For* found numerous examples of individuals below the 200% FPL that had medical debt judgements and wage garnishments put in place. The examples found appear to be violation of not only the provisions of HB 3076, but also federal code - 26 CFR 501(r)-6(c)(10)<sup>10</sup> which requires hospitals to make reasonable efforts to determine if an individual is FAP eligible prior to taking extraordinary collection actions.

### **Hospital Perspectives**

Consistent with the problems noted above, hospitals raise lack of clarity in HB 3076 as a challenge, and several have requested guidance on the meaning of income. OHA's consistent response has been that, in alignment with common understanding of the term income, there are no types of assets that may be considered income.

Many hospital interviewees also asked for greater clarity around the bill's requirement that they contact patients that may qualify for financial assistance prior to sending any accounts to collection. Several noted the bill's lack of clarity regarding the form (paper vs electronic) of the application patients must receive prior to a collection referral. One hospital system reported in an interview that it spends an average of \$7,000 a month mailing financial assistance applications to patients that may be subject to collection actions and receives less than 1% of applications in return. Multiple hospitals noted that patients do not answer phone calls and or respond to mail. Several asked about the period of time the hospital should allow for potential response before sending the account to collections.

Some hospitals reported a significant administrative burden in implementing HB 3076 requirements. Larger hospitals with existing

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<sup>9</sup> <https://www.courts.oregon.gov/services/online/pages/ojcin.aspx>

<sup>10</sup> [https://www.law.cornell.edu/cfr/text/26/1.501\(r\)-6](https://www.law.cornell.edu/cfr/text/26/1.501(r)-6)

financial assistance programs and staff time already assigned to the work had an easier time with uptake of the changes. Other hospitals, emphasized that a substantial investment of staff time was necessary to create, distribute, and communicate about the new program, in addition to setting up a tracking system for eligibility screenings.

Some hospital staff expressed frustration with their facility's internal inefficiencies associated with the financial assistance application process. One commonly cited example is that many hospitals have third party vendors that are responsible for billing and revenue collection, and a different entity responsible for financial assistance applications and approvals. In some hospitals, the two entities do not regularly interact and some issues with financial assistance approval and medical debt collection can be attributed to failures in these internal communications. One hospital interviewee shared that information from the software that forecasts a patient's ability to pay and likelihood of needing financial assistance, is not always sent to the billing vendor. It is worth noting that the existing federal regulation requires hospitals to notify third party debt collectors of financial assistance requirements.<sup>11</sup>

Rural hospitals have noted that there are disproportionate financial assistance burdens placed on them due to predominately serving low-income areas. Many rural hospitals, particularly in eastern and southern Oregon, serve communities with median household incomes that are among the lowest in the state.

One rural hospital reported over one hundred patients between 201-400% FPL in its catchment area chose to utilize hospital financial assistance rather than enroll in marketplace coverage. The hospital interviewee reported that these patients then repeatedly sought services which the interviewee noted exposed another gap in the law. HB 3076 does not specify how long a qualifying patient is approved and eligible for financial assistance.

An analysis of hospital financial data confirms disproportionate charity care rates, as a percent of total charges, for rural hospitals when compared with urban hospitals. Among the ten hospitals with the highest charity care rate,

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<sup>11</sup> 26 CFR 501(r)-6(c)(10)

eight of them are rural hospitals<sup>12</sup>. Rural hospitals experience higher expenses related to charity care as a percent of total expenses<sup>13</sup>. In short, relative to their size, Oregon's rural hospitals provide more charity care and have higher expenses than their urban counterparts.

## Summary

### **Launch of Oregon's new Community Benefit Program has been successful**

OHA implemented the requirements of HB 3076 to create a new minimum spending floor methodology. All Oregon's non-profit hospitals were assigned their first spending floors, effective in fiscal years 2022 and 2023. OHA has changed reporting requirements to reflect removal of unreimbursed Medicare as a community benefit category and to collect more information about hospital's community needs assessments and actions that address the social determinants of health.

Future OHA reports will highlight hospital activities that prioritize actions on the social determinants of health as well as performance relative to the minimum spending floor.

Many elements of the new community benefit program, particularly the minimum spending floor, have never been attempted before. The ultimate success of the implementation of this program can be attributed to ongoing, effective collaboration with partners. As OHA looks to the future of community benefit, they will continue to engage in a collaborative effort to transform community benefit practices in Oregon.

Many hospitals expressed concerns with their ability to forecast their future financial status due to the uncertainty of COVID. Hospital have noted the stress of this uncertainty when making proactive community benefit plans. On the other hand, hospitals have also noted the benefits of expanding their community benefit programs and engaging in a more proactive

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<sup>12</sup> Oregon Hospital Financial and Utilization Dashboard available at:  
<https://www.oregon.gov/oha/hpa/analytics/pages/hospital-reporting.aspx>

<sup>13</sup> Oregon Community Benefit Data, Community benefit data and pivot table 2010-2021, available at:  
<https://www.oregon.gov/oha/hpa/analytics/pages/hospital-reporting.aspx>

approach. Some hospitals have noted hiring more staff due to HB 3076. While this is an example of administrative costs, most hospitals reported favorable outcomes from their expanded programs.

**Hospital financial assistance policies are largely in alignment with the new legal requirements for patient financial assistance and medical debt. However, hospital practices around sharing information about financial assistance, screening patients for eligibility and referring accounts to debt collection remain areas of concern.**

OHIS data reveal a recent decline in the numbers of people reporting medical debt and/or delaying medical care due to cost. However, this generally favorable trend masks stark inequities regarding the distribution and impact of medical debt within Oregon's communities. HB 3076 targets the burden of medical debt through expansion of hospital financial assistance and new requirements for hospital debt collection practices.

As of December 2022, all posted hospital financial assistance policies reflected the income-based tiers of assistance called for in HB 3076. Review of hospital financial assistance policies indicate that *policies* themselves are largely compliant with medical debt protections as well. However, OHA has ongoing concerns about hospital *practices* regarding financial assistance and medical debt collection. Information about financial assistance remains difficult to access on hospital websites. In addition, most financial assistance applications forms ask for asset information even though eligibility for financial assistance is based on income, not assets. OHA continues to receive questions and reports of hospitals using assets in determining eligibility, despite state issued guidance that only household income may be considered.

Finally, there is evidence that hospitals may be sending debts to collection without first complying with required waiting periods and notifying potentially eligible patients of the availability of financial assistance.

Hospitals, particularly those in rural areas, note significant investments in staffing and processes to comply with new provisions in Oregon's hospital financial assistance law. Data indicates that rural hospitals provide a

disproportionate share of financial assistance when compared with urban hospitals. Hospitals note challenges in several areas, including patient notification of financial assistance, patient screening and processes for third party debt collection.

OHA has no enforcement or monitoring role in Oregon's hospital financial assistance system and lacks comprehensive data on patient experience and hospital practices. SEIU reports ongoing challenges for patients in accessing financial assistance and calls for a formal audit of financial assistance compliance. Both SEIU and *Dollar For* also advocate for state enforcement action by either the state attorney general or OHA. Data from review of recent enforcement action in other states is shared in Appendix B. Appendix C provides information regarding a recent Government Accountability Office (GAO) report with recommendations for strengthening federal oversight tax-exempt hospital community benefits programs. Recommendations for strengthening Oregon's financial assistance law are beyond the scope of this implementation report and warrant further study by the legislature.

## Appendix

### Appendix A

#### Community Benefit Minimum Spending Floor Rules Advisory Committee

OHA conducted a robust Rules Advisory Committee, which attracted over 40 participants in a three-part series of regulatory meetings. OHA began formal rulemaking for the new spending floor program in September of 2020, conducting broad outreach across all Oregon counties to solicit member applications for the Rules Advisory Committee (RAC). The RAC held three meetings throughout September, each of which were well attended by a variety of interested parties as well as the RAC members. Legislators were notified of the proposed rules in October of 2020, and the proposed rules were posted in the Secretary of State bulletin in the beginning of November. A rules hearing was held on November 17<sup>th</sup>, 2020, to collect final comments. Final rules were sent to the Secretary of State on the first of December, becoming effective on the legislative mandated date of January 1<sup>st</sup>, 2021.

#### Community Benefit Minimum Spending Floor RAC Members



Organization	Contact Person
Project Access NOW	Linda Nilsen
Health Share of Oregon	Maria Tafolla
Service Employees International Union, Local 48	Felisa Hagins
Oregon Nurses Association	Deborah Riddick
National Consumer Law Center	Jennifer Bosco
Oregon Law Center	Alicia Temple
Northwest Health Foundation	Laura Curtis
Oregon Association of Hospitals and Health Systems	Sean Kolmer
Adventist Health System	Joyce Newmyer
Asante Health System	Scott Kelly
Bay Area Hospital	Samuel Patterson
Blue Mountain Hospital	Cameron Marlowe
Catholic Health Initiatives	Kelly Morgan
Columbia Memorial Hospital	Zach Schmitt
Coquille Valley Hospital	Michelle Reyna
Good Shepherd Hospital	Dennis Burke
Grande Ronde Hospital	Bob Seymour
Harney District Hospital	Catherine White
Kaiser Permanente	Jennifer Smith
Lake District Hospital	Cheryl Cornwell
Legacy Health	Kathryn Correia
Lower Umpqua Hospital	Lori Groves
McKenzie-Willamette Hospital	Adam Loris
Mid-Columbia Medical Center	Wendy Apland, Ron Walton
Oregon Health and Science University	Diana Gernhart
PeaceHealth System	Kimberly Hodgkinson
Providence Health and Services	William Olson
Saint Alphonsus Health System	Lynsey Todd
Salem Health	Cheryl Wolfe
Samaritan Health Services	Doug Boysen
Santiam Hospital	Terry Fletchall
Shriners Children's Portland	Dereesa Reid
Sky Lakes Medical Center	Richard Rico
Southern Coos Hospital and Health Center	Alan Dow
St. Charles Health System	Jenn Welander

Hillsboro Medical Center	Meredith Peterson
Wallowa Memorial Hospital	Lawrence Davy
Willamette Valley Medical Center	Jonathan Avery

## Appendix B

OHA assessment of state enforcement actions around financial assistance and medical debt

OHA reviewed recent significant actions taken by states related to issues with financial assistance, billing practices and medical debt. We excluded enforcement actions related to fraudulent billing, which is the most widespread and common example of enforcement related to billing.

State	Date	Summary
California	2018	State AG ordered two hospitals to donate money in response to falling financial assistance amounts <sup>14</sup>
California	2022	In response to widespread failure of hospitals notifying patients about financial assistance, state AG sent a letter to hospitals warning of legal action and issues a consumer alert informing residents of their rights <sup>15</sup>
Massachusetts	2022	Reached a settlement against a debt collection agency for illegal debt collection practices <sup>16</sup>
Minnesota	2020	AG reached a settlement with hospitals engaged in unfair bill collection practices <sup>17</sup>
New Mexico	2022	State AG in active litigation against a hospital for illegal billing practices <sup>18</sup>
New York	2022	State AG reached a settlement with an ambulance provider over illegal billing and debt collection practices <sup>19</sup>

<sup>14</sup> <https://www.fiercehealthcare.com/regulatory/california-hospitals-must-cough-up-millions-to-meet-charity-care-rules>

<sup>15</sup> <https://oag.ca.gov/news/press-releases/attorney-general-bonta-issues-consumer-alert-following-reports-hospitals-failing>

<sup>16</sup> <https://www.mass.gov/news/ag-healey-secures-12-million-in-relief-from-debt-collection-company-and-subsidiaries-over-unlawful-practices>

<sup>17</sup> [https://www.ag.state.mn.us/Office/Communications/2020/10/29\\_HutchinsonHealth.asp](https://www.ag.state.mn.us/Office/Communications/2020/10/29_HutchinsonHealth.asp)

<sup>18</sup> <https://www.abqjournal.com/2556628/attorney-general-sues-northern-nm-hospital.html>

<sup>19</sup> <https://ag.ny.gov/press-release/2022/attorney-general-james-secures-relief-patients-illegally-charged-ambulance>

Washington	2022	State AG is in active litigation against the state’s largest health system and two associated collection agencies over financial assistance and debt collection practices <sup>20</sup>
Washington DC	2020	State AG reach an agreement with two nursing facilities over deceptive billing, including deceiving family members into signing financial responsibility forms <sup>21</sup>

**Appendix C**

Government Accountability Office Report

In September 2020, the U.S. Government Accountability Office (GAO) produced a report to congressional requestors entitled “Tax Administration Opportunities Exist to Improve Oversight of Hospitals’ Tax-Exempt Status”<sup>22</sup>. The study reviewed the Internal Revenue Service’s (IRS) implementation of requirements for tax-exempt hospitals from the 2010 Patient Protection and Affordable Care Act (PPACA). The report assesses two things: IRS oversight of tax-exempt hospital provided community benefits and enforcement of PPACA related to tax-exempt hospitals.

The PPACA established requirements for non-profit hospitals to better serve their communities through community benefit, mandating that all non-profit hospitals must spend in community benefit in order to maintain their tax-exempt status. To support this law, the IRS identified factors and activities for hospitals to demonstrate community benefit, but the IRS lacks the authority to make these factors and activities requirements for hospitals to perform. The GAO reports that the IRS also lacks a defined process in code to ensure non-profit hospitals are in compliance with the PPACA requirements for community benefit spending. From 2015-2019, the IRS referred almost 1,000 hospitals to its audit division for possible violations yet was unable to say if these referrals were due to community benefit noncompliance. The GAO recommends the IRS needs a codified and well-documented hospital community benefit review process. The IRS agrees with GAO recommendations for an audit process with clear instructions for

<sup>20</sup> <https://www.atg.wa.gov/news/news-releases/ag-ferguson-providence-s-collection-agencies-broke-law-while-collecting-medical>

<sup>21</sup> <sup>21</sup> <https://oag.dc.gov/blog/stopping-deceptive-billing-practices-nursing-homes>

<sup>22</sup> <https://www.gao.gov/assets/gao-20-679.pdf>

community benefit reviews to ensure it is effectively reviewing hospitals' community benefit activities and ensuring compliance with federal law.

GAO suggests the Tax Exempt and Government Entities (TE/GE) division of IRS use proposed, codified processes to enhance enforcement and hospital compliance with PPACA. GAO recommends TE/GE have a clear, well-documented process with instructions on referring hospitals for audit during its triennial reviews, and to add automated queries to identify hospitals at risk for noncompliance. TE/GE currently does not have a system to track these actions. While conducting audits of non-profit hospitals, TE/GE does not have specific questions or direction that signal when a hospital should be referred to audit, based on any unverifiable factors. Thus, GAO suggests developing this methodology for identifying when a hospital should be referred to audit based on multiple factors relating to noncompliance with the community benefit standard, and how to track those hospitals referred to audit, as well as authoritative action taken.