A Prescription for Charity Care: How National Medical Debt Ills Can Be Alleviated by Integrating State Financial Assistance Policies into the Nonprofit Tax Exemption

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INTRODUCTION

Despite having the most expensive healthcare system in the world, the United States has been consistently ranked as having the worst system in terms of equity, efficiency, and healthcare outcomes among industrialized nations.1 The effects of these systemic issues are grounded in the patient experience as nearly forty-four percent of individuals have forgone recommended treatments and thirty-two percent have reported that they were unable to afford a prescription due to the high cost, according to a study conducted in 2018.2 Health is sacred, and financial circumstances should not determine the difference between treatment and illness, or life and death. “Financial assistance” or “Charity Care” programs provide free or discounted care for “appropriate hospital-based

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medical services\textsuperscript{3} to individuals on a sliding scale.\textsuperscript{4} The Charity Care models of Washington and California provide invaluable support for low-income individuals who cannot afford healthcare and fall through the cracks of the Affordable Care Act (ACA).\textsuperscript{5} If several key components of the Washington and California Charity Care statutes become requirements for nonprofit hospitals to receive the federal tax exemption under § 501(r) of the Internal Revenue Code and related federal regulations, these critical safety nets can be expanded to provide protection for the most vulnerable healthcare consumers nationally.

Part I of this Comment will discuss the unique nature of medical debt in the context of the healthcare system as a whole, as well as the impacts medical debt has on uninsured and underinsured individuals\textsuperscript{6} and individuals in traditionally marginalized communities. Part II will discuss the landscape of private health insurance discrimination prior to the passage of the ACA and the impacts of several significant components of the ACA on healthcare access. Part III will discuss the Charity Care and Fair Pricing systems in Washington and California respectively, and will address the benefits and shortfalls of each. Part IV will consider how Washington’s and California’s financial assistance models can be emulated in the regulations for § 501(r) of the tax code for nonprofit hospitals so that the protections they provide to low-income patients are available nationally.

\textsuperscript{3} In Washington State, for example, “Appropriate hospital-based medical services” means those hospital services which are reasonably calculated to diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective more conservative or substantially less costly course of treatment available or suitable for the person requesting the service. WASH. ADMIN. CODE § 246-453-010(7) (2018).

\textsuperscript{4} “Sliding scale” refers to the policy created by a hospital that establishes the size of discounts applied for the services rendered, relative to the patient’s household income as measured by the federal poverty level. See id. § 246-453-050.


I. THE PROBLEM OF MEDICAL DEBT AND THE HIGH COST OF HEALTHCARE

The nature of medical pricing and billing creates a unique and often overwhelming set of circumstances for consumers to navigate after receiving medical care. Specifically, unregulated rates and surprise charges create a field of high-cost landmines that can entrap consumers in unmanageable bills. When these bills go unpaid, individuals often face detrimental impacts on both their financial and physical health. Moreover, individuals in traditionally marginalized communities, including the black and undocumented immigrant communities as two examples, often disproportionately experience the worst effects of medical debt. A background understanding of the nature of hospital billing and debt collection practices and the effect these systems have on the most vulnerable patients is critical for understanding why hospital-funded financial assistance is a crucial public policy that should be meaningfully expanded on a national scale.

A. The Unique and Unpredictable Nature of Medical Debt

Medical debt is unlike other forms of consumer debt: it often occurs unpredictably, it is incurred involuntarily, and its magnitude may be catastrophic. While debts that arise following a missed payment on a bill, a credit card purchase, or a student loan are predictable at least with respect to the amount of the principal owed, patients are rarely told and cannot predict the principal amount they will owe prior to receiving medical services. The high variability of costs for medical services compounds the lack of predictability, as the cost for the same procedure can vary tremendously between hospitals in the same region, and even the same city. Hospitals are able to set prices for medical procedures at effectively any rate they desire, known as the “chargemaster rate,” with very little regulation and transparency. A “chargemaster” is a hospital-specific

8. See id.
9. Erin C. Fuse Brown, Irrational Hospital Pricing, 14 HOUS. J. HEALTH L. & POL’Y 11, 26 (2014). The first release of hospital chargemaster data to the public revealed tremendous pricing disparities, including the cost for treating heart failure in Jackson, Mississippi, which ranged from $9,000 to $51,000, and the cost for treating esophagitis, which ranged from $8,100 to $38,000. Id.
master price list for all the procedures a hospital provides as well as all the supplies used during these procedures.\(^{11}\) The prices of these services and supplies are often “arbitrary and capricious” and “ludicrously high,” sometimes running about ten-times higher than the amount the hospital would accept as full payment from a private health insurance company.\(^{12}\) Thus, the chargemaster primarily functions as an “anchoring point for negotiations with third-party payers” and is entirely unrelated to the actual costs of services.\(^{13}\) Most concerning, uninsured patients are typically held responsible for the full chargemaster rate unless some form of statutory protection exists because they cannot negotiate and set prices with the hospital.\(^{14}\) For example, a 2015 study found that fifty hospitals charged uninsured patients ten times the actual cost of care.\(^{15}\)

Additionally, “out-of-network” healthcare providers further exacerbate the unpredictability of medical costs and increase the size of patients’ medical bills. Surprise charges on medical bills are common occurrences that can be financially ruinous.\(^{16}\) As described above, private insurers negotiate with healthcare providers for discounted reimbursement rates for services and then charge a portion of that price to the patient.\(^{17}\) However, about twenty percent of emergency room visits involve an out-of-network physician, and about fifty-one percent of ambulance rides are an out-of-network service.\(^{18}\) When patients receive services or treatment from out-of-network healthcare providers, these providers have not previously negotiated reimbursement rates with the patients’ insurer and therefore charge higher fees.\(^{19}\) In turn, private insurers cover less of the medical bill, and the patients are typically responsible for the difference.\(^{20}\)

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\(^{13}\) Id.


\(^{17}\) Id.

\(^{18}\) Id.

\(^{19}\) Id.

\(^{20}\) Id.
For the foregoing reasons, when a medical issue arises, the cost of medical care often forces individuals into substantial debt and exposes them to aggressive collection tactics.21

B. Medical Debt Possession and Aggressive Debt Collection by Third Party Creditors Adversely Impact the Physical and Financial Well-Being of Patients

The effects of medical debt create pervasive financial and health consequences for many individuals, regardless of their health insurance status.22 Medical debt remains the leading cause of personal bankruptcy and accounts for a larger share of debt in collections than credit cards and bank debts combined, according to a 2014 study.23 In a separate study, individuals who previously reported medical debt problems also reported foregoing necessary medical care out of fear of undertaking additional debt at a rate of two to three times that of individuals who did not previously have medical debt.24 Further, among the same sample group, approximately sixty-two percent of both insured and uninsured individuals stated that they struggled to meet other financial obligations as a result of their medical debt.25 Finally, more than a third of the surveyed individuals from both the insured subgroup and the uninsured subgroup reported that they could not afford food, heat, or housing because of their medical debt.26

Possession of health insurance does not make a substantial difference with respect to timeliness of bill payment as both insured and uninsured individuals frequently missed payments on bills related to medical and others debts, experiencing financial hardships as a result.27 The inability to afford basic needs and to make timely payments of medical and other debts has resulted in approximately fifty-eight percent of those with


24. HAMEL ET AL., supra note 22, at 17.

25. Id. at 1.

26. Id. at 15.

27. Id. at 20.
medical debt facing collections actions from third-party debt collectors. 28 Over half of the debts that appear on credit reports nationwide are medical debts, stemming in large part from high deductible and out-of-pocket plans. 29 Although credit scoring companies such as FICO have modified their models to account for the unique nature of medical debt by lowering the credit score penalty as compared to other forms of debt, medical debt continues to have a profoundly negative impact on an individual’s borrowing capacity. 30

Medical debt collection practices are often aggressive and further exacerbate the negative impact of medical debt. 31 Hospitals and other medical providers frequently contract with third-party debt collectors and assign unpaid patient accounts to them for collection. 32 If the collectors cannot obtain payment, they often sue patients for the full amount of the debt plus substantial additional fees associated with the legal action; 33 the result of which is typically a default judgment in favor of the debt collector because most defendants do not respond. 34 Judges in many courts with busy collection dockets routinely enter hundreds if not thousands of default judgments in such lawsuits every year. 35 Once a default judgment has been entered, debt collectors obtain payment by garnishing wages, 36 seizing funds from bank accounts, placing liens on patients’ property, 37 or in some cases, the court will issue arrest warrants and place debtors in jail for medical debts totaling less than $1,000. 38 Finally, in some hospital
networks, if a patient has unsettled debt, the hospital or associated clinic will refuse to provide additional care (except emergency care) until the debt has been settled.39

C. The Disparate Impact of Medical Debt Experienced by Individuals in Traditionally Marginalized Communities

Traditionally, marginalized communities are among the most perilously impacted by the problem of medical debt and consequently suffer poorer healthcare outcomes. For example, black individuals have undergone disparities in health outcomes that are “pervasive, pernicious, pricey, and persistent.”40 As compared with white individuals, black individuals tend to experience “earlier onset of multiple illnesses, greater severity and more rapid progression of diseases, . . . and increased mortality rates.”41 Lower incomes, higher unemployment rates, de facto racial segregation, and lack of access to health insurance are social determinants that have historically contributed to poorer health in communities of color.42 A 2015 study of non-elderly adults found that about seventeen percent of black individuals are uninsured as compared to twelve percent of white individuals, making this community more likely to experience difficulties in paying unanticipated medical debts.43

Additionally, undocumented immigrants are excluded from receiving coverage under Medicaid expansion; they are barred from purchasing insurance through the marketplaces, and they cannot receive federal subsidies that lower premium rates.44 Moreover, increased fears among immigrant communities, due in part to the Trump Administration’s focus on immigration enforcement,45 may also deter families from


41. Id.

42. Id.


44. See generally Jie Chen et al., Latino Population Growth and Hospital Uncompensated Care in California, 105 AM. J. PUB. HEALTH. 1710, 1710–17 (2015).

enrolling eligible children and adults in coverage and from obtaining needed care. 46 Lack of access to adequate and affordable healthcare coverage, in combination with poorer health outcomes, therefore increases the prevalence of medical debt in these communities and the severe financial problems that inevitably follow. 47

The high and unpredictable cost of healthcare has profound impacts on the most vulnerable patients who face serious consequences when bills pile up. Because rationing healthcare can have deadly consequences, incurring these costs is unavoidable. 48 Creating a national financial assistance scheme that matches the comprehensive programs in Washington and California could provide critical support in precisely these situations. The ACA represents a substantial improvement from the previous healthcare system, and many of the problems addressed in the preceding Section have been reduced as a result. 49 Nevertheless, many issues remain that contribute to continuing inequity and disparity in healthcare outcomes among lower-income populations and historically marginalized communities.


The ACA represents the most comprehensive healthcare system reform and the broadest attempt to reduce the rate of uninsured individuals since the creation of Medicare and Medicaid in 1965. 50 Prior to the ACA’s passage in 2010, the largely unregulated market rendered health insurance inaccessible and unaffordable for millions of Americans. 51 The individual mandate, Medicaid expansion, and changes to the nonprofit hospital tax exemption are several key provisions that were designed to address systemic inequities. 52 Although the ACA has stimulated some significant

47. See Crossley, supra note 40, at 60.
48. See Bram Sable-Smith, Insulin’s High Cost Leads to Lethal Rationing, NPR (Sept. 1, 2018, 8:35 AM), https://www.npr.org/sections/health-shots/2018/09/01/641615877/insulins-high-cost-leads-to-lethal-rationing [https://perma.cc/E24U-BTYW]. Because the cost of insulin has more than doubled since 2012, a 26-year-old man recently removed from his parents’ insurance was forced to ration his insulin until his next paycheck, and he passed away as a result. Id.
50. Id. at 525.
51. Id. at 527.
52. See id. at 527–29.
progress in addressing long-standing challenges related to healthcare affordability, substantial barriers continue to impede access to healthcare for many individuals.53 Because the individual mandate was effectively repealed in 2017 by the Tax Cuts and Jobs Act,54 and fourteen states declined to expand Medicaid,55 the nonprofit hospital tax exemption remains a critical safety net that can protect low-income individuals from amassing insurmountable medical debts.

A. Health Insurance Discrimination Before the Affordable Care Act

Before the ACA passed, the private health insurance system in the United States was driven primarily by unrestricted market forces.56 Private insurers arranged individuals into groups using “actuarial science techniques,” which classified individuals by designated characteristics that determined the likelihood these individuals would require healthcare and cause a financial loss to the insurer.57 Insurers would attempt to capture the profitable segments of the market (individuals who likely would not need healthcare) and avoid taking on unprofitable segments (individuals who likely would need healthcare) by charging higher premiums for the unprofitable segments or denying these individuals coverage entirely.58

Predictably, this market-driven system caused discrimination in health insurance access based on chronic and pre-existing illnesses and racial and gender classifications.59 Specifically, black communities were historically burdened with higher insurance premiums and complete coverage exclusions as compared to non-black communities.60 Additionally, women were charged higher premiums than men because the actuarial data tended to show higher rates of usage of healthcare

53. See id. at 529–30.
57. Id. at 3.
60. Id.
services, especially related to reproductive health.\textsuperscript{61} This discrimination was largely tolerated due to a lack of federal regulation of the health insurance system.\textsuperscript{62} Healthcare discrimination based on pre-existing conditions and poorer health is not addressed within general anti-discrimination laws; where such laws could be applied to health insurance, they did not prohibit the use of some of the most egregious discriminatory mechanisms that many individuals were subject to before the enactment of the ACA.\textsuperscript{63}

B. The Impacts of the Affordable Care Act’s Individual Mandate and Medicaid Expansion on Healthcare Access

The ACA was an attempt to mitigate some of the discriminatory aspects of the largely unregulated health insurance industry through implementing the individual mandate.\textsuperscript{64} The ACA specifically required all individuals to maintain “minimum essential coverage” or be subject to a “shared responsibility payment,” which functioned in the same manner as a tax.\textsuperscript{65} This requirement is known as the “individual mandate” and is necessary for the creation of “the type of robust risk pool on which fundamental health insurance reform can be built.”\textsuperscript{66} Ensuring that more individuals participate in the insurance market means that private insurers will have both healthy customers who require less care, and might not have bought insurance otherwise, and customers who are more likely to need and use their health coverage.\textsuperscript{67} When considered in light of the minimum

\begin{footnotes}
\item[62.] Joanna V. Theiss, It May Be Here to Stay, but Is it Working? The Implementation of the Affordable Care Act Through an Analysis of Coverage of HIV Treatment and Prevention, 12 J. HEALTH & BIOMEDICAL L. 109, 123 (2016).
\item[63.] ROSENBAUM, supra note 56, at 2 (“Congress has limited the use of actuarial techniques that exclude persons from group insurance altogether. However, Congress has only modestly tackled risk management techniques linked to the actual content and administration of coverage. The use of discriminatory practices based on health status to limit coverage is especially apparent in the individual insurance market.”).
\item[64.] See Sara Rosenbaum, Realigning the Social Order: The Patient Protection and Affordable Care Act and the U.S. Health Insurance System, 7 J. HEALTH & BIOMEDICAL L. 1, 13 (2011).
\item[65.] 26 U.S.C. § 5000A(a)–(b) (2018) (defining minimum essential coverage requirement and the tax consequences of failure to maintain standard of coverage).
\item[66.] Rosenbaum, supra note 64, at 12.
\item[67.] See id. at 12, 20–21; see also MATTHEW BUETGENS ET AL., URBAN INST., WHY THE INDIVIDUAL MANDATE MATTERS 2 (2010), http://www.urban.org/sites/default/files/publication/29456/412280-Why-the-Individual-Mandate-Matters.PDF [https://perma.cc/U5VG-64YA] (“Three important goals of reform are to increase health insurance coverage, to eliminate discrimination by health status in the sale and maintenance of health insurance, and to increase the affordability of
\end{footnotes}
coverage requirements and other quality regulations imposed on insurers, the ACA intended to end the prior actuarial risk-driven discrimination. Indeed, the ACA compelled private insurers to profit by competing for customers rather than by being selective for customers that are “good risks.”

However, in December of 2017, Congress passed the Tax Cuts and Jobs Act, which removed the individual tax penalty for declining to purchase health insurance, thereby effectively repealing the individual mandate provision of the ACA. Thus, insurance premiums are predicted to rise by ten percent to cover the costs of healthy individuals leaving the insurance market. Rates of uncompensated care will likely increase as a result, and many individuals who are priced out of the private market will be unable to afford medical care when the need inevitably arises. If indeed the rates of uninsured patients increase following this effective repeal of the individual mandate, the financial assistance provided by nonprofit hospitals through § 501(r) will likely become even more critical.

Additionally, the ACA attempted to address the lack of health coverage and medical debt for the lowest-income individuals through the expansion of Medicaid to all individuals with incomes up to 138% of the federal poverty level. Thirty-four states, including the District of Columbia, have expanded Medicaid under the ACA. Medicaid expansion has been shown to improve the financial security of those newly


69. Rosenbaum, supra note 64, at 26.


72. See id.

73. Previously, Medicaid was only available for “low-income children and some of their parents; poor pregnant woman; certain low-income seniors; and some individuals with disabilities who are under the age of 65.” Sarah Baron, 10 Frequently Asked Questions About Medicaid Expansion, CTR. FOR AM. PROGRESS (Apr. 2, 2013, 4:22 PM), https://www.americanprogress.org/issues/healthcare/news/2013/04/02/58922/10-frequently-asked-questions-about-medicaid-expansion/ [https://perma.cc/UT7E-5D4G].

74. Current Status, supra note 55.
insured under the program. For example, the expansion of Medicaid has reduced the amount of debt sent to a collection agency by an estimated $600–$1,000 per person now eligible for coverage. Although Medicaid expansion was originally envisioned to apply nationally, the United States Supreme Court determined in 2012, in National Federation of Independent Business v. Sebelius, that Congress could not use its spending power to compel states to expand the program within state borders. The Court determined that revocation of all federal funding for states that declined to expand Medicaid was an improperly coercive measure that robbed states of a genuine choice. The Court then ruled that states could instead opt into Medicaid expansion. As of September 11, 2018, fourteen states have not expanded their Medicaid programs. In those states, financial assistance provided by nonprofit hospitals may be one of the only available sources of relief from unmanageable medical debt for low-income patients.

States that have declined to expand Medicaid following the Sebelius decision have left their lower-income, uninsured populations in a precarious position in the likely event that medical care becomes necessary. Specifically, in those states, 3.1 million individuals “fall into a ‘coverage gap.’” The “coverage gap” is a descriptive term that refers to individuals who, based on their income level, would have been eligible for Medicaid if their state had elected to expand the program. Many individuals in the coverage gap do not qualify for the tax subsidies that reduce the cost of insurance premiums because these subsidies only begin at 100% of the federal poverty level. Frequently, these individuals do not have employer-sponsored coverage and are therefore “likely to find the

76. Obama, supra note 49, at 527.
78. See id. at 542.
79. See id. at 587.
80. Current Status, supra note 55.
83. See id.
84. Id.
cost of unsubsidized marketplace insurance prohibitively expensive.\textsuperscript{85} People of color in states that have declined Medicaid expansion experience a disproportionate share of adverse effects, as they are also more likely to comprise groups that would have been eligible.\textsuperscript{86} Because uninsured patients may be responsible for paying a hospital’s full chargemaster rate, they are likely to face tremendous and unaffordable medical bills.\textsuperscript{87}

\textbf{C. The Affordable Care Act’s Changes to the Nonprofit Hospital Tax Exemption}

As part of the ACA, Congress established § 501(r) and imposed additional requirements on nonprofit hospitals to maintain their tax-exempt status.\textsuperscript{88} These requirements were meant to ensure that nonprofit, tax-exempt hospitals provided community benefits and financial assistance to low-income individuals.\textsuperscript{89} Prior to the ACA, hospitals could be “nonprofit” and remain tax exempt if they provided a “community benefit,” a requirement that was largely undefined and subject to the discretion of individual hospitals.\textsuperscript{90} Because this standard was so vague, there was effectively no enforcement mechanism to ensure that nonprofit hospitals provided any benefits to the communities they served.\textsuperscript{91} Moreover, the lack of required measurable actions, in many cases, made nonprofit hospitals with tax-exempt status essentially indistinguishable from for-profit institutions.\textsuperscript{92} In 1969, the Internal Revenue Service (IRS) issued Revenue Ruling 69-545, which eliminated the prior and more clearly defined requirement to provide uncompensated care in favor of this more ambiguous community benefit standard.\textsuperscript{93} As a result of this ruling, nonprofit hospitals were required to provide little, if any, financial assistance or uncompensated care for low-income patients as a condition of their nonprofit tax status.\textsuperscript{94}

Section 501(r) was enacted as part of the ACA and imposed additional and more specific requirements on nonprofit hospitals for

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\textsuperscript{85.} Id.

\textsuperscript{86.} Id.

\textsuperscript{87.} See Reinhardt, supra note 11, at 62.


\textsuperscript{89.} See id.


\textsuperscript{91.} Id.

\textsuperscript{92.} See Susannah Camic Tahk, Tax-Exempt Hospitals and Their Communities, 6 COLUM. J. TAX L. 33, 40–41 (2014).


\textsuperscript{94.} See Rosenbaum & Margulies, supra note 90, at 283–84.
maintaining their tax exemption, though several key areas of ambiguity persist. Section 501(r) is superior to Revenue Ruling 69-545 because it mandates that tax-exempt hospitals: (1) conduct community health needs assessments; (2) create and publicize written financial assistance policies; and (3) exhaust all reasonable collection measures before engaging in “extraordinary collection efforts.”

First, the ACA required tax-exempt hospitals to conduct a “community health needs assessment” (CHNA) every three years. After identifying the needs of the community through the CHNA, hospitals must then design and implement a strategy to meet them. Hospitals are also required to “widely publicize” their CHNAs. Failure to meet this requirement results in a $50,000 excise tax.

Second, the new tax code provision requires hospitals to establish specific written financial assistance policies and policies for emergency medical care. Nonprofit hospitals are prohibited from charging patients who are eligible for financial aid amounts that are greater than the amounts charged to insured patients. In effect, this means that to maintain federal tax-exempt status, hospitals must not bill patients who are eligible for financial assistance at the chargemaster rate.

Third, when a hospital attempts to collect payment from a patient for a service, it is first required to “make reasonable efforts to determine whether an individual is eligible for financial assistance before engaging in ‘extraordinary collection actions’” (ECAs) against the individual. “Reasonable efforts” means that nonprofit hospitals are required to: (1) make a presumptive determination of eligibility for financial assistance based on third-party information or prior applications, if applicable; (2) notify patients regarding financial assistance in writing and make

96. Id. § 501(r)(4).
97. Id. § 501(r)(6).
98. Id. § 501(r)(3)(A)(i).
100. Id. § 501(r)(3)(B)(ii).
101. Id. § 501(r)(3). Due to the costliness of performing the CHNA, one hospital willfully declined to conduct the assessment and its nonprofit status was revoked. Michael Wyland, Hospital Loses IRS Tax Exemption for Noncompliance with ACA, NONPROFIT Q. (Aug. 18, 2017), https://nonprofitquarterly.org/2017/08/18/hospital-loses-irs-tax-exemption/ [https://perma.cc/4SF7-YNMT]. The hospital determined that the value of the tax exemption was not substantial enough to warrant the expense of conducting and implementing a CHNA. Id.
reasonable efforts to notify patients orally; (3) not engage in any ECAs for 120 days after the first billing statement is sent to the patient; (4) provide 30 days’ prior written notice before engaging in an ECA; and (5) if a patient applies for Charity Care in the first 240 days, suspend any collections actions until the application is processed. 106 “Extraordinary Collections Actions” include: (1) selling a patient’s debt to a debt collector; (2) reporting a patient’s debt to a credit bureau or agency; (3) denying further medical care due to existence of a medical debt; and (4) engaging in any legal or judicial processes aimed at obtaining payment for the debt.107

The new tax code provision is more robust than its predecessors; however, it fails to provide sufficient protections for low-income patients. Primarily, the rules are constructed in a manner that provides hospitals nearly unlimited discretion in defining which patients are eligible for financial assistance,108 and the protections under § 501(r) apply only to patients who are eligible for financial assistance.109 A hospital could therefore employ a restrictive financial assistance policy that excludes all insured patients, maintain narrow income requirements, or make the application process prohibitively difficult and still qualify for the tax exemption.110 Among a sample of 140 nonprofit hospitals across fourteen states, “eligibility cutoffs for financial assistance ranged from 100% of the [federal poverty level] up to 600% of the FPL.”111 Moreover, though some hospitals provided free care to some patients, other hospitals “did not offer any free care and only offered [moderate] discounts to a limited range of patients.”112 Several hospitals also expressly stated that individuals with insurance could not obtain any financial assistance whatsoever.113

For example, Mosaic Life Care, a nonprofit hospital in Missouri (a state that declined to expand Medicaid) sued more patients than any other hospital in the state, many of whom were uninsured, and charged them the full chargemaster rate. 114 The hospital paid no income or property taxes

106. 26 C.F.R. § 1.501(r)-6(c) (2018).
107. Id. § 1.501(r)(6)(b).
111. Id.
112. Id. at 530–31.
113. Id. at 531.
114. Kiel, supra note 36.
due to its nonprofit status and earned a profit of $45 million in 2013.\footnote{115. \textit{Id.}} Though the hospital does maintain a financial assistance policy, without the threat of losing its tax exemption, it has little outward incentive to enforce it, and many uninsured patients end up getting their wages garnished for medical bills priced at the hospital’s full chargemaster rate.\footnote{116. \textit{Id.}}

Though the ACA is a substantial improvement from the previous market-regulated healthcare system, many individuals are still unable to afford health coverage entirely, and many others cannot afford to pay their high out-of-pocket and deductible expenses.\footnote{117. \textit{See Helaine Olen, \textit{Even the Insured Often Can’ t Afford Their Medical Bills}, ATLANTIC (June 18, 2017), https://www.theatlantic.com/business/archive/2017/06/medical-bills/530679/ [https://perma.cc/LR4Z-RKDB].}} The lack of federally defined financial assistance policies and income requirements allows institutions to behave opportunistically and still receive a tax exemption.\footnote{118. \textit{See Fuse Brown, supra note 110.}} Therefore, aspects of Washington State and California’s Charity Care laws can be used to draw definitions for financial assistance policies on a national scale.

III. CHARITY CARE: WASHINGTON’S AND CALIFORNIA’S FINANCIAL ASSISTANCE POLICIES AS CRITICAL AND COMPREHENSIVE SAFETY NETS FOR LOW-INCOME PATIENT

A. Charity Care in Washington

Washington’s Charity Care laws were enacted in 1989 to prevent the most vulnerable populations in the state from amassing insurmountable medical debts.\footnote{119. \textit{See WASH. REV. CODE \S 70.170.010(2)–(4) (2018).}} Broadly, Washington hospitals are prohibited from creating policies or procedures that would lead to a significant reduction in patient access to care based on an assumption that they will not be able to pay for the services, that they will not be able to pay for the full cost of services, or that the services themselves will be unusually costly and the anticipated treatment will be prolonged.\footnote{120. \textit{See id. \S 70.170.060(1)(a)–(c).}} Additionally, Washington hospitals are prohibited from denying emergency room admission to patients due to their inability to pay.\footnote{121. \textit{Id. \S 70.170.060(2).}}

All hospitals within Washington, without regard to their ownership and tax status, are affirmatively required to develop and maintain “[u]niform procedures, data requirements, and criteria for identifying...”
patients receiving charity care.” Charity Care refers to a complete or partial discount for medically indigent patients who either have no third-party coverage or who cannot afford their deductibles or co-insurance costs if they do have coverage. An individual is considered indigent if the individual’s family income is at or below 200% of the federal poverty level. All “appropriate hospital-based medical services” are eligible for Charity Care coverage. Hospitals develop their own sliding-scale schedule for discounts subject to broader guidelines and oversight from the Washington State Department of Health. All individuals with a household income at or below 100% of the federal poverty level qualify for a complete discount for appropriate hospital-based medical services, and those with incomes 100%–200% of the federal poverty level receive a partial discount.

To receive Charity Care in Washington, patients are typically required to complete a written application, which may be unique to every hospital or chain of hospitals, and to provide proof that their income qualifies them for a discount. A single document, such as a pay stub, income tax return, or W-2 for the previous year should be sufficient to prove income eligibility according to the regulation. Hospitals are also under an affirmative duty to inform patients of their eligibility for Charity Care. Importantly, hospitals are also required to conduct an affirmative initial determination of eligibility prior to engaging in any bill collection efforts, and patients are entitled to receive Charity Care “at any time.” A patient’s right to receive a Charity Care discount exists even after an account has been referred to a third-party debt collector and a lawsuit has been filed.

122. Id. § 70.170.060(4)(a).
123. Id. § 70.170.020(4).
125. Id. § 246-453-010 (defining “appropriate hospital based medical services” as those that are medically necessary and for which there is no “equally effective more conservative or substantially less costly course of treatment available or suitable for the person requesting the service”); Id. § 246-453-040.
127. See WASH. ADMIN. CODE § 246-453-040.
128. See id. § 246-453-020(5).
129. Id. § 246-453-030(2).
130. Id. § 246-453-020(10).
131. See WASH. REV. CODE § 70.170.060(5); WASH. ADMIN. CODE §§ 245-453-010(4), 020(1), 020(10).
Though Washington’s Charity Care program has been largely successful and is a leader nationally, there are many ways in which it can be improved. First, hospitals are not adequately addressing language barriers despite laws requiring that hospitals make Charity Care accessible to patients who speak languages other than English.133 The Equal Rights Center conducted a study in which test calls were placed to twenty hospitals in Washington;134 the testers were matched by gender and other characteristics, so the only difference between the callers was the apparent ability or inability to understand and speak English.135 The study found that eighty percent of the hospitals hung up on at least one Spanish speaking tester, and only twenty percent of hospitals provided assistance for the Spanish speaking tester.136 This lack of assistance for non-English speaking patients is especially problematic given that undocumented individuals are denied access to Medicaid, and anyone within the income range for eligibility for Medicaid would also be eligible for Charity Care.137

Second, some Washington hospitals routinely fail to conduct the required initial determination of Charity Care eligibility before initiating collection efforts directed at patients.138 Hospitals ask about public and private insurance status but seldom inquire about Charity Care eligibility during intake, even though performing such a screening only requires two additional questions about household size and an approximate annual household income.139 By failing to conduct this required affirmative screening, many hospitals shift to patients the burden of identifying the availability of assistance, understanding the need for assistance, determining eligibility for assistance, and navigating the process of applying for assistance.140 Patients also frequently reported that hospitals have disregarded signals that indicate both their need and eligibility for Charity Care, including statements that the patient was “uninsured, couldn’t afford to pay, couldn’t work for some time due to the injury,” and other similar cues.141

133. Duhamel, supra note 21, at 14.
134. Id. at 15 (“Hospitals were carefully selected to provide a representative variety of hospitals based on their geographic and demographic characteristics.”)
135. Id.
136. Id.
139. Duhamel, supra note 21, at 18–20.
140. Id.
141. Id.
Despite these issues, if properly enforced, Washington’s Charity Care law provides a crucial safety net for low-income individuals who would otherwise face the devastating consequences of insurmountable medical debt. Additionally, the state legislature passed a statute, effective October 1, 2018, that aims to standardize the way hospitals notify patients about the availability of Charity Care, clarifies certain terms, and requires training of certain staff regarding Charity Care policies and interpreter services.\footnote{Zosia Stanley, Effective October 1: Changes to State Charity Care Law, WASH. ST. HOSP. ASS’N (Sept. 6, 2018), http://www.wsha.org/articles/effective-october-1-changes-to-state-charity-care-law/ [https://perma.cc/T3GE-9KHD].} Undocumented individuals without insurance are denied access to Medicaid under the expansion due to their immigration status.\footnote{A Look at Access to Health Services and the Intersection of Immigration Status with Medicaid and Insurance Eligibility, ASS’N ST. & TERRITORIAL HEALTH OFFICERS: ASTHOEXPERTS BLOG (July 5, 2018, 2:39 PM), http://www.astho.org/StatePublicHealth/A-Look-at-Access-to-Health-Services-and-the-Intersection-of-Immigration-Status-with-Medicaid-and-Insurance-Eligibility/07-05-18/ [https://perma.cc/Y3PV-4RFS].} Conversely, immigration status is irrelevant to a determination of Charity Care eligibility.\footnote{Id. at 3–4.} Additionally, even with the increase in Medicaid health coverage enrollment following the expansion and access to the private market through the state healthcare exchange, many individuals in Washington remain underinsured and cannot afford the co-insurance costs and high deductibles.\footnote{Id. at 4.} Taken together, Washington’s Charity Care laws provide an essential service for a large component of the state’s uninsured and underinsured populations. Without this vital public policy, these individuals would have little recourse in dealing with unpredictable and unaffordable bills when a medical event occurs.

**B. Hospital Fair Pricing Policies in California**

Similar to the protections offered by Washington State’s Charity Care laws, California has strong protections in place for low-income patients through its Hospital Fair Pricing Policies law. The statute provides that uninsured patients or “patients with high medical costs” who are at or below 350% of the federal poverty level are eligible to apply for Charity Care, which refers to a complete discount under the statute, or to apply for participation in a hospital’s discount payment policy.\footnote{CAL. HEALTH & SAFETY CODE § 127405(a)(1)(A) (2018). “High medical costs” refers to costs above ten percent of the individual’s gross income. Id. § 127400(g)(1).} Hospitals are also permitted to provide similar financial assistance to patients with incomes above 350% of the federal poverty level if they elect to do so.\footnote{Id. § 127405(a)(1)(A).} When determining a patient’s eligibility for financial assistance, hospitals may...
consider both income and monetary assets, however they may not consider retirements or deferred compensation plans.\footnote{Id. \S 127405(c).}

The keystone piece to California’s fair pricing law is the limitation on expected payment for services provided to patients who meet the income eligibility requirement.\footnote{Id. \S 127405(d).} Specifically, patients who are income eligible cannot be billed more than “the hospital would expect, in good faith, to receive for providing services from Medicare, Medi-Cal,\footnote{“Medi-Cal” is California’s version of Medicaid. \textit{Medi-Cal}, \textsc{Covered Cal.}, https://www.coveredca.com/medi-cal/ [https://perma.cc/8SDA-N55X].} the Healthy Families Program,\footnote{The Healthy Families Program is a program that provides low cost medical and dental coverage to children age nineteen and under whose families meet certain income requirements. \textit{Healthy Families Program}, \textsc{Blue Shield Cal.}, https://www.blueshieldca.com/bsha/find-a-plan/health-plans/individual-family/individual-family/affordable/healthy-families/home.sp [https://perma.cc/EM6A-XD6M].} or another government sponsored health program . . . in which the hospital participates, whichever is greater,” as opposed to the chargemaster rate.\footnote{CAL. HEALTH \& SAFETY CODE \S 127405(d).} If the eligible patient received a service that is not typically covered by any government sponsored coverage program, in which the hospital participates, the hospital has a duty to establish an appropriate discount for the procedure.\footnote{Id.} The actual price paid by the patient depends on the hospital’s pricing behavior, and reduced hospital charges play a critical role in relieving uninsured and underinsured patients’ medical-debt obligations and protecting them from financial hardship.\footnote{See \textit{California Law Protects Uninsured Patients from High Hospital Charges}, \textsc{Spotlight on Poverty \& Opportunity} (May 27, 2014) [hereinafter \textsc{Spotlight on Poverty}], https://spotlightonpoverty.org/spotlight-exclusives/california-law-protects-uninsured-patients-from-high-hospital-charges/ [https://perma.cc/B3X7-6L7U].}

When a patient or the patient’s legal representative requests a discount or Charity Care, or informs the hospital that the patient will require assistance in paying for the bill, the patient or representative “shall make every reasonable effort to provide the hospital with documentation of [the patient’s] income and insurance information.”\footnote{CAL. HEALTH \& SAFETY CODE \S 127405(d).} Income documentation is limited to recent pay stubs and tax returns, and if the patient fails to provide information that is “reasonable and necessary” for the hospital to make its determination, the hospital may consider this failure in determining whether that patient is eligible for Charity Care or a discount.\footnote{Id. \S 127405(e)(1).} Like Charity Care in Washington, patients are eligible for
Charity Care in California “at any time” the hospital has a patient’s income documentation available.157

Hospitals are required to provide notice of the availability of financial assistance to patients several times during their visit and afterwards.158 Notice must be posted “clearly and conspicuously” in emergency rooms, billing and admissions offices, and other outpatient locations.159 Hospitals are also required to provide written notice of their charity care policies to uninsured patients and patients who received emergency or outpatient care who will be billed for those services.160 This information must include specific eligibility information and contact instructions directing patients to hospital administrative staff who can provide application assistance, and it must be provided in English and other languages.161 Hospitals are also required to include information regarding the availability of financial assistance in all bills sent to uninsured patients.162

California’s Fair Pricing law has been successful; by 2011 most hospitals had adopted the policies and complied with the state’s laws.163 Some hospitals even created policies that are more generous than those required by law.164 Perhaps most importantly, although the California law does not expressly require hospitals to provide free care, ninety-seven percent of all California hospitals reported offering some degree of free care to uninsured patients who were at or below the poverty line.165

California’s Fair Pricing Act is a successful responsive measure that arose following five class action lawsuits filed against California hospitals in 2005 and 2006.166 These suits challenged the “exorbitant and unconscionable pricing of medical care for uninsured Californians” who were billed at the inflated chargemaster rates.167 Though the hospitals denied liability, eventually the claims with each institution ended with comprehensive settlements and refunds for nearly one million patients.168 The California Fair Pricing Act arose as a result of this litigation and directly addressed the practice of charging uninsured patients at the

157. Id. § 127405(c)(4).
158. Id. § 127410(b).
159. Id.
160. Id. § 127410(a).
161. Id.
162. See id. § 127420(b).
163. SPOTLIGHT ON POVERTY, supra note 154.
164. Id.
165. Id.
167. Id.
168. Id.
unregulated chargemaster rates. All of the institutions involved in the litigation were nonprofit hospitals that were required to adhere to largely undefined community-benefit standards that granted a substantial degree of discretion onto each institution to determine its own policies. This litigation is evidence that voluntary or discretionary community health-benefit systems that were not sufficiently prescriptive did not adequately protect patients from aggressive billing and collection practices. California’s Fair Pricing Act directly addresses these issues and has been largely cited as an example of an effective and comprehensive policy for ensuring affordable prices for low-income patients.

Washington and California both have financial assistance systems that aim to alleviate some of the debt burden incurred when a medical event arises. Though Washington’s Charity Care program could be improved with proper enforcement and proactive screening, the program remains a vital safety net for low-income patients. Similarly, California’s transition from a discretionary system based on loosely-defined community benefits to a well-regulated, prescriptive system is a motion towards meaningful protection for the most vulnerable patients. Though § 501(r) compels nonprofit hospitals to establish financial assistance programs, the grant of discretion to individual institutions to develop their own policies, and to then tie every benefit provided within the tax code to those discretionary policies, creates a condition similar to that in California prior to the passage of the Hospital Fair Pricing Act. To ensure patients receive the benefits intended by § 501(r), certain provisions of both the Washington and California systems are incorporated into § 501(r) to ensure patients receive its intended benefits.

IV. SECTION 501(R) CAN BE MEANINGFULLY IMPROVED TO PROVIDE AN IMPORTANT SAFETY NET FOR LOW-INCOME PATIENTS BY INTEGRATING KEY ASPECTS OF WASHINGTON’S AND CALIFORNIA’S CHARITY CARE LAWS.

Several aspects of the ACA, including the expansion of Medicaid, the creation of the individual mandate, the establishment of minimum

169. Id.
170. California nonprofit hospitals were required to conduct Community Health Needs assessments every three years and to develop plans to address the identified needs. There were no defined standards or requirements necessary to receive tax benefits. “Community benefits may include, but are not limited to, free care services, wellness and health promotion services, research, medical education, and professional training.” Janet P. Sutton & Jeffrey Stensland, Promoting Accountability: Hospital Charity Care in California, Washington State, and Texas, 15 J. HEALTH CARE FOR POOR & UNDERSERVED 237, 238 (2004).
quality guidelines in health insurance products, and the reduction of healthcare costs through provision of income-based federal subsidies, indicate a national movement towards ensuring access to healthcare as a right.\footnote{172} Despite these important reforms, 27.6 million Americans remain uninsured\footnote{173} Moreover, the Tax Cuts and Jobs Act’s effective repeal of the individual mandate has been projected to result in 13 million Americans becoming uninsured by the year 2027.\footnote{174}

Because many individuals are likely to remain or become uninsured, and others who are insured might still face difficulties affording healthcare, it is critical to clearly define aspects of § 501(r)\footnote{175}. Although the provisions apply only to nonprofit hospitals for the purpose of providing a tax exemption, and not to for-profit or government-run hospitals,\footnote{176} nonprofit hospitals still account for approximately fifty-one percent of registered hospitals in the United States.\footnote{177} The Secretary of the Treasury is empowered to provide “regulations and guidance as may be necessary to carry out the provisions” of § 501(r). To that effect, the Secretary of the Treasury issued final regulations pertaining to this section of the tax code in 2014.\footnote{178}

In response to “some commenters” who asked for the final regulations to confirm that hospital facilities will be given the flexibility to develop [financial assistance policy] eligibility criteria that respond to local needs[,] . . . the final regulations do not mandate any particular eligibility criteria and

\begin{itemize}
\item\footnote{172} See generally Lindsay F. Wiley, Health Law as Social Justice, 24 CORNELL J.L. \\& PUB. POL’Y 47 (2014).
\item\footnote{173} Key Facts about the Uninsured Population, HENRY J. KAISER FAM. FOUND. (Nov. 29, 2017), https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/ [https://perma.cc/6Q4D-L7M8].
\item\footnote{175} Only eighteen states and the District of Columbia “set legislative or regulatory standards for certain healthcare providers or services in determining eligibility for free care,” and only thirteen states and the District of Columbia have “legislative or regulatory mandates that require certain medical providers to provide free care, without reimbursement, to those who are unable to pay.” National Snapshot, COMMUNITY CATALYST: FREE CARE COMPENDIUM, https://www.communitycatalyst.org/initiatives-and-issues/initiatives/hospital-accountability-project/free-care/national-snapshot [https://perma.cc/M6CV-LXE5].
\item\footnote{176} Fuse Brown, supra note 110, at 511.
\item\footnote{178} 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. 250, 78954, 250, 78972 (Dec. 31, 2014) (codified as amended at 26 C.F.R. §§ 1.501(r)-3 to -7 (2018)).
\end{itemize}
require only that a [financial assistance policy] specify the eligibility
criteria for receiving financial assistance under the [policy].\textsuperscript{179}

However, a clear definition of financial assistance eligibility is
critical for meaningful implementation of § 501(r) because low-income
patients cannot receive the protections intended within § 501(r) unless the
hospital has determined that they are eligible.\textsuperscript{180} In California, the effects
of loosely defined and discretionary standards for community benefits
resulted in nonprofit hospitals aggressively billing uninsured patients at
chargemaster rates.\textsuperscript{181} More recently, in Missouri, the aggressive
collection practices of Mosaic Life Care further demonstrate the
inadequacy of merely requiring hospitals to develop and publicize
financial assistance policies with no penalties for failure to meet the
requirements of their own policies.\textsuperscript{182}

Charity Care in Washington and Fair Pricing in California are
effective laws because they combine serious incentives with clearly
defined minimum standards. Washington laws require all hospitals within
the state to provide some discount for patients at 200% of the federal
poverty level and below and a complete discount for patients at or below
100% of the federal poverty level.\textsuperscript{183} The California law requires hospitals
to provide a discount at 350% of the federal poverty level or lower.\textsuperscript{184}
There is no independent requirement that hospitals in California provide
complete discounts, though many elect to do so.\textsuperscript{185} Additionally, in
Washington, any time a hospital wishes to expand, increase its number of
beds, or provide a new service, it must submit a Certificate of Need to the
Department of Health and approval is conditioned on providing Charity
Care in “amount[s] comparable to or exceeding the average amount of
charity care provided” in hospitals in that region.\textsuperscript{186} Similarly, in
California, the State Attorney General can impose strict Charity Care
quotas on nonprofit hospitals seeking mergers or changes of ownership.\textsuperscript{187}

\textsuperscript{179} Id.
\textsuperscript{181} See California Uninsured Patients, supra note 166.
\textsuperscript{182} See Kiel, supra note 36.
\textsuperscript{183} WASH. ADMIN. CODE § 246-453-040 (2018).
\textsuperscript{184} CAL. HEALTH & SAFETY CODE § 127405(a)(1)(A) (2018).
\textsuperscript{185} SPOTLIGHT ON POVERTY, supra note 154.
\textsuperscript{186} See, e.g., Letter from Wash. State Dep’t of Health to Elaine Couture, Reg’l Chief Exec. of
Providence Health Care 6 (Feb. 20, 2018) (available on the Department of Health website,
https://www.doh.wa.gov/Portals/1/Documents/2300/2018/18-01.pdf) (This Decision Letter from the
Washington State Department of Health approves a certificate of need application from Providence
Hospital and lists Charity Care requirements among the conditions of approval.).
\textsuperscript{187} Pauline Bartolone, California Hospitals Must Cough Up Millions to Meet Charity Care
Rules, CAL. HEALTHLINE (Apr. 18, 2018), https://californiahealthline.org/news/california-hospitals-
must-cough-up-millions-to-meet-charity-care-rules/ [https://perma.cc/XN2U-GLPH].
When nonprofit hospitals do not meet the quota, they must donate the difference to local nonprofit organizations that provides medical services to indigent or homeless patients.\footnote{188}

Section 501(r) provides important tax incentives for adherence to the financial assistance policies but provides no minimum guidelines by which a hospital’s adequate performance can be measured.\footnote{189} Section 501(r)(1) specifically states that unless a hospital or organization meets the requirements laid out in §§ 501(r)(3) through (6), it will not be tax-exempt under § 501(r)(3).\footnote{190} Thus the consequences of failing to comply with § 501(r) are steep if such non-compliance is discovered during an audit. One hospital has had its tax-exempt status revoked for failing to comply with the Community Health Needs Assessment requirements under § 501(r)(3).\footnote{191} If these incentives are coupled with well-defined (1) eligibility standards for financial assistance; (2) requirements for proof of income documentation; and (3) limits on amounts charged to eligible patients, § 501(r) can become an effective mechanism at curtailing the devastating impact of medical debt on a national scale. To achieve this goal, the Secretary of the Treasury should create new regulations that implement: (1) Washington State’s minimum standard for complete discounts, (2) California’s limit on amounts charged to patients at or below 350% of the federal poverty level, and (3) Washington’s flexible proof of income requirements.

First, the new regulations should emulate Washington’s Charity Care laws and provide that any individual at or below 100% of the federal poverty level\footnote{192} should get a complete discount on “medically necessary care.”\footnote{193} On a national scale, employing this element of Washington’s laws and provide that any individual at or below 100% of the federal poverty level should get a complete discount on “medically necessary care.”
Charity Care law would be especially beneficial because federal subsidies for private insurance purchased on the healthcare exchange only begin at 100% of the federal poverty level. Therefore, many low-income patients in states that declined to expand Medicaid likely cannot afford insurance coverage and will struggle to afford expensive medical procedures. Financial Assistance policies are only meaningful if they can provide support to patients in precisely these circumstances.

Second, the regulations should follow California’s definition on limitations for amounts billed to patients who meet income eligibility requirements in two respects. Eligibility for the discount should begin at 350% of the federal poverty level or higher, and the maximum amount billed to patients should be no greater than what the hospital would expect to receive from government sponsored coverage providers. Presently, § 501(r)(5)(A) provides that hospitals may not bill patients who meet the hospital’s financial assistance eligibility requirements “more than the amounts generally billed to individuals who have insurance covering such care.” The regulations allow for two different calculation methods to determine the “amount generally billed,” one of which permits hospitals to include the amounts billed to private insurers who tend to pay more than government insurers. The effect of this provision in the tax code is to prohibit hospitals from billing patients who meet their financial eligibility requirements at the chargemaster rates. This protection is only extended to eligible patients based on that hospital’s financial assistance policy. For the reasons explained above, it is important to define at minimum which patients should be granted this protection. Moreover, due to the variability in chargemaster rates and negotiated prices with private insurers, applying government insurer prices would create uniformity and ensure affordable pricing.

Third, the regulations should establish proof of income requirements similar to Washington State’s Charity Care proof of income requirements.


195. See id.
198. Fuse Brown, supra note 189, at 764.
Under the current regulations, while hospitals cannot deny financial assistance for failure to provide documentation not requested within their published policies, they are granted complete discretion to determine which documents are required to determine eligibility and provide discounts. In Washington, patients are only required to submit one document. If the patients are unable to locate that information, they are permitted to submit a personal statement describing their income. Washington’s regulations expressly limit hospitals to only ask for proof of income that is “reasonably necessary and readily available to substantiate the responsible party’s qualification for charity sponsorship, and may not be used to discourage applications for such sponsorship.” For example, Mosaic Life Care claimed it cannot be faulted when individuals who might be eligible for financial assistance do not apply. Onerous applications, however, likely discourage individuals who have just suffered serious medical emergencies from applying for financial assistance. A regulatory system that specifically proscribes this behavior can help ensure that more patients apply for assistance.

In granting too much deference to individual hospitals to determine their own financial assistance policies, § 501(r) does not adequately support low-income patients. Programs in Washington and California have been successful because they establish clear expectations of the individual hospitals, set minimum standards by which compliance can be measured, and provide incentive systems for meeting these standards. Because individuals will likely continue to need safety nets like financial assistance, especially in states that did not expand Medicaid, the federal program can be substantially improved by implementing components of Washington’s and California’s programs.

CONCLUSION

Medical debt is a critical issue that deeply impacts many individuals but disproportionately affects individuals from historically marginalized communities. Because the impacts of medical debt create pervasive and

203. Id. § 246-453-030(4).
204. Id. § 246-453-030(5).
205. See Kiel, supra note 36.
206. Washington State Attorney General Bob Ferguson filed a suit against St. Joseph Medical Center in 2017, alleging, amongst other serious complaints, that the hospital withheld Charity Care from thousands of state residents by, in part, requiring multiple documents to prove income as opposed to the single document required by the state law. Melissa Santos, State Sues Tacoma’s St. Joseph Medical Center, Saying It Illegally Withheld Charity Care, NEWS TRIBUNE (Sept. 6, 2017, 02:42 PM), https://www.thenewstribune.com/news/politics-government/article171326762.html; see also Fuse Brown, supra note 110.
long-lasting problems in both financial, and most importantly, physical health, measures should be undertaken to relieve communities of this debt to create a more equitable, accessible, and efficient healthcare system. Though the ACA has addressed some aspects of the medical debt crisis, it is neither a complete nor final resolution of this issue. With the individual mandate effectively repealed, there will likely be many uninsured individuals in the market who will necessarily require healthcare at some point. Section 501(r) is an important provision of the ACA that can provide a critical pillar of support for low-income individuals if properly enforced. However, the key terms that activate the protections in this section rely on discretionary definitions by nonprofit hospitals, some of whose interests are not necessarily aligned with that of low-income patients. To expand the vital protections provided by Charity Care programs on a national scale, the IRS should pass regulations that more clearly define financial assistance programs based on state models like California and Washington so that hospitals benefiting from the tax exemption provide the patient support to warrant it.