



Protecting Consumers, Encouraging Community Dialogue: Reform's New Requirements for Non-profit Hospitals

The *Patient Protection and Affordable Care Act* (PPACA) signed into law on March 23, 2010, added new requirements private non-profit hospitals must meet as a condition of their federal tax-exempt status. PPACA also increased reporting and oversight mechanisms to ensure compliance with hospital charity care and community benefit standards while increasing transparency.¹ This summary analyzes those changes.

Questions about the role providers play in ensuring access to affordable care failed to attract much attention throughout the national reform debate. In practice, however, providers' pricing, billing and financial assistance policies² often prove critical to determining whether people who cannot afford to pay for care are able to find and receive necessary care in a timely manner. Historically, non-profit hospitals have anchored the safety-net system by making charity care and other community benefit programs available to the uninsured, underinsured and underserved in their communities. The expectation that hospitals will continue to offer such care stems in large part from their tax status: in exchange for valuable tax exemptions, the public expects these hospitals to provide medically necessary services to those in need.³

But in many communities, consumer complaints about unfair billing and debt collection tactics and wide variation in hospitals' self-reported charity care and community benefit spending have sparked considerable debate on whether the standards are too vague.⁴ The provisions in national health reform strengthen the health care safety net by responding to some of the most glaring problems raised in those debates. Because most of the provisions become effective this year, they offer immediate relief to the millions who lack affordable coverage (See Table 1).

¹ Section 9007 of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (2010).

² For purposes of this summary, "financial assistance" is synonymous with terms such as "charity care," "free care," or "discounted/reduced-cost care."

³ "Americans Overwhelmingly Believe Non-profit Hospitals Should Provide Charity Care," Community Catalyst, available at http://www.communitycatalyst.org/press_room/press_releases?id=0085.

⁴ Pryor, C., et al. *Best Kept Secrets: Are Non-Profit Hospitals Informing Patients about Charity Care Programs?* The Access Project and Community Catalyst, May 2010, available at http://www.communitycatalyst.org/doc_store/publications/Best_Kept_Secrets_May_2010.pdf

Higher standards: four new requirements for tax-exempt hospitals

Section 9007 of the PPACA amends Section 501(c)(3) of the Internal Revenue Code by adding four new conditions that private hospitals must meet in order to qualify for federal tax-exempt status. Hospitals must:

- Develop written financial assistance policies
- Limit what they charge for services
- Observe fair billing and debt collection practices
- Conduct regular community needs assessments

With the exception of the community needs assessment, these requirements go into effect this year, in 2010. The Secretary of the Treasury is charged with enforcing the new provisions and has authority to issue further guidance and regulations as needed to make sure they are correctly implemented.

Discussion: Generally, the scope of the law is limited to private, tax-exempt hospitals; these provisions do not apply to for-profit or government-owned hospitals, or to other kinds of providers.⁵ It is also unclear to what extent, if any, the new requirements will apply to joint ventures and other entities operated by non-profit hospitals. Because Section 9007 relates to *federal* taxation issues only, these provisions do not preempt stronger *state* laws, which appear elsewhere in state codes or apply to separate state taxation structures.

Develop written financial assistance policies

The new law requires private non-profit hospitals to develop written financial assistance policies that provide patients and the public with basic information about what a hospital offers. At a minimum, the policy must state:

- Whether the hospital offers free or discounted care
- Eligibility criteria for receiving financial assistance
- The basis used to decide how much patients are charged for care
- A description of how to apply for financial assistance
- Steps the hospital might take to collect payment, unless the hospital has a separate billing and debt collection policy already in place
- Measures to publicize the policy widely in the community the hospital serves

⁵ While private tax-exempt hospitals still hold a clear majority in terms of sheer hospital numbers and patient beds, some states may have a higher prevalence of other kinds of hospitals. See "Fast Facts on US Hospitals," American Hospital Association, available at <http://www.aha.org/aha/resource-center/Statistics-and-Studies/fast-facts.html> (accessed 5/5/10). A recent GAO report details the distribution of non-profit hospitals across states. *Non-profit Hospitals: Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements*, GAO, September 2008, Figure 1. Available at <http://www.gao.gov/new.items/d08880.pdf>.

Hospitals must also have a separate policy that states they are required to provide emergency medical care to all individuals, as defined in the Emergency Medical Treatment and Active Labor Act, regardless of whether they qualify for financial assistance.⁶

Discussion: People must know that hospital financial assistance programs exist, and the new standards can go a long way to ensuring patients are adequately informed. But the law, again, is limited. It does *not* say hospitals have to provide financial assistance, and it is silent with regard to minimum eligibility criteria, application procedures, and steps hospitals should take to notify the public about the programs. To a great extent, the value of these requirements will depend on the Secretary of the Treasury developing specific and robust regulations to further define them. Absent stronger regulation, hospitals retain considerable discretion in developing policies and procedures on all of these fronts, including who qualifies and what services get covered.

Limit what patients are charged for care

Hospitals are uniformly prohibited from using “gross charges.”⁷ If patients need “emergency or other medically necessary care” and qualify for the hospital’s financial assistance policy, they may only be charged the “amounts generally billed” to insured patients for the same services.

Discussion: This provision attempts to rein in the widely-accepted practice of overcharging self-pay patients – those in least position to negotiate fair prices, let alone pay for care. The reforms are steps in the right direction, but they were weakened over the course of the legislative process. In their final form, they are highly problematic for consumers. Obtaining gross charges and divining what insured patients are billed requires transparency about hospital pricing not yet present in the health care system. Although Section 2718 of the PPACA requires all hospitals, not just non-profits, to publish a list of their standard charges annually, typically the amounts billed to insured patients are not the same as the lower amounts they pay. Absent further guidance from the Secretary, the provision is vague enough to still permit hospitals to overbill the uninsured, even when they qualify for financial assistance.

Practice fair billing and debt collection

The new law prohibits non-profit hospitals from engaging in “extraordinary collection actions” before making a “reasonable effort” to determine whether a person qualifies for the hospital’s financial assistance policy.

⁶ The Emergency Medical Treatment and Active Labor Act (EMTALA) defines “emergency medical condition” as any situation in which the absence of immediate medical care would jeopardize the patient’s health or lead to serious bodily impairment or dysfunction. This definition also explicitly includes women in labor where there is insufficient time to safely transfer the mother to another facility. 42 U.S.C. § 1395dd(e)(1).

⁷ While not defined in the new law, “gross charges” generally means the hospital’s list price for services—that is, the full amount it charges for services prior to negotiating a discounted price with insurers. See Reinhardt, U., “How Do Hospitals Get Paid? A Primer,” *New York Times* Economix Blog, January 23, 2009. Available at <http://economix.blogs.nytimes.com/2009/01/23/how-do-hospitals-get-paid-a-primer/>.

Discussion: This provision acknowledges the need to reform hospital debt collection practices. Moving forward, we expect the Secretary to play a vital role in determining what debt collection practices (e.g. wage garnishments, high-interest payment plans, liens) are prohibited and whether restrictions are placed on third-party agencies with whom hospitals might contract. Other federal agencies may play a role in determining how robust protections under this requirement will be. For example, the Secretary of Health and Human Services (HHS) might request that a “reasonable effort” to determine eligibility for a hospital’s financial assistance policy also include assisting individuals in applying for public programs, such as Medicaid or Exchange subsidies.

Conduct community needs assessments

Hospitals must conduct a community needs assessment at least once every three years. In doing so, they must seek input from people who “represent the broad interests” of the hospital’s community, including public health experts. Hospitals must make their assessments available to the public, and they must adopt strategies to meet the community health needs identified. This requirement goes into effect for tax years after March 23, 2012, giving hospitals two years to begin the assessment process.

Discussion: Community needs assessments that actively involve the community are a fundamental, necessary component of developing effective community benefits plans that target unmet needs. Overall, this provision is strong. Of all the new requirements for non-profit hospitals, only this one comes with an accompanying penalty: a \$50,000.00 excise tax for failure to comply. But more importantly, it creates opportunities for advocates, public health officials and others to approach local hospitals about working collaboratively to find solutions to unresolved health needs in their communities.

Open secrets: new reporting requirements

The new law strengthens the federal government’s oversight of non-profit hospitals and community benefits. Moving forward, non-profit hospitals must attach audited financial statements and descriptions of how they are addressing community needs, as identified through their community needs assessments, to the tax reports they file annually with the Internal Revenue Service (IRS). Hospitals that are *not* meeting certain needs must give an explanation. The Secretary of the Treasury must review each private, non-profit hospital’s community benefit activities at least every three years.

It also requires the Secretary of the Treasury to track what hospitals are spending on key safety-net services and report this information every year to Congress. Working in consultation with the HHS Secretary, the Treasury Secretary must report on:

- Levels of bad debt, charity care, and unreimbursed costs from government programs for *all* hospitals – public and private, for-profit and non-profit
- Community benefit costs borne by private non-profit hospitals

The Secretary of the Treasury must study trends in these expenses and submit a report to Congress on its findings within five years of enactment.

Discussion: Monitoring the provision of safety-net services through individual hospital reporting and tracking system-wide expenses will encourage hospitals to comply with the new requirements. It will also provide useful information about the impact that health care reform and other developments have on the safety-net and the health care system as a whole. It will be important to publicize and widely disseminate this information so it can be used by communities to determine if their hospitals are complying with their charitable obligations.

Conclusion

The requirements for non-profit hospitals found in the PPACA are an important first step towards strengthening the health care safety net, adding much-needed transparency standards to a system riddled with inconsistencies. Though there is significant work to be done at the regulatory level to build on these requirements in a way that benefits consumers, the gains in transparency and requirements to conduct community needs assessments are particularly positive. These provisions demystify hospitals' financial assistance programs, putting the onus on hospitals to communicate these policies to communities, and to require better collaboration between hospitals and communities to address unmet needs.

These provisions represent a significant early victory for national health care reform. By increasing transparency and promoting fair billing and debt collection standards for non-profit hospitals, the law strengthens the safety net immediately for people who cannot afford to pay for care. Since state laws and providers' voluntary standards have varied so greatly, educating consumers about the new requirements and working with hospitals as they revisit their policies will be key to making sure the full benefit of these provisions is realized. And while the need for safety-net services may decrease after reform is fully implemented, coverage may still prove unaffordable for low-income families, immigrants and others. Investing in a strong safety net now will pay off in the longer term, providing stability and peace of mind to those who need it most.

Resources

Please visit the Community Catalyst website at <http://www.communitycatalyst.org/projects/hap/> for additional resources, including:

- Health Care Community Benefits: A Compendium of State Laws
- Map It: Free Care Compendium (Interactive Map of State Laws)
- Hospital Free Care Web Tool (Interactive Build-A-Financial-Assistance-Bill Tool)
- Community Benefits Model Act and Commentary
- Free Care Monitoring Project Guide and Toolkit
- Summary of Form 990, Schedule H Reforms
- Community Benefits: The Need for Action, an Opportunity for Healthcare Change (via The Access Project at <http://www.accessproject.org/publications.html>)

Table 1: Non-profit hospitals and reform at-a-glance

Requirement	Effective Date	Worth Noting
Financial Assistance Policy	Tax Years after 3/23/10	Many of the other protections hinge upon how robust a hospital's financial assistance policy is. Hospitals have considerable discretion in establishing these policies.
Limits on Charges	Tax Years after 3/23/10	Possibly intersects with Section 2718, which requires hospitals to annually publish a list of their standard charges.
Fair Billing/Debt Collection	Tax Years after 3/23/10	In granting the Secretary authority to issue regulations, the law specifically mentions "reasonable efforts" to determine eligibility before pursuing certain collection activity as an area ripe for further guidance.
Community Needs Assessments	Tax Years after 3/23/12	Failure to comply with this provision will result in a \$50,000 excise tax, making this the only provision with an interim penalty. Hospitals should begin the assessment process now to ensure assessments are timely.
Reporting	Effective Date	Worth Noting
Hospitals file audited financial statements, descriptions of their community benefit activities with tax returns. Community benefit activities subject to audit every three years.	Tax Years after 3/23/10	
Secretary of the Treasury tracks trends in safety-net spending.	Tax Years after 3/23/10	Looks at all hospitals' bad debt, charity care, and unreimbursed public programs expenses. Requires Treasury to consult with HHS. Useful for understanding impact of health reform on safety net spending.