

DOLLAR FOR



BRIDGING THE CHASM

Closing the \$14 Billion Access Gap in Charity Care



Every year, patients are billed
\$14 billion that should be waived
through charity care.

To understand how much charity care falls through the gaps each year, Dollar For reviewed hospital tax filings and publicly available studies. Affordable Care Act (ACA) regulations require nonprofit hospitals to adopt charity care policies, yet charity care is not applied to many eligible patient accounts.

We found that hospitals fail to provide at least \$14 billion annually in charity care to patients, instead recording unpaid, unaffordable bills as “bad debt.”

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This research relied on two sources: hospital self-reported numbers from their tax filings and a first-of-its-kind study in Maryland that matched patient billing records to their income filings. After extrapolating hospital self-reported amounts (charity care and bad debt) in their tax filings, we found that approximately \$7 billion per year in charity care eligible amounts end up as bad debt. However, the Maryland data suggests that hospitals self-report less than half of their charity care-eligible bad debt, so the actual amount is likely twice that number.

About Dollar For

Dollar For is a national nonprofit that crushes hospital bills by helping patients access charity care. We empower patients and advocate on their behalf. To date, we have helped patients submit over 13,500 financial assistance applications and crushed over \$46 million in medical debt.

We recommend that hospitals, governments, and agencies invest in programs and processes that remove patients’ obligation to learn about charity care, estimate whether they may be eligible, and then get through the application process. Instead, hospitals can improve processes to identify eligible patients, and governments and agencies can create programs that allow patients to authorize the hospital to verify their income directly with the government.

While the U.S. is one of the wealthiest countries in the world by many metrics, it struggles to provide medical care to its neediest citizens. As a result, medical debt is a pervasive and growing problem. More than a quarter of adults in America have reported delaying or skipping care because they could not afford it.¹ It is the leading cause of bankruptcy,² severely affects housing and food security,³ and plagues nearly 100 million Americans.⁴ Within the medical debt bucket, more than half is from hospital care.⁵

The Affordable Care Act of 2010 legislated a requirement for nonprofit hospitals to have financial assistance or “charity care” policies.⁶ The law obligates nonprofit hospitals to adopt policies that give patients a discount on any out-of-pocket payments, depending on their Federal Poverty Level (FPL) percentage.⁷

About Charity Care

Mandated in the Affordable Care Act, nonprofit hospitals must reduce or waive bills for lower-income patients. These community benefit programs, known as “charity care” prevent patients from falling into poverty. Every hospital has its own unique policy and process for deciding who qualifies and how to apply.

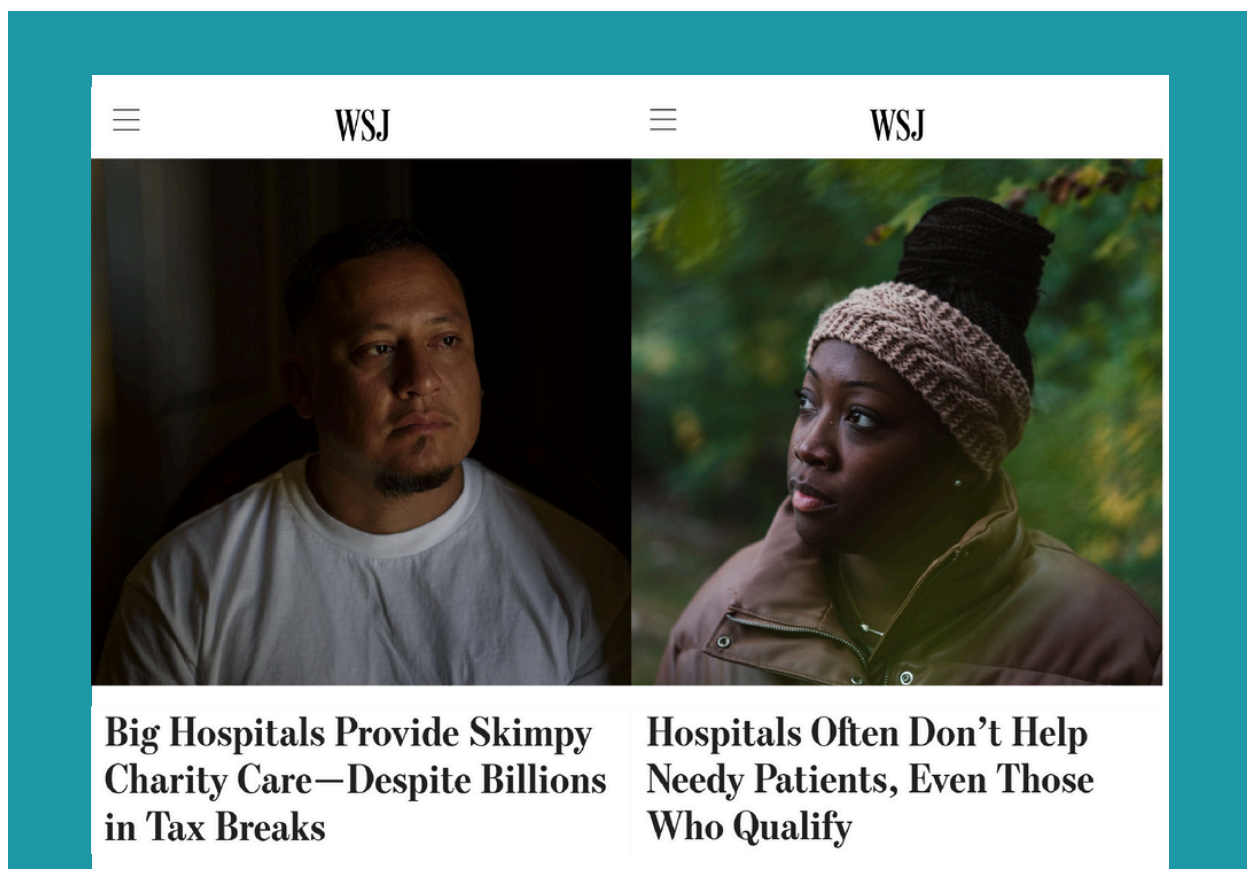
Yet there is no systematic enforcement of charity care laws. Most Americans aren’t aware of these programs. Instead, patients experience needless financial burdens.

Hospitals can choose the thresholds for patient eligibility and discount level, but discounts should be consistent with the needs of the community they serve.⁸ Some states have set a floor that establishes the generosity of hospital charity care policies.⁹ As a result, charity care terms tend to vary from hospital to hospital and state to state. While there are certainly outliers, hospitals across the country generally have a policy that gives free care to patients up to 100% - 200% of FPL, and varying levels of discounts up to 300% - 400% FPL.

Hospitals are not required to apply these discounts to the amounts they bill to other payers, such as government or commercial insurance – only to the portion of the bill that is the patient's responsibility. While the law only mandates that nonprofit hospitals have a charity care policy to maintain their tax exemption, most for-profit hospitals also have charity care policies.

When charity care is not applied to a bill, it is generally sent through the normal hospital billing and collection process. While this is a different process at every hospital, it is common for the hospital to attempt collection directly from the patient for several months, and then send the bill to a debt collector. If unpaid, the patient may ultimately be sued which could lead to garnishment, credit score impacts, or bankruptcy. Ultimately, if a hospital determines that the patient will not ever pay the bill it is categorized as “bad debt.”

In theory, charity care should dramatically reduce American medical debt. However, today, the amount of charity care extended to patients is far below its potential. This is not just a theoretical issue. Millions of Americans who fall through the cracks left by the policy’s failed implementation suffer significantly as a result. This report aims to assess the scale of this failure.



Methodology, Analysis, and Context

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Hospital Self-Reported Data

Tax-exempt hospitals must file an IRS form 990 to report certain earnings and expenses every year.¹⁰

If a tax-exempt organization operates one or more hospitals, they must also file a Schedule H with their Form 990.¹¹ There are four fields on the Schedule H that are pertinent to this analysis:

1. How much bad debt the hospital accrued;
2. How much charity care they granted;
3. How much of their bad debt they believe is likely charity care eligible; and
4. Their methodology for calculating their charity care-eligible bad debt.¹²

SCHEDULE H (Form 990) Hospitals

OMB No. 1545-0047
2021
Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
Go to www.irs.gov/Form990 for instructions and the latest information.

Attach to Form 990.

Name of the organization _____ Employer identification number _____

Part I Financial Assistance and Certain Other Community Benefits at Cost

1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a. **1a** Yes No

1b If "Yes," was it a written policy? **1b** Yes No

2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year.

☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities

☐ Generally tailored to individual hospital facilities

3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.

a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: **3a**

☐ 100% ☐ 150% ☐ 200% ☐ Other _____ %

b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: **3b**

☐ 200% ☐ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other _____ %

c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.

4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? **4** Yes No

5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? **5a** Yes No

5b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? **5b** Yes No

5c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? **5c** Yes No

6a Did the organization prepare a community benefit report during the tax year? **6a** Yes No

6b If "Yes," did the organization make it available to the public? **6b** Yes No

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1)						
b Medicaid (from Worksheet 3, column d)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total. Financial Assistance and Means-Tested Government Programs						
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j Total. Other Benefits						
k Total. Add lines 7d and 7j						

For Paperwork Reduction Act Notice, see the Instructions for Form 990. Cat. No. 50192T Schedule H (Form 990) 2021

Unfortunately, there is no standard methodology for calculating charity-care eligible bad debt. Different hospitals base their estimates on historical payment data,¹³ census demographics for their service area,¹⁴ third-party data aggregators, and other factors.

In 2019, KFF Health News published findings that nonprofit hospitals and health systems collectively estimated that \$2.7 billion of their bad debt was billed to patients who were likely eligible for charity care.¹⁵ The analysis examined Schedule H filings for 1,134 systems that collectively operate 1,651 hospitals. This leaves, however, 1,327 nongovernment nonprofit hospitals that were not part of KFF's reported \$2.7 billion.

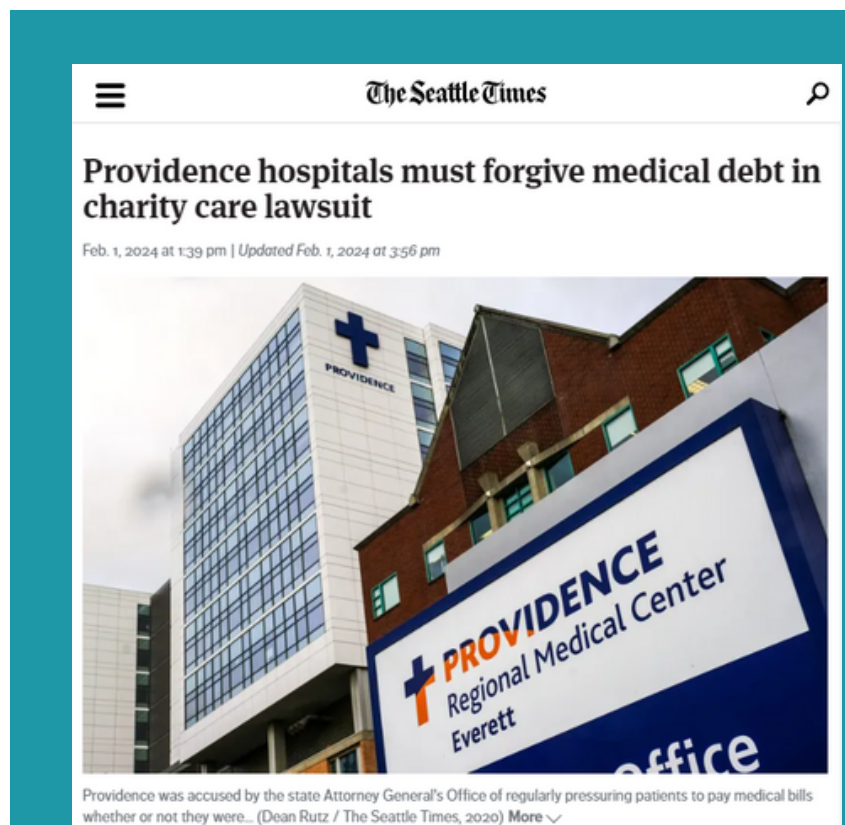
Approximately half of the Schedule Hs in the KFF analysis did not report any charity care-eligible bad debt.¹⁶ Many, if not most, of those hospitals, did not fill out the field, nor did they give a methodology or reason for not reporting an estimate to the IRS. While it is possible that these hospitals caught 100% of their charity-care eligible patients, it seems extremely unlikely, given the behavior of similar hospitals.

There is no shortage of investigations and lawsuits exposing hospitals that fail to report charity care-eligible bad debt but aggressively pursue collections from low-income patients.

Many hospitals carry charity care-eligible bad debt but do not report any to the IRS

Providence Health & Services Washington, Swedish Health Services, Swedish Edmonds, and Kadlec Regional Medical Center all reported that none of their bad debt was likely eligible for charity care and did not state a methodology to justify their position.¹⁷ However, after a lawsuit by Washington's Attorney General, we know this was not accurate. The Washington AG's investigation into these hospital systems culminated in a lawsuit filed in February 2022. The lawsuit alleged that:

"From September 2019 through September 2021, Providence sent 46,783 accounts with outstanding balances of over \$53 million associated with patients identified as having income between 151-200% FPL to Debt Collectors. In the same time frame, Providence assigned 8,454 accounts of currently enrolled Medicaid patients, totaling \$20.3 million dollars in charges, to Debt Collectors."¹⁸



Washington law requires hospitals to provide charity care for medically necessary services to patients up to 400% FPL, so the investigation would only have uncovered a portion of the charity care-eligible patients sent to collections.¹⁹ Ultimately, the lawsuit was resolved in a settlement obligating Providence to refund nearly \$21 million to patients and forgive an additional \$137 million in debt.²⁰

Another example of a hospital not reporting charity care-eligible bad debt is a *Baltimore Sun* investigation that found that The Johns Hopkins Hospital had filed more than 2,400 lawsuits against patients who lived in low-income neighborhoods from 2009 to 2018.²¹ Maryland state law obligates nonprofit hospitals to give patients discounts up to 500% FPL.²² Despite this, Johns Hopkins' Schedule H filings consistently reported that none of its bad debt was held by patients who were likely charity-care eligible.²³

LOCAL

Johns Hopkins Hospital sues patients, many low income, for medical debt

By Meredith Cohn and Lorraine Mirabella
May 20, 2019 at 5:02 p.m. EDT



A general view of Johns Hopkins Hospital in Baltimore. (Rosem Mortory/Reuters)

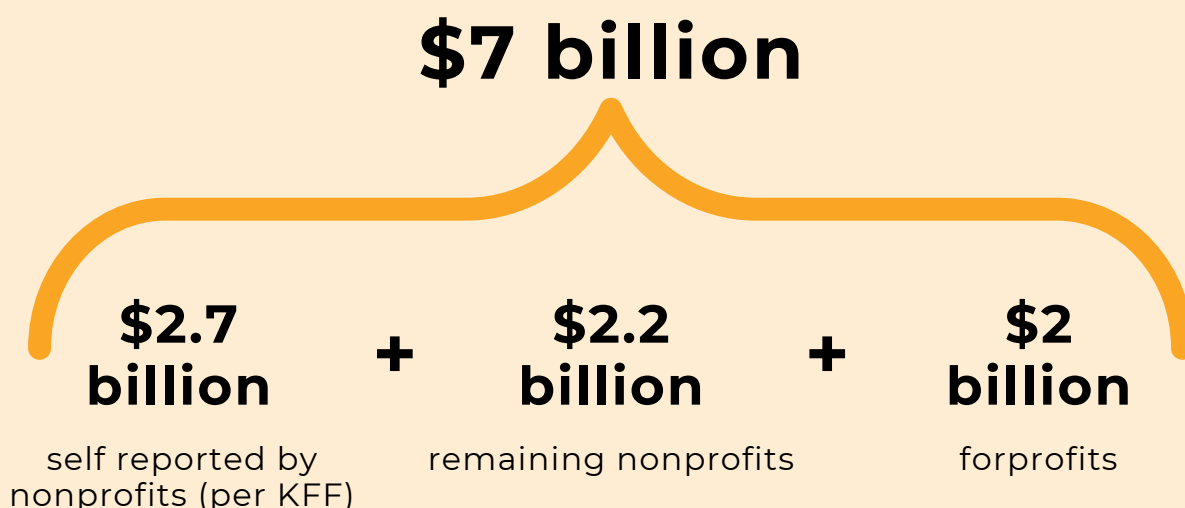
Similarly, in 2022, the Post Bulletin interviewed just 20 patients sued by Mayo Clinic and found that 14 of them would have been eligible for charity care.²⁴ However, Mayo Clinic did not report that any of its bad debt was likely eligible for charity care in its Schedule H.²⁵ Many similar examples have been uncovered via thorough investigations.²⁶

We estimate \$7 billion of charity-care eligible bad debt based on self reported numbers

We lack data showing the actual amount of charity care-eligible bad debt at non-reporting hospitals. However we assume that the average amount of bad debt eligible for charity care per nongovernment nonprofit hospital in the United States is \$1.6 million. This number was obtained by dividing the hospital's self-reported \$2.7 billion of bad debt eligible for charity care in the KFF Health News analysis by 1,651, the total number of reporting hospitals included in the KFF analysis. With 2,987 U.S. nongovernment nonprofit hospitals, this credits an additional estimated \$2.2 billion in charity care eligible bad debt to the nonprofit hospitals not included in the \$2.7 billion reported by the KFF analysis.

Finally, research demonstrates that when charity care is calculated as a percentage of expenses, there is no meaningful difference in the amount of charity care nonprofit and for-profit hospitals grant. Accordingly, we imputed the same average amount of charity care-eligible bad debt derived from the KFF analysis to the U.S. 1,235 for-profit hospitals. This added another \$2 billion in charity-care eligible bad debt.

In total, the KFF Health News' analysis reviewed tax filings for 1,651 out of 2,987 nongovernmental nonprofit hospitals and found they self-reported \$2.7 billion in annual charity care-eligible bad debt.



That analysis served as the basis to impute \$2.2 billion in charity-care eligible bad debt to the remaining 1,336 nonprofit hospitals and \$2 billion to the 1,235 for-profit hospitals. Adding these together totals nearly \$7 billion of bad debt annually, which should have been forgiven as charity care. This, however, is likely an undercount.

It is shocking enough that charity care-eligible patients are billed nearly \$7 billion every year and may ultimately be sued, have their wages garnished, or declare bankruptcy. However, the amount is likely much higher.

In Maryland, hospitals self-report less than half of their charity care-eligible bad debt

Maryland has one of the country's most unique, regulated, and robust healthcare payment systems. Maryland law mandates that patients within 500% FPL receive discounts, a payment plan, or both for out-of-pocket costs.³⁰ The state also created the Health Services Cost Review Commission (HSCRC), which sets the price hospitals must charge for every service in the state. The state also established the Health Education and Advocacy Unit within the Attorney General's office, which mediates medical billing disputes for patients.

Maryland's regulatory regime takes charity care and controlling health care costs more seriously than many, if not most, states. Even in Maryland, however, the bills for most low-income patients end up as bad debt and not charity care.

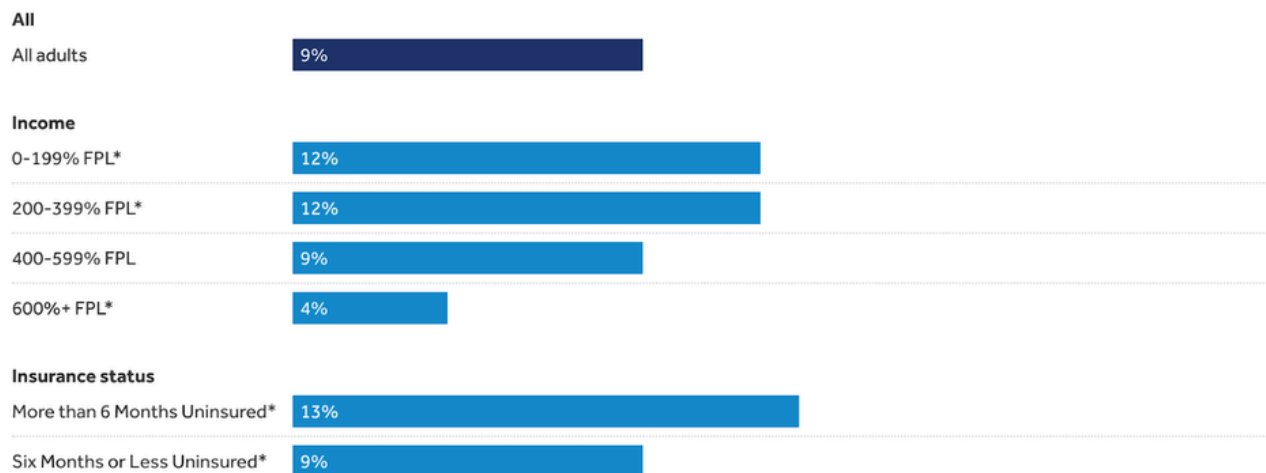
In 2020, the HSCRC used data from its hospital case mix dataset, including demographic and financial information for approximately two million Maryland hospital patients from 2017 and 2018.³¹ The state also received over 1.2 million tax data points from the Office of the Comptroller, which was used to estimate each patient's income range.³²

Under Maryland law, all patients within 200% FPL should not be charged for medically necessary care. Despite this, the HSCRC found that the bills for 60% of patients at or below 200% FPL ended up as bad debt.³³

This is particularly relevant because, unsurprisingly, people with lower incomes are far more likely to be burdened with medical debt. While 9% of the adult population has reported having medical debt, 12% of adults with incomes below 400% FPL have medical debt, whereas only 4% of adults with incomes 600% FPL or above have medical debt. This suggests that bad debt pools are likely disproportionately filled with charity care-eligible bills.

People with lower incomes are far more likely to be burdened with medical debt.

Share of adults who have medical debt, by household income and insurance status, 2019



*Estimate is statistically different from estimates for all other adults ($p < 0.05$).

Note: This analysis is limited to adults owing over \$250 in medical debt. FPL stands for Federal Poverty Level. In 2019, the federal poverty line was \$12,490 for a person living on their own and \$25,750 for a family of four. Six months or less uninsured includes people who were insured the whole year.

Source: KFF Analysis of Survey of Income and Program Participation

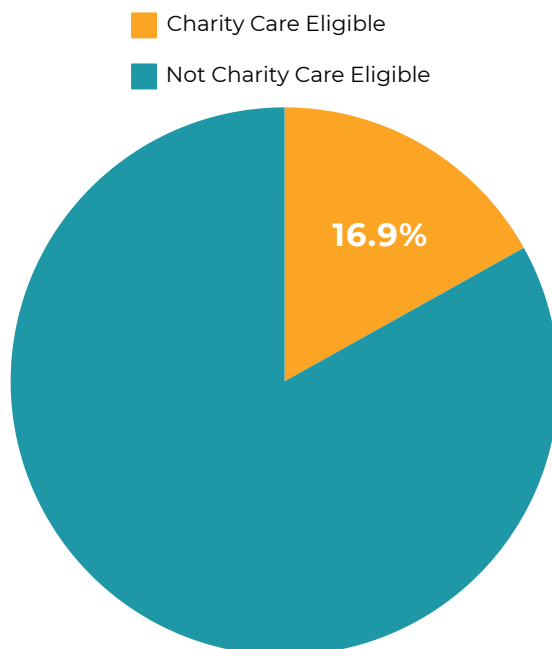
Peterson-KFF
Health System Tracker

In our research, Dollar For compared the findings in the HSCRC analysis against how much charity-care-eligible bad debt Maryland hospitals self-reported in their 2018 Form 990 Schedule H. Dollar For found 40 Maryland hospital 990s with a Schedule H filed in 2018.³⁴ Eighteen of those hospitals reported how much of their bad debt is likely eligible for charity care. The other 22 hospitals did not fill out that field.³⁵ The 18 hospitals that reported their charity care-eligible bad debt collectively reported \$187 million in bad debt and estimated that \$31 million of it was probably eligible for charity care. The average amount of charity care-eligible bad debt per reporting Maryland hospital is \$1.7 million. This is extremely close to the average derived from the KFF analysis of \$1.6 million.

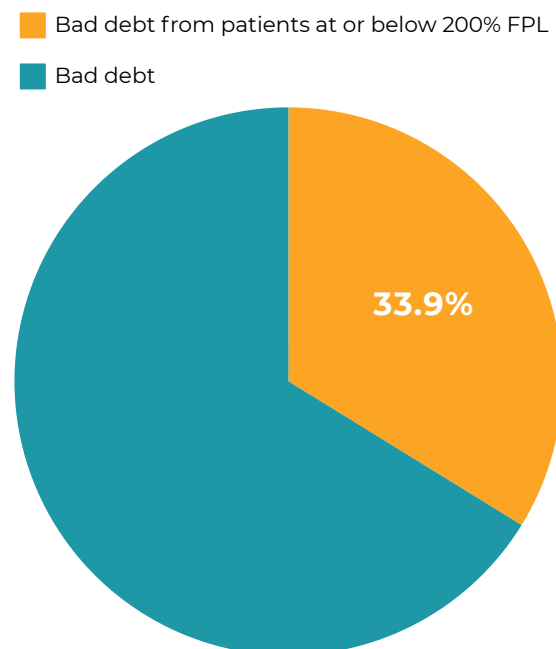
On average, Maryland hospitals self-reported that 16.9% of their bad debt was likely charity care eligible in 2018. However, the HSCRC analysis reported \$245 million in uncompensated care (UCC), which it defined as a hospital's bad debt plus its charity care for patients at or below 200% FPL. Further, it found that 60% of that amount was ultimately classified as bad debt and not charity care.³⁶ As a result, Maryland hospitals accrued \$147 million in bad debt in 2018 from billing patients who were at or below 200% FPL and entitled to free care for medically necessary services.

In 2018, Maryland hospitals reported over \$433.5 million in bad debt.³⁷ Since the Maryland report found that \$147 million in bad debt was for patients at or below 200% FPL, 33.9% of Maryland hospitals' bad debt was held by patients who were at or below 200% FPL. The entire self-reported amount of charity-care-eligible bad debt reported by Maryland hospitals in 2018 was less than half of the charity-care-eligible debt just held by patients at or below 200% FPL. That amount is significant because it is only a portion of charity-care-eligible patients in Maryland.

**Maryland hospital
self reported charity care-
eligible bad debt**



**Actual Maryland bad debt
distribution**



It is also likely that a disproportionate share of the remaining bad debt is held by lower-income, charity care-eligible patients given that, in the year examined people within 200% FPL only comprised 20.9% of the population,³⁸ but they held 33.9% of hospital bad debt. However, Dollar For currently lacks sufficient data to estimate charity care-eligible bad debt for patients over 200% FPL.

Finally, it is worth noting that the HSCRC found that only 1% of bills sent to patients within 200% FPL were paid.³⁹ Receipt of this 1% of bills is insignificant to a hospital's bottom line, but for the patient, it could be the difference between being able to afford food or housing. One study found that in 2018, patients with medical debt were between two and three times more likely to be unable to pay rent, a mortgage, or utilities. They would also be two to three times more likely to have food insecurity or be forced to move due to eviction or foreclosure.⁴⁰

Conclusion and Recommendations

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While the available data makes it impossible to know exactly how much charity care falls through this chasm, the answer is certainly in the billions. Extrapolation of hospital self-reported data shows a minimum of approximately \$7 billion in ungranted charity care annually. However, as the Maryland study shows, at least 50% of charity care-eligible bad debt goes unreported. Thus, we conservatively estimate that \$14 billion is missed in charity care annually.

The sheer number of Americans saddled with hospital debt proves that charity care as it was contemplated in the ACA is not working. The only question is how big of a role charity care could play in relieving the medical debt problem in the United States. Below are recommendations for hospitals and policymakers to address this issue.



Global Recommendation

Remove the burden to access charity care from the patient

It may seem reasonable to ask patients to fill out a short application and provide “routine and accessible” financial documents for discounted or free care. However, charity care needs to be viewed in the broader context of healthcare and social benefits. Charity care is just one of many complicated and siloed benefits programs with different and specific eligibility criteria, application processes, and deadlines. These include applying for Medicaid, insurance premium subsidies, pharmaceutical rebates, disease specific funds, county or tribal programs, and more.

The current system obligates patients to know about all these programs, decipher or guess which ones they might be eligible for, and navigate the application processes. This problem is highlighted by the fact that nearly 20 million people have recently lost Medicaid. It has been reported that 70% were for procedural reasons instead of being determined ineligible.⁴¹

We envision a future where, upon entering a hospital, individuals are automatically or presumptively screened for charity care.

We envision a future where, upon entering a hospital, individuals are automatically or presumptively screened for charity care. This transformative process could allow patients to walk into a hospital for care, answer basic questions about their income and household size, agree to some basic financial background checks, and be seamlessly given a charity care eligibility determination. We believe that the tools to execute this solution already exist and that – once proven in this context – will eliminate complicated application systems, ensure a straightforward process to save patients from needless bills, and save money on the hospital's bottom line by preventing “bad debt” and decreasing administrative costs.

Recommendation for Hospitals

Prioritize identifying charity care-eligible patients over billing, collections, and bad debt

The HSCRC study in Maryland found that hospitals are likely less effective at screening for charity care than they think. In a tightly regulated state for charity care, Maryland hospitals estimated that only a small amount of its bad debt was charity care-eligible compared to reality. Further, the study confirmed that few low-income patients who were billed were actually able to pay. It is possible, if not likely, that Maryland hospitals spent more in administrative costs to bill and pursue payment from patients under 200% FPL than they actually collected.

If Maryland hospitals had identified charity care-eligible patients early in the process, it's likely that both the hospital and the patient would have been financially better off. The hospital would not have wasted resources to pursue monies that would never be paid, and the patients would not have suffered incalculable social and financial devastation from those bills.

If automatic screening is not available, make charity care programs more visible and accessible.

If hospitals cannot automatically screen patients for charity care, they should do everything they can to inform patients about charity care programs and should remove as many barriers to access as possible. In addition to notices in emergency room lobbies and bills, hospitals should train all staff to discuss charity care with patients. They should post plain language program descriptions on their website homepages. They could also build online application portals that guide patients through the process and remove friction from the existing, fax, mail, or hand-delivery methods employed by most programs.

Recommendations for Federal and State Regulators

Design guidance for consistent reporting of hospital charity care utilization

Inconsistent methodologies for reporting charity care and bad debt make it very challenging for hospitals, advocates, and governments to accurately measure and compare charity care utilization nationally or across states. Leaving hospitals to define their own methodology is unfair to hospitals and the public. For hospitals, the current policy adds an administrative burden to create a model from scratch. As a result, the wide array of methodologies leads to quite different interpretations from hospital to hospital. For the tax-paying public, we are left comparing apples to oranges when evaluating hospitals' ability to screen for charity care.

The IRS could help address this problem by providing hospitals with guidance on standard methodologies for calculating and reporting charity care-eligible bad debt.

Further, to Dollar For's knowledge, the 2020 Maryland Health Services Cost Review Commission study was the first and only of its kind to audit charity care utilization and bad debt reporting in a state. No other study has matched actual patient billing records with reliable patient income records, at least not to a similar scale. Other states and agencies should create similar hospital charity care performance audits.

Enforce existing regulations regarding charity care

Approximately half of nonprofit hospitals leave blank the required field on the Schedule H regarding how much bad debt is eligible for charity care. The IRS should, at a bare minimum, require nonprofit hospitals to complete their tax documents.

The IRS and state regulators should also ensure that hospitals meet their obligation to inform patients about charity care programs. The federal law requires hospitals to widely publicize their charity care policies. At a minimum hospitals must make their policy and plain language summary widely available on its website, inform the community in the hospital's service area about charity care in a way that is reasonably calculated to reach them, offer patients a copy of their charity care plain language summary at intake or discharge, have a conspicuous statement about charity care on every bill, have a conspicuous public display about charity care, and more.⁴² The IRS should create enforcement mechanisms to ensure that hospitals are meeting their notice requirements.

Help hospitals identify eligible patients using existing income verification systems

Charity care discounts operate on a sliding scale based on the patient's income. In practice, identifying eligible patients and verifying their income is a large barrier to charity care.

The IRS has a database of income information for nearly every U.S. household.⁴³ The IRS commonly makes these data available, with the taxpayer's consent, to government and private entities to verify a person's income to confirm eligibility for a program.⁴⁴ For example, with the taxpayer's consent, health insurance providers may obtain a person's tax return to verify their eligibility for insurance subsidies.⁴⁵ Loan applicants already authorize their mortgage broker or lending institution to access tax returns using the IRS Income Verification Express System.⁴⁶ The IRS should create a program allowing taxpayers to authorize hospitals to verify income directly with IRS data using these same processes.

Further, most states require their residents to file income taxes and process filings – and practically all have data on which citizens receive means-tested benefits, such as food stamps or housing assistance. States could also offer this same service by creating or expanding hospital access to processes that allow patients to others to access income verification data.

Government-supported income verification would remove almost all friction between the patient and hospital in the charity care process. Removing the patient's responsibility to learn about and apply for charity care would significantly increase its utilization, decrease the burden on state courts, and give much-needed relief to residents in need. This one slight process improvement could eradicate the billions in charity care-eligible bad debt.

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