

# What Does the Affordable Care Act Say about Hospital Bills?

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## I. Introduction

The Patient Protection and Affordable Care Act of 2010 (ACA) included a bipartisan provision that addresses systemic problems with billing, collections, and community benefit within the hospital industry.<sup>1</sup> The law, which applies solely to non-profit (tax-exempt) hospitals, aims to do the following:

- **Increase transparency** about financial assistance and collections policies and practices
- **Limit** the practice of overcharging certain patients for care
- **Institute stronger safeguards** to protect patients from overly aggressive collections by hospital staff and third parties
- **Improve community benefit planning, collaboration, and investment** by requiring hospital facilities to conduct regular community health needs assessments and develop implementation strategies for addressing needs<sup>2</sup>

These basic standards have been in effect since 2010, but the final regulations that definitively state the federal requirements were issued recently by the Internal Revenue Service and the Treasury Department in December 2014.<sup>3</sup> As a result, many hospitals will be revisiting their policies and procedures related to billing and collections in 2015 to ensure compliance with the law. **This publication outlines the key elements of the final regulations related to patient billing—financial assistance, charges, billing and collections.<sup>4</sup> Where relevant, it provides brief contextual insight into the policy issues the regulations seek to address.** It concludes with a short discussion section intended to guide community-based organizations, consumer advocates, and state and local policymakers as they assess where additional engagement with local hospitals and hospital associations, advocacy to advance further local or state public policies, or a combination of both approaches might yield a stronger outcome for patients and the public in the communities they serve.

Finally, this brief is not intended to substitute for legal guidance or advice. The final regulations include several areas of greater nuance and detail than what is covered in these pages.

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## II. Overview of Final Regulations

### A. Financial Assistance

Under the ACA and the final regulations, **tax-exempt hospitals must develop and implement written financial assistance policies and widely publicize the policies so that patients and the public can easily find, understand, and use them.** These new requirements are in response to historical problems hospital patients and their advocates across the country have experienced in seeking timely, accurate information about financial assistance.<sup>5</sup>

#### 1. Developing a Financial Assistance Policy

##### *Content Requirements for Financial Assistance and Billing Policies*

Non-profit hospitals must establish **written financial assistance policies that apply to all emergency and medically necessary care.**<sup>6</sup> The final regulations specify the information that a financial assistance policy must contain (see sidebar, “What Must a Financial Assistance Policy Include?”).<sup>7</sup> Hospitals may either include detailed information about their billing and collections policies and practices in the financial assistance policy itself, or cover these in a separate document.<sup>8</sup> Either way, the financial assistance policy should contain sufficient detail to allow patients and the public to understand the timeframe, process, and methods a hospital (or an authorized third party) will use to collect on past-due bills.<sup>9</sup>

##### *Emergency Medical Care Policy*

The Emergency Medical Treatment & Labor Act (EMTALA) requires most hospitals, not just non-profits, to screen and stabilize patients who present with emergency medical conditions and patients in active labor regardless of their ability to pay for care.<sup>10</sup> Further guidance on EMTALA from the Centers for Medicare and Medicaid Services (CMS) identifies certain emergency room billing practices as potential barriers to care, stating:

“CMS has learned of instances where hospitals request immediate payment, by cash, check, or credit card, from individuals who are in the ED [emergency department]. Payment demands have been made for the current emergency services being offered to the individual, even though their ED encounter is still in progress, as well as for past hospital services. [...] **A request for payment carries a very high risk of unduly discouraging individuals, particularly those who lack the ability to pay, from remaining for further evaluation[.]**”<sup>11</sup>

CMS concluded that, with regard to their EMTALA obligations, hospitals could avoid problems by waiting to request payment from patients until after the patient is screened, stabilized, or admitted for inpatient treatment.<sup>12</sup>

### What Must a Financial Assistance Policy Include?

- ✓ All **levels of financial assistance** (such as free or discounted care) available under the hospital’s policy and the **eligibility criteria** for each level
- ✓ **How to apply** for financial assistance
- ✓ **How the hospital calculates patient charges**
- ✓ Statement that patients eligible for financial assistance may not be charged more than the amounts generally billed to insured patients
- ✓ **Steps the hospital might take to collect** an outstanding bill
- ✓ Any **third-party sources** the hospital uses to presumptively determine whether a patient is eligible for financial help
- ✓ A complete list of **providers covered** by the policy

#### *Either the policy or application form must also:*

- ✓ Include **contact information**, including a physical location and phone number, for the hospital department or office that can provide more information
- ✓ Describe **all information and documentation the patient must provide**

The ACA and final regulations also address the issue of patient payment in the emergency room. Non-profit hospitals must **establish written emergency medical care policies** that expressly state the hospital's obligation to screen and stabilize patients with emergency medical conditions, regardless of whether they are eligible for hospital financial assistance.<sup>13</sup> Furthermore, the final regulations **require non-profit hospitals' emergency care policies to expressly prohibit "engaging in actions that discourage individuals from seeking emergency medical care."**<sup>14</sup> Prohibited practices include **demanding that ER patients pay upfront prior to treatment for emergency services and debt collection activities that "interfere" with the provision of emergency care.**<sup>15</sup> This is an important protection for patients, particularly the uninsured and underinsured, who might otherwise jeopardize their health and safety in an emergency by delaying medical treatment and evaluation due to financial strains. These protections, coupled with CMS's additional EMTALA guidance, should prompt most hospitals to carefully evaluate and, if necessary, modify their ER registration procedures and staff training to ensure that requests for payment do not occur prior to screening or treatment.

### *"Establishing" a Policy*

Financial assistance policies, emergency medical care policies, and (if relevant) billing and collections policies must be **adopted by hospital leadership**, such as the governing board, a board committee, or board-authorized manager.<sup>16</sup> **And, they must be fully implemented, which the IRS defines as being "consistently carried out."**<sup>17</sup> Practically speaking, the regulations imply that hospital leadership must give appropriate time and attention to crafting the policies and to providing adequate resources to ensure hospital staff can comply with the law.<sup>18</sup> This may include some financial investment and/or staff training, particularly to admissions and emergency room staff; billing and collections staff; social workers, patient navigators or assisters and others who interact with patients.

### *Application Forms and Procedures*

The financial assistance policy must **specify how patients are to apply for assistance**, and either the policy itself or an accompanying application form **must include a complete list of any and all information and documentation patients must provide** to support their applications, as well as contact information for hospital staff and/or non-profit or government agency that can assist the patient with the application process.<sup>19</sup> Beyond this requirement for disclosure, however, the final regulations give hospitals a free hand in structuring the nuts and bolts of the application for financial assistance. Hospitals could conceivably make the application process tedious and burdensome for patients. However, because the regulations are structured to require transparency, it should at least be easier for community organizations and advocates to identify roadblocks and work with hospitals to develop more streamlined approaches.<sup>1</sup>

### *Plain Language Summary*

Non-profit hospitals must **develop a plain language summary of the financial assistance policy that uses clear, concise, easy-to-understand language to summarize the financial assistance policy's key elements:** eligibility, levels of financial help offered under the policy, how to apply, and a statement that patients who qualify for financial assistance will also be protected from overcharging. The plain language summary must include a direct URL to the website where the full financial assistance policy and application can be found, along with the physical location and phone number of hospital office or department that can provide more information.<sup>20</sup> And, it must direct patients to translated versions of key documents—the financial assistance policy, application form, and plain

<sup>1</sup> The final regulations also state that hospitals may grant financial assistance based on partially complete applications, third-party information, or even the patient's own attestation of eligibility. Treas. Reg. § 1.501(r)-4(b)(3).

language summary—in accordance with the language needs of the hospital's community.<sup>21</sup> Finally, it must provide contact information for hospital staff or third-party organizations that can assist patients who want to apply.<sup>22</sup>

For many patients and community members, the plain language summary will likely be the simplest, most straightforward presentation of the hospital's financial assistance policy. Non-profit hospitals have to make it available online, by mail, in public areas of the hospital and upon request.<sup>23</sup> Importantly, hospital staff must offer it to every patient at either intake or discharge, as part of their requirements to “widely publicize” the financial assistance policy.<sup>24</sup> The hospital must also provide a plain language summary to patients in instances where the hospital intends to pursue an extraordinary collection action (ECA) for a past-due bill.<sup>25</sup>

### **2. Widely Publicizing the Financial Assistance Policy**

Under the ACA, it is not enough for hospitals to have a financial assistance policy. They must also take steps to ensure that the communities they serve know about it in a timely manner. Section 9007 of the ACA requires non-profit hospitals to describe the measures they will take to “widely publicize” the financial assistance policy.<sup>26</sup> The final regulations are more specific, requiring non-profit hospitals to take the following steps:

- **Post information online.** The full financial assistance policy, application form, and plain language summary must be made “widely available” online.<sup>27</sup> Non-profit hospitals must maintain complete, current versions of these documents online by posting them to either the facility's website; the system website, if the facility is part of a bigger system; or a third-party website.<sup>28</sup> The documents must be freely available for viewing, accessing and downloading.<sup>29</sup> Hospitals cannot require people to enter personally identifiable information in order to access the documents.<sup>30</sup>
- **Make hard copies freely available and on display.** Hard copies of the full financial assistance policy, application form, and plain language summary must be available for free upon request, by mail, and in public locations within the hospital including the emergency room and admissions areas.<sup>31</sup>
- **Inform and notify visitors and members of the public.** A third requirement—that hospitals inform and notify visitors and members of the public about the financial assistance policy in a “manner reasonably calculated” to reach community members most likely to need financial assistance—is less specific, and ripe for discussion among hospitals, advocates and community representatives who can help ensure a hospital's outreach strategies are effective.<sup>32</sup>
- **Inform and notify patients receiving care at the hospital.** The threshold for notifying hospital patients about financial assistance is slightly higher than it is for hospital visitors and the public at large, requiring hospitals to be more proactive. Patients must be offered a plain language summary describing the financial assistance policy at either intake or discharge.<sup>33</sup> And, every billing statement must include a conspicuous written notice about the financial assistance policy with a phone number to the office or department that can offer more information and a direct URL to the full policy, application form, and plain language summary.<sup>34</sup> Hospitals must also set up conspicuous public displays or use “other measures reasonably calculated to attract patients' attention” in the emergency and admissions areas, at a minimum, to notify and inform patients about the financial assistance policy.<sup>35</sup>

### *Translation requirements*

Non-profit hospitals must assess the language needs of the communities they serve and translate key documents—defined to include the financial assistance policy, application form, and plain language summary—into “the language spoken by each [Limited English Proficiency] language group that constitutes the lesser of 1,000 individuals or 5 percent of the community served by the hospital facility or the population likely to be affected or encountered by the hospital facility.”<sup>36</sup> Hospitals may use any reasonable method for determining these numbers.<sup>37</sup>

## **B. Charges**

All hospitals, non-profit or otherwise, use a chargemaster,<sup>ii</sup> a comprehensive listing of prices for all services, diagnostic tests, medical procedures, supplies, medicines and equipment fees, and other items for which a hospital might bill a patient, insurer or other payer. With the major exceptions of Maryland and West Virginia, where hospital charges are regulated by the state<sup>38</sup>, hospitals have complete freedom to set their chargemaster rates, i.e., prices. As a result, hospital charges can significantly exceed the cost of providing patient care and fluctuate greatly from one facility to the next.<sup>39</sup>

Numerous analysts and commentators have pointed out that the chargemaster primarily functions as a negotiating tool, since “gross charges”—the term used for chargemaster rates in the ACA and final regulations—are often used as a starting point in providers’ negotiations with private insurance carriers.<sup>40</sup> Private insurers, in turn, generally negotiate a lower rate for their beneficiaries than the chargemaster rates (gross charges). Medicare and Medicaid, both public coverage programs, set their own rates for paying providers, and these rates are also less than gross charges. An unintended consequence of the chargemaster system is that patients without adequate insurance coverage, particularly the uninsured, may be the only patients who receive hospital bills that request they pay gross charges.<sup>41</sup> In effect, this means that patients who have relatively little bargaining clout and limited finances are asked and often expected to pay for care at rates that are much higher than those paid by either private insurance companies, public payers, and their beneficiaries.<sup>iii</sup>

### **1. General Limitation on Charges**

The ACA and final regulations take important steps to protect certain patients from overcharging. First, they stipulate that non-profit hospitals must charge patients who are eligible for financial assistance a lower rate than gross charges (chargemaster rates) for any care they receive at the hospital.<sup>42</sup> (Note that the final regulations only address charges for patients who qualify for financial help, rather than curbing overcharging in general.) Second, the regulations establish an outer limit for the rates non-profit hospitals may charge certain patients for medically necessary and emergency care: patients who are eligible for financial assistance cannot be charged more for these services than the “amounts generally billed” (AGB) to an insured patient (see Table A).<sup>43</sup> While this new

<sup>ii</sup> The regulations use the technical terms “gross charges” and “chargemaster rate” interchangeably: both are defined as the “full, established price for medical care that the hospital facility consistently and uniformly charges all patients before applying any contractual allowances, discounts or deductions.” Treas. Reg. §1.501(r)-1(b)(16). These terms refer to the listed prices hospitals set, prior to negotiating payments with private insurers or accepting public payers’ rates. By contrast, the regulations define the amount “charged” to a patient as the amount a patient is personally responsible for paying after all deductions, discounts (including financial assistance), and insurance payments have been applied. Treas. Reg. §1.501(r)-5(b)(2). On a standard hospital bill, this will be the amount the patient owes and is asked to pay.

<sup>iii</sup> Although some hospitals offer discounts to “self-pay” patients who meet certain criteria (such as paying upfront for care or paying the bill by a certain deadline), the amount patients owe after the discounts often exceed the negotiated rates private insurers are able to secure for their beneficiaries, or that public payers set.

concept of AGB requires further explanation, **the most basic impact of these provisions is that non-profit hospitals can no longer expect patients who qualify for financial help to pay the often-inflated chargemaster rates.** Instead, the amounts that these patients are responsible for paying at the outset—before any discounts or write-offs available to them through financial assistance or other hospital programs are applied—should now be on par with what private insurers, public payers, and their beneficiaries are expected to pay when seeking medically necessary or emergency care.<sup>44</sup>

**Table A: Limitation on Charges for Patients Eligible for Financial Assistance**

Type of Care	Charge Limitations
Any care, regardless of medical necessity	Less than gross charges
Medically necessary or emergency care	Equal to or less than the “amounts generally billed” to an insured patient

## 2. Determining “Amounts Generally Billed” (AGB)

The regulations spend some time explaining how hospitals must arrive at the “amounts generally billed” (AGB) to their insured patients. **Non-profit hospitals must choose either the prospective method or the look-back method to determine the “amounts generally billed” (AGB)** to insured patients for all emergency and medically necessary services.<sup>45</sup> They may change the methodology they use to determine AGB at any time,<sup>46</sup> though their financial assistance policies must be updated to reflect the change.<sup>47</sup>

### *Prospective Method*

Non-profit hospitals that use the prospective method for determining AGB will **use their typical billing and coding procedures to determine how much public payers—either Medicare or Medicaid, or some combination of both—would pay for the services rendered.**<sup>48</sup> This amount, plus the amount the beneficiary would be personally responsible for paying (coinsurance, copayments, deductibles) for services, equals the hospital’s AGB.<sup>49</sup>

### *Look-back Method*

Non-profit hospitals that follow the look-back method must first calculate an “AGB percentage” that demonstrates the percentage of gross charges—i.e., the percentage of the hospital’s chargemaster rates—that insured patients and health insurers are ultimately expected to pay.<sup>50</sup> Unlike the prospective method, which requires hospitals to use billing codes from only public payers, **hospitals using the look-back method may also incorporate data from private health insurers.**<sup>51</sup> Hospitals using this method may calculate one AGB percentage for all emergency or medically necessary care; or, they can calculate different AGB percentages for different categories of care, e.g. inpatient, outpatient, by department, or for different kinds of services.<sup>52</sup>

To calculate an AGB percentage, non-profit hospitals must “look back” at actual claims data they submitted for all emergency and medically necessary care over a previous 12-month period and calculate the full amounts “allowed” by health insurers for these services.<sup>53</sup> This is defined to include both the insurer’s reimbursement and any out-of-pocket amounts the patient is personally responsible for paying (copayments, co-insurance, deductibles).<sup>54</sup> As shown below in Figure A, this total is then divided by the gross charges (chargemaster rates) the hospital submitted to the insurers for the associated claims. The resulting number is the AGB percentage.<sup>55</sup>

**Figure A: Calculating an AGB Percentage**

$$\frac{\text{Allowed Claims (Insurer Reimbursements + Patient Out-of-pocket Amounts)}}{\text{Gross Charges (Hospital Chargemaster Rates for Allowed Claims)}} = \text{AGB percentage}$$

In the final step, hospitals multiply the AGB percentage by gross charges to obtain the new, base rate(s) they expect patients who are eligible for financial assistance policy to pay.<sup>56</sup> Perhaps due to the complexity of this approach, the regulations require hospitals that use the look-back method to provide additional detail about it in their financial assistance policies.<sup>57</sup> The financial assistance policy must either directly state the AGB percentage and describe how it was calculated, or explain how members of the public (not just patients) can freely access a written description.<sup>58</sup>

**The AGB Percentage at Work**

Let’s explore how the AGB percentage works, using a single office visit as an illustration. Suppose the gross charge (chargemaster rate) for a consultation with Apple Hospital’s orthopedic surgeon is \$500. However, the rate negotiated by Insurer Aardvark is \$150. Alonso Acorn sees the surgeon for a consult. He is insured by Aardvark and owes a \$25 copay for all office visits. Using the AGB formula, we find that Apple Hospital’s AGB percentage is 35 percent of gross charges:

$$\frac{\$150 \text{ Aardvark reimbursement} + \$25 \text{ Alonso's copay}}{\$500 \text{ Apple Hospital's gross charge}} = \frac{\$175}{\$500} = 35\% \text{ (AGB percentage)}$$

Betty Blueberry is an uninsured patient who also sees Apple’s orthopedic surgeon. She is very worried about the \$500 price tag for the visit listed in the hospital’s chargemaster. Betty is thrilled to learn that, because she qualifies for Apple’s financial assistance policy, the hospital is applying its 35 percent AGB percentage and charging Betty an adjusted rate of \$175.

$$\$500 \text{ gross charge} \times 35\% \text{ AGB} = \$175$$

As this example illustrates, Betty is now expected to pay the same \$175 that Alonso and his insurer paid Aardvark Hospital for the consultation.

### 3. Hospital Safe Harbor

Hospitals do not typically know whether a patient is eligible for financial assistance at the time of service or before the first bill is sent. However, the ACA and regulations prohibit hospitals from overcharging patients who qualify for financial help. This is problematic, since the language of the law requires non-profit hospitals to limit charges to patients who qualify for financial help or risk penalties for noncompliance. (Technically, a non-profit hospital that sent an initial bill for full charges to a patient who was later found eligible for financial help would be violating the law, even if the staff did not know that the patient qualified for financial help or took steps later to adjust the bill.) In order to make compliance with the law workable for hospitals, the final regulations provide a safe harbor for hospitals that send a bill with the chargemaster rates (gross charges) or an amount higher than AGB to a patient who is later found to be eligible for financial assistance in the following circumstances:

- The charge was not requested as a precondition for receiving medically necessary care (the most common example of this would be requiring the patient to pay upfront before providing services);
- At the time of the charge, either the patient has not yet submitted a completed application for financial assistance or the hospital has not yet made an eligibility determination; and
- The hospital refunds any amount the patient overpaid for care.<sup>59</sup>

These limits are in place to ensure low- and moderate-income patients who qualify for financial help are protected from overcharging, without causing impractical disruptions to the hospital billing cycle. The Preamble also acknowledges that requesting upfront payments from medically indigent patients can be “tantamount to denying care”; accordingly, hospitals cannot claim safe harbor under this section if the overcharge occurred during an upfront request for payment.<sup>60</sup>

### C. Billing and Collections

Many of the non-profit hospital issues that have raised Congressional ire and garnered media attention over the past years have had to do with collection of past-due hospital bills, either by the hospital itself or a third party hired to do the work. Rather than prohibit the use of certain collection approaches, the ACA and final regulations take the intermediate step of introducing new procedural requirements that non-profit hospitals, hospital debt collectors and buyers must follow if they wish to use “extraordinary collection actions” (ECA) to pursue payment on an overdue bill. In general, **the law requires non-profit hospitals to first make a “reasonable effort” to determine whether a patient is eligible for financial assistance before they engage in an ECA.**<sup>61</sup> These requirements are outlined below.

#### 1. Defining “Extraordinary Collection Action” (ECA)

The IRS defines “extraordinary collection action” as follows:

- **Actions a hospital takes to collect a bill that requires a legal or judicial process.**<sup>62</sup> The non-exhaustive list of examples includes wage garnishment, property liens, arrests, foreclosures on real property (homes, etc.), and civil lawsuits.
- **Reporting adverse information** to consumer credit reporting agencies or credit bureaus.<sup>63</sup>

- **Selling patient debt**<sup>64</sup>, with limited exceptions.<sup>65</sup>
- **Denying, deferring, or requiring the patient to make a payment for services already rendered before providing medically necessary care.**<sup>66</sup> Note that hospitals are still permitted, under the final regulations, to require patients to pay upfront for care they are to receive that day, and that this is not considered an extraordinary collection action.<sup>iv</sup> The protection here applies only in situations where a patient owes and is asked to pay money for previous services before being seen for further treatment.

### 2. Making a “Reasonable Effort”

#### General Rule

The regulations establish a 240-day “application period,” during which time non-profit hospitals have certain duties to inform patients about financial assistance, and patients are protected from ECAs.<sup>67</sup> The clock starts ticking once the hospital provides the first billing statement after the patient has received care, whether inpatient or outpatient, and has left the hospital facility.<sup>68</sup> Non-profit hospitals will have made a “reasonable effort” to determine whether patients qualify for financial help if they:

- **Observe a ban on ECAs during an initial 120-day “waiting period.”**<sup>69</sup>
- **Accept and process financial assistance applications received during the 240-day application period in a timely manner.**<sup>70</sup>
- **Provide an additional 30-day notice to patients when the hospital intends to initiate ECAs.**<sup>71</sup>

Obtaining a waiver, such as a signed statement that the patient does not wish to apply for or receive information about financial assistance, will not meet hospitals’ obligations to make a reasonable effort.<sup>72</sup> Instead, hospitals must follow the procedures and timelines described below to ensure patients have ample opportunity to learn about and apply for financial help.

**Figure B: Application Period for Financial Assistance**



#### Gathering information for determining eligibility

In general, the regulations do not stipulate how much or what kinds of information and documentation non-profit hospitals can require patients to provide throughout the application process.<sup>73</sup> Instead, they simply require hospitals to fully disclose what patients must provide in the application form or financial assistance policy.<sup>74</sup> By contrast, hospitals can use third-party data, the patient’s own attestation of eligibility, previous applications for financial help, and even incomplete data to award eligibility.<sup>75</sup> Hospitals can obtain information for the financial assistance policy application orally, as well.<sup>76</sup>

<sup>iv</sup> However, requesting upfront payment in the emergency room may violate either the hospital’s EMTALA obligations or the regulations’ requirements for emergency medical care policies. See “Emergency Medical Care Policy,” *supra* page 2.

### *Processing patient applications for financial assistance*

Hospitals that receive completed financial assistance policy applications must make eligibility determinations in a “timely manner,” a term undefined by the regulations.<sup>77</sup> They are allowed to postpone making a financial assistance policy determination if they believe the patient qualifies for Medicaid, until Medicaid eligibility is determined.<sup>78</sup> However, once a patient submits a complete financial assistance policy application, hospitals cannot use extraordinary collection actions while the eligibility determination for financial assistance policy (or for Medicaid, if applicable) is pending.<sup>79</sup>

Hospitals are required to notify patients in writing of their determination and provide the basis for their findings.<sup>80</sup> If a patient is found eligible for financial assistance, the hospital must take these steps:

- **Send the patient a billing statement** that specifies the amount, if any, that they still owe after financial assistance is applied. The statement must show or describe how the hospital determined the patient’s portion and describe how it arrived at “amounts generally billed.”<sup>81</sup>
- **Refund any excess payments** the patient made that exceeded what they owe once financial assistance is applied (unless the overcharge is less than \$5).<sup>82</sup>
- **Take all “reasonably available measures” to reverse an extraordinary collection action** (some exceptions apply to debt sales). This includes vacating judgments, removing adverse credit information, and reversing lien or levy on property.<sup>83</sup>

### *Responding to Incomplete Applications for Financial Help*

If a patient submits an incomplete application, the hospital must provide the patient with written notice describing the additional information or documentation it needs, along with contact information for the hospital department that can provide more information about the financial assistance policy and direct the patient to in-house staff or third-party partners that can assist the patient in successfully completing the application process.<sup>84</sup> If a patient then submits a completed application during the application period, the hospital must honor the application and process it accordingly.<sup>85</sup> The regulations acknowledge that some patients may need additional time to compile the additional information, and indicate that these applications ought to be honored by the hospital so long as the patient submitted an incomplete application form during the application period.<sup>86</sup>

### *Suspending ECAs during the Application Period*

Hospitals that have lawfully initiated an extraordinary collection action are required to suspend these activities when a patient submits a complete or partially complete application form during the 240-day application period.<sup>87</sup> **“Suspending” an extraordinary collection action means that the hospital either does not initiate new extraordinary collection action, or takes no further action on an already-initiated extraordinary collection action, until a determination of eligibility is complete.**<sup>88</sup> In cases where the patient has submitted an incomplete application, the regulations allow hospitals to restart extraordinary collection actions when the patient has failed to respond to requests for more information, and a “reasonable time” has passed.<sup>89</sup>

### **3. Notifying Patients of Intent to Engage in ECAs**

Under the timeframes outlined in the regulations, it is possible that a hospital may choose to initiate an extraordinary collection action during the application period if a patient has been found ineligible for financial assistance or has yet to start the application process (see Figure B).<sup>90</sup> Alternatively, a hospital could delay initiating an extraordinary collection action until after the application period has passed. The regulations aim to

protect patients in both scenarios by requiring hospitals to take additional steps to notify patients prior to initiating an extraordinary collection action against them, no matter when the extraordinary collection action is initiated.<sup>91</sup> **If a hospital intends to use an extraordinary collection action, it must provide the patient with 30 days' written notice that states which actions the hospital intends to take to obtain payment and the deadline by which the hospital will initiate extraordinary collection actions.**<sup>92</sup> The written notice must include information about financial assistance, including a plain language summary of the financial assistance policy.<sup>93</sup> And, the hospital must make a reasonable effort to orally notify the patient about financial assistance policy and ways to get assistance with the application process.<sup>94</sup>

### *Exception for Certain Upfront Payments*

The regulations make an exception when hospitals defer, deny or precondition day-of-treatment on a patient's payment for previously rendered care. This is an extraordinary collection action.<sup>95</sup> Instead of providing advance notice to the patient, hospitals are required to give the patient oral notice and a plain language summary of the financial assistance policy.<sup>96</sup> In this scenario, presumably because the harm to the patient from delaying care is greater than with other extraordinary collection actions, the hospital must also provide the patient with an application form and written notice of the financial assistance policy, along with a deadline for applying.<sup>97</sup> Hospitals must expedite completed applications submitted by patients under these circumstances.<sup>98</sup>

### **4. Presumptive Eligibility**

The final regulations allow non-profit hospitals to use third-party information and prior financial assistance policy applications to determine whether a patient is “presumptively eligible” for financial help.<sup>99</sup> What constitutes a “reasonable effort” in these instances depends on the findings of the preliminary inquiry. If a patient is found eligible for “the most generous assistance” available under the FAP, no additional steps are required by the patient (though the hospital should send the patient a revised bill indicating no money is owed).<sup>100</sup> If, however, the presumptive eligibility determination finds that the patient is *ineligible* for financial aid, or eligible only for partial financial help, the patient must be informed of the findings and given an opportunity to apply for more generous help within a “reasonable” time frame.<sup>101</sup>

### **5. Applicability to Debt Collectors and Debt Buyers**

The requirements to make a “reasonable effort” to determine financial assistance eligibility prior to engaging in extraordinary collection actions also apply to third-party debt collectors or debt buyers.<sup>102</sup> Non-profit hospitals that opt to farm out their billing and collections work to third parties or to sell patient debt must execute legally binding agreements that are reasonably designed to ensure the third party's compliance with the law.<sup>103</sup> The duty is on the hospital to enforce the agreement.<sup>104</sup> At a minimum, the agreement must state that the third party will suspend extraordinary collection actions if the patient submits a financial assistance policy application within the 240-day application period.<sup>105</sup> Furthermore, the third party must agree to ensure that patients who are found eligible for financial assistance policy do not pay more than they owe under the hospital's policy.<sup>106</sup> The third party must also agree to take necessary steps to reverse extraordinary collection actions if a patient is found eligible for financial assistance policy, unless the hospital retains this authority in the contract.<sup>107</sup>

## D. Compliance

### 1. Who Must Comply?

**The laws and regulations discussed in this brief apply to all hospitals with tax-exempt status under Section 501(c)(3) of the federal Internal Revenue Code.**<sup>108</sup> The ACA requirements (with the exception of some reporting requirements) apply to both publicly- and privately-owned hospitals with 501(c)(3) status.<sup>109</sup> (Tax-exempt hospitals may be owned by private corporations or public entities, like a state or county government.)

**However, though they are required to comply with the substantive provisions of the ACA and these final regulations, publicly-owned tax-exempt hospitals—known as “dual status” hospitals—are generally exempted from the filing requirements that apply to privately-owned hospitals.**<sup>110</sup> Public hospitals do not have to file the annual tax Form 990 or its hospital-specific Schedule H, which (among other things) requires non-profit hospitals to attest to their compliance with the final regulations and to break down their financial outlays on financial assistance and other types of community benefit, community-building, and bad debt from patient accounts.<sup>111</sup> The Form 990 includes detailed financial information about hospital revenues, total spending on financial assistance and community benefit, and other information that can help advocates and community organizations assess how a hospital is reinvesting in the community it serves. Those seeking to understand how dual status hospitals' financial assistance and collections practices fit into a more comprehensive view of their financial health or community benefit investment will need to look elsewhere for that data.<sup>112</sup>

The regulations also apply to **third-party debt collectors and purchasers**<sup>113</sup> and to **“substantially related entities,”**<sup>114</sup> such as partnerships with medical groups where the hospital owns a capital or for-profit interest.<sup>115</sup> **However, they do not apply to for-profit hospitals. Nor do they apply to physicians and other medical providers who offer care in the hospital, but are not hospital employees.** This can be a confusing distinction and a shock for patients who receive multiple bills for a single date of service. As a result, patients who qualify for financial aid from the hospital may still face out-of-pocket costs from doctors, labs, and others who treated or provided services during the course of a visit or stay. To help patients understand which parts of their care might be eligible for financial help, the regulations require each non-profit hospital to include a complete list of all providers that offer emergency and medically necessary services in the financial assistance policy.<sup>116</sup> The list must specify which of these providers are covered by the financial assistance policy, and which are not.<sup>117</sup>

### 2. What Services Are Covered?

A non-profit hospital's financial assistance policy—and, by extension, most of the protections against overcharging and extraordinary collection actions—must apply to all “emergency and other medically necessary care.”<sup>118</sup> **While the regulations adopt the EMTALA definition of “emergency care,”<sup>119</sup> they permit hospitals to choose how they define “medically necessary care” for financial assistance policy and collection purposes.**<sup>120</sup> For example, a hospital could adopt a definition applicable under state law, the Medicaid definition, or a definition that refers to the generally accepted standards of medicine in the community or the attending physician's judgment.<sup>121</sup>

### 3. When Must Hospitals Comply?

The IRS has given hospitals until early 2016 to come into compliance with the final regulations.<sup>122</sup> But while hospitals have some time to transition their policies, materials

and current practices, they should have been taking steps already to meet the underlying statutory requirements. The regulations state that hospitals may rely on a “reasonable, good faith interpretation” of Section 9007 for 2015 and prior tax years.<sup>123</sup> Hospitals that adopted the procedures outlined in the Proposed Rules, which were published in 2012, will be automatically deemed to have complied with the law.<sup>124</sup>

#### 4. Penalties for Non-compliance

The ACA amended the Internal Revenue Code, making the new requirements for financial assistance, charges and collections a condition of hospital’s tax-exempt status.<sup>125</sup> While failure to comply with the requirements related to community health needs assessments can lead to a \$50,000 excise tax<sup>126</sup>, the only statutory penalty for noncompliance with the financial assistance, charging, or collection provisions is revocation of tax status and taxing of income.<sup>127</sup> Such a “zero-sum” approach to compliance could pose significant problems for hospitals that are making good-faith efforts to comply with the law, without providing any real boon for patients. (Since for-profit hospital facilities are not bound by these requirements and few states regulate their billing and collections activity, revocation of a hospital’s tax exemption could have the unintended effect of leaving future patients exposed to greater risk of poor billing practices without providing an adequate remedy for the patients who were harmed in the first instance.)

##### *Minor Errors and Omissions*

The final regulations and additional IRS guidance provide a softer landing for non-profit hospitals where minor omissions or errors have led to lapses in compliance.<sup>v</sup> Minor violations that are either inadvertent or due to a reasonable cause will not be considered failures to comply, so long as the hospital moves to correct the problem as soon as reasonably possible once it is discovered.<sup>128</sup> As part of the correction, hospitals must establish, review or revise internal policies and procedures to facilitate and promote compliance with the final regulations.<sup>129</sup>

##### *Excusing Certain Failures: Correction and Disclosure*

The IRS may also “excuse” more serious failures, if hospitals proactively correct and disclose the problem.<sup>vi</sup> This option is intended to address hospital violations that are more than minor, but are not willful or egregious.<sup>130</sup> IRS guidance outlines the “**correction principles**” hospitals must meet and stipulates disclosure protocols, as follows:

1. **The hospital makes good faith efforts to restore patients impacted by non-compliance.** The hospital should restore affected individuals to the position they would have been in, had the failure not occurred, to the extent reasonably feasible (e.g., refunding financial assistance policy -eligible patients who overpaid; reversing extraordinary collection actions used inappropriately).<sup>131</sup> This is the case even if the harm was suffered in previous tax years.<sup>132</sup>
2. Correction is **reasonable and appropriate** for the failure.<sup>133</sup>
3. Correction should occur **as promptly as reasonable** after the failure is discovered.<sup>134</sup>

<sup>v</sup> Examples of minor errors include technological glitches that cause a financial assistance policy or community health needs assessment report to be temporarily unavailable online, or inadvertently knocking down or blocking financial assistance policy signage in the emergency room. Rev. Proc. 2015-21, 2015-13 I.R.B. 817 at 818-19.

<sup>vi</sup> IRS guidance on correction and disclosure incentivizes hospitals to be diligent in reviewing their policies and procedures, and proactive about addressing and disclosing systemic problems with compliance. For example, non-profit hospitals that have been contacted for examination by the IRS can use the “correct and disclose” procedures only if the hospital has already corrected the failure or is in the process of doing so, and the hospital has disclosed the failure before the due date for filing its annual return. Rev. Proc. 2015-21, 2015-13 I.R.B. 817 at 819.

4. The hospital **establishes (or modifies) and implements policies and procedures**, informal or formal, as needed to ensure compliance or prevent a failure in the future.<sup>135</sup>

Typically, hospitals will report the failure on the Form 990.<sup>136</sup> Dual status hospitals, which are typically exempt from filing, must either file a 990 for purposes of disclosing the failure or make a similar disclosure “widely available” on a website.<sup>137</sup> Hospitals must describe the failure, including the type, the cause, the facilities involved, the dates of the failure and discovery, and the number of occurrences; the correction(s), including method and date of correction and the restoration of individuals involved (if restoration is not feasible, the hospital must state so and explain why); and the policies and practices that were changed or implemented as a result of the failure.<sup>138</sup>

### *Revocation*

The IRS may revoke a hospital’s tax-exempt status for willful or egregious failures to comply with the law and final regulations.<sup>139</sup> “Willful” failures include those due to gross negligence, reckless disregard, or willful neglect.<sup>140</sup> “Egregious” failures include only very serious failures, taking into account the severity of the impact and number of affected people.<sup>141</sup> In general, the IRS will use a “facts and circumstances” approach to determine the scope and severity of the problem before determining whether correction and disclosure or revocation is warranted.<sup>142</sup> (Note, however, that a hospital’s actions to correct and disclose a problem will be taken as an indication that the failure to comply was not willful.<sup>143</sup>)

## III. What Comes Next?

### 1. Limitations and Challenges: What’s Left Undone

While these new requirements are a positive step forward for consumers, several factors limit their potency. **First, the protections and requirements for transparency they include apply only to a subset—albeit a significant subset—of providers.** With for-profit medicine increasing its foothold in the hospital marketplace, it is critical that policymakers and advocates begin to seriously consider and pursue policy alternatives that apply to for-profit facilities. Furthermore, medical debt is driven, in part, by poor billing practices of providers other than hospitals, such as physician practices, dental practices, ambulance services, and laboratory and diagnostics providers. Even with these regulations, existing state and federal laws appear to be inadequately structured to protect low- and middle-income families from unethical, unsustainable, or aggressive collection practices.

**Second, the regulations still place hospital leadership squarely in the driver’s seat.** Notably, the regulations do not set minimum eligibility standards for financial assistance, or even require hospitals to provide a set amount of financial assistance. They merely require non-profit hospitals to describe the policies they have. Because the regulations are structured to provide greatest protection to patients who qualify for financial assistance, many low- and moderate-income patients who cannot meet the hospital’s criteria will continue to struggle to afford hospital charges, or be subject to aggressive collection practices. The risk here is heightened if the hospital’s financial assistance policy is skimpy or does not apply to patients who are underinsured.

**Third, hospitals still have carte blanche when it comes to deciding their billing and collections strategies.** While many consumer advocates called for either outright bans or serious

limitations on the more aggressive practices employed by some hospital facilities and third-party agents, the approach adopted by the IRS in the final regulations is much more measured. The final regulations do not bar non-profit hospitals from collecting on an outstanding debt. Instead, they shift a fairer part of the burden onto hospitals by requiring a good-faith effort to give patients an opportunity to apply for financial assistance and to notify patients about the potential ramifications for falling behind on bills. This is a good step, but it is not enough.

Fourth, while the strength of the regulations arguably rest in the increased transparency they require of non-profit hospitals, **there is no central database that will allow patients, regulators, or the general public to compare the information that will soon be available to them.** Eligibility criteria, application requirements, collection activities, and the basis for charges—all of this information must now be publicly available at no cost and easy to find on a hospital's website. But “comparison shopping” across hospital facilities will be a harder slog, whether the shopper is a patient seeking information about eligibility for financial assistance or a public official interested in seeing how “amounts generally billed” fluctuates across local hospitals. Patients, advocates, and others will need to research and evaluate hospital policies individually, a process that could require more time and effort than is feasible.

**Finally—and importantly—it is currently unclear whether the enforcement mechanisms outlined in the regulations will be sufficient to protect individual patients who are harmed by hospitals that fail to comply.** For example, neither the ACA nor the regulations expressly provide patients with a private right of action against hospitals that violate the law, and courts have been reluctant to award claims for breach of contract or charitable trust based solely on a hospital's obligations for tax exemption under Section 501(c)(3).<sup>144</sup>

## 2. Making the Most of It: Engaging Local Hospitals

Despite these limitations, or perhaps because of them, the time is ripe for advocates to engage local hospitals to ensure that their financial aid and billing policies match what the community needs. **Non-profit hospitals have this year to come into compliance with the federal regulations and should be evaluating their policies for compliance purposes.** Hospital boards should understand the scope of financial need in their communities and the impact their approach to billing and collections has on patients' access to care and long-term financial health. The regulations provide a timely opportunity for consumer advocates and hospitals to co-design policies that work for the communities they serve. Advocates, legal service attorneys, and other community representatives have had success working with state associations, hospital systems and individual facilities to narrow the types of gaps that remain in the wake of these regulations. Examples include:

- Designing plain language summaries and public notices of financial assistance policies
- Co-developing application forms that reasonably limit the information patients must provide
- Agreeing to minimum eligibility standards for financial assistance
- Crafting successful outreach strategies so patients and community members are aware of financial assistance and know how to resolve billing issues
- Creating a direct line of communication with hospital billing staff to flag and resolve persistent issues reported by patients

- Identifying presumptive eligibility methods that streamline the determination process, saving hospitals time and money, and are fair to patients (relying on SNAP or Medicaid eligibility instead of requiring patients to complete a lengthy application form; identifying area shelters and granting assistance to patients who indicate they reside there, etc.)

Additionally, the regulations create some opportunities for natural partnerships between hospitals and other non-profit organizations or government agencies. This is true for public outreach, particularly to “communities within communities” of limited English proficiency (LEP) speakers, where community-based organizations may already know the most effective ways to disseminate information about financial assistance policies or have the relationships in place to allow the hospital to gather the community’s input and ideas. Hospitals can also partner with non-profit and government agencies to support patients throughout the application process.<sup>145</sup>

Advocates and community partners may already have a strong sense of the challenges patients face with hospital billing and collections. They may come to the table with a predefined set of solutions they would like hospitals to embrace. There are good resources available to assist community partners and hospitals alike in identifying best practices. For example, the Healthcare Financial Management Association (HFMA) is a well-respected resource for accountants, chief financial officers, and other financial management professionals in the health care sector. Their Patient-Friendly Billing project, among others, offers hospitals concrete suggestions for improving their revenue cycles—including financial assistance, billing and collections—in fiscally sound, patient-friendly ways.<sup>146</sup>

### 3. Further on up the Road: Public Policy Changes

The federal regulations establish a minimum threshold. They are not intended to preempt state and local laws with more stringent standards.<sup>147</sup> Since many states have addressed some aspect of hospital collections, advocates and community partners should cross-check state and local laws to get a full picture of the current regulatory landscape for hospitals in their community. This analysis may yield additional legal protections beyond what is found in the final regulations.<sup>vii</sup> It may also outline areas where state or local public policies could be bolstered to address the gaps left by the federal regulations (e.g., applying similar standards to for-profit hospitals and other medical and dental providers; mandating minimum eligibility standards for financial assistance; increasing public reporting on financial assistance, billing and collections, and other community benefit data for public and for-profit hospitals). There is good precedent for state action in these and other areas. Furthermore, there may be more public appetite and political will at the state and local level for tackling the big issues left unresolved by the ACA, such as hospital pricing.

And, of course, the federal story is not finished. So long as the Schedule H, Form 990 is the primary method for gathering publicly reported data on hospitals’ community benefit practices and spending, consumer advocates and community-based organizations working with vulnerable populations have a vested interest in ensuring that the Schedule remains a comprehensive public document. Community-based and patient advocates have a critical part to play in ensuring that the IRS’ oversight of the hospital sector is effective, and that future federal policy changes at the regulatory and Congressional levels place a premium on transparency, fairness and affordability across all health care providers, not just non-profit hospitals.

<sup>vii</sup> Examples include other state laws governing hospital billing and collections, state common law defenses for collections suits, and other state statutes such as Unfair, Deceptive, or Abusive Acts and Practices (UDAP) laws. National Consumer Law Center, Collection Actions § 9.3.1 (3d ed. 2014), updated at [www.nclc.org/library](http://www.nclc.org/library).

## IV. Appendix

### Terminology

#### **Amounts generally billed (AGB)\***

The amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care.

#### **Application period\***

The period during which a hospital facility must accept and process an application for financial assistance submitted by an individual in order to have made “reasonable efforts” to determine whether the individual is eligible for financial assistance. In general, the application period begins on the date of service and ends 240 days after the first post-discharge billing statement is provided.

#### **Community benefit**

Programs or activities that provide treatment or promote health and healing as a response to identified community needs. Community benefit activities also seek to achieve objectives such as improving access to health services, enhancing public health, advancing increased general knowledge through education or research that benefits the public, and relieving government burden to improve health. The IRS further describes non-profit hospital community benefit in Revenue Ruling 69-545<sup>1</sup> and the Instructions to Schedule H, Form 990.<sup>2</sup>

#### **Extraordinary collection action (ECA)**

A type of collection action that, while permissible, warrants additional consumer protections under the final regulations. ECAs are defined in Section 1.501(r)-6(b)1 of the final regulations as selling patient debt; reporting adverse information about the patient to consumer credit reporting agencies or credit bureaus; deferring or denying, or requiring a payment before providing, medically necessary care because of an individual’s nonpayment of one or more bills for previously provided care covered under the hospital facility’s financial assistance policy; and actions to collect an outstanding bill that require a legal or judicial process.

#### **Financial assistance**

Financial assistance includes free or discounted health services provided to people who are unable to pay for all or a portion of the services they receive, who qualify for the hospital’s financial assistance policy. The IRS does not allow hospitals to count the following as financial assistance: self-pay or prompt-pay discounts; contractual adjustments by third-party payers (e.g., insurers); bad debt or uncollectible charges that the organization recorded as revenue but wrote off due to a patient’s failure to pay, or the cost of providing such care to such patients; Medicare or Medicaid shortfalls.<sup>3</sup>

#### **Gross charges (also referred to as the “chargemaster rate”)\***

The full, established price for medical care that the hospital facility consistently and uniformly charges patients before applying any contractual allowances, discounts, or deductions.

<sup>1</sup> Available at <http://www.irs.gov/pub/irs-tege/rr69-545.pdf>.

<sup>2</sup> Available at <http://www.irs.gov/pub/irs-pdf/i990sh.pdf>.

<sup>3</sup> Form 990, Schedule H Instructions, Line 1 (2014). Available at <http://www.irs.gov/pub/irs-pdf/i990sh.pdf>.

### **Hospital facility\***

A facility that is required by a state to be licensed, registered, or similarly recognized as a hospital. The final regulations also apply to non-profit hospital organizations that operate one or more hospital facilities.

### **Non-profit (tax-exempt) hospital**

A hospital facility or organization, whether privately or publicly owned, that is considered to be a charitable organization under Section 501(c)(3) of the Internal Revenue Code and is exempt from paying federal income taxes. Non-profit organizations conduct business for the benefit of the general public and without a profit motive.

### **Reasonable effort**

Steps hospitals and third-party actors must take to notify and inform patients about financial assistance prior to using an ECA (see “Billing and Collections” for a full discussion of what constitutes a reasonable effort).

*\*As defined in Treasury Regulations § 1.501(r)-1(b).*

- <sup>1</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9007, 42 U.S.C. § 18001 et seq (2010).
- <sup>2</sup> Section 9007 amends the Internal Revenue Code by adding these new requirements for tax-exempt hospitals, giving the IRS and Treasury Department (referred to collectively as “IRS” in this publication) jurisdiction for developing rules and monitoring compliance.
- <sup>3</sup> Department of the Treasury and the Internal Revenue Service, “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,” 79 Fed. Reg. 78954, available at <https://federalregister.gov/a/2014-30525>; and “Rulings and Determination Letters,” Rev. Proc. 2015-21, 2015-13 I.R.B. 817, available at <http://www.irs.gov/pub/irs-drop/rp-15-21.pdf>.
- <sup>4</sup> For a short summary of the fourth requirement on community health needs assessments and implementation planning, see Catholic Health Association, “Summary of Community Health Needs Assessment and Implementation Strategy Requirements (January 2015,” available at <http://www.chausa.org/docs/default-source/community-benefit/summary-of-chna-requirements.pdf?sfvrsn=2>.
- <sup>5</sup> See *generally* Community Catalyst, “Best-kept Secrets: Are Non-profit Hospitals Informing Patients about Charity Care Programs?” (May 2010), available at [http://www.communitycatalyst.org/doc-store/publications/best\\_kept\\_secrets\\_may\\_2010.pdf](http://www.communitycatalyst.org/doc-store/publications/best_kept_secrets_may_2010.pdf).
- <sup>6</sup> I.R.C. § 501(r)(4)(A).
- <sup>7</sup> Treas. Reg. § 1.501(r)-4(b)(1)(iii).
- <sup>8</sup> Treas. Reg. § 1.501(r)-4(b)(1)(iii)(D), -4(b)(4).
- <sup>9</sup> Id. Patients need to be able to easily find full information about the actions the hospital or a third party will take to collect on a bill, including extraordinary collection actions, and the process and time frames used to determine eligibility for financial assistance prior to collections. The hospital also has to identify who has the authority to determine when the hospital has met its obligations to make a “reasonable effort” and can begin using extraordinary collection actions.
- <sup>10</sup> Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd (1986).
- <sup>11</sup> Centers for Medicare and Medicaid Services, “Emergency Medical Treatment and Labor Act (EMTALA) Requirements & Conflicting Payor Requirements or Collection Practices,” S&C: 14-06-Hospitals/CAHs (Dec. 13, 2013), available at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-06.pdf>.
- <sup>12</sup> Id.
- <sup>13</sup> I.R.C. § 501(r)(4)(B); Treas. Reg. § 1.501(r)-4(c).
- <sup>14</sup> Treas. Reg. § 1.501(r)-4(c)(2).
- <sup>15</sup> Id.
- <sup>16</sup> Treas. Reg. § 1.501(r)-4(d)(1), -4(d)(3).
- <sup>17</sup> Treas. Reg. § 1.501(r)-4(d)(2).
- <sup>18</sup> See Department of the Treasury and the Internal Revenue Service, “Rulings and Determination Letters,” *supra* note 3, at 10 (listing implementation or modification of informal or formal practices or procedures designed to ensure compliance with the law as a principle for corrective action).
- <sup>19</sup> Treas. Reg. § 1.501(r)-4(b)(3).
- <sup>20</sup> Treas. Reg. § 1.501(r)-1(b)(24).
- <sup>21</sup> Id.
- <sup>22</sup> Id.
- <sup>23</sup> Treas. Reg. § 1.501(r)-4(b)(5).
- <sup>24</sup> Treas. Reg. § 1.501(r)-4(b)(5)(D)(1).
- <sup>25</sup> Treas. Reg. § 1.501(r)-6(c)(4)(B).
- <sup>26</sup> I.R.C. § 501(r)(4)(A)(v).
- <sup>27</sup> Treas. Reg. § 1.501(r)-4(b)(5)(i)(A).
- <sup>28</sup> Treas. Reg. § 1.501(r)-1(b)(29).
- <sup>29</sup> Id.

<sup>30</sup> Id.

<sup>31</sup> Treas. Reg. § 1.501(r)-4(b)(5)(i)(B).

<sup>32</sup> Treas. Reg. § 1.501(r)-4(b)(5)(i)(C).

<sup>33</sup> Treas. Reg. § 1.501(r)-4(b)(5)(i)(D)(1).

<sup>34</sup> Treas. Reg. § 1.501(r)-4(b)(5)(i)(D)(2).

<sup>35</sup> Treas. Reg. § 1.501(r)-4(b)(5)(i)(D)(3).

<sup>36</sup> Treas. Reg. § 1.501(r)-4(b)(5)(ii).

<sup>37</sup> Id.

<sup>38</sup> See, e.g., Sommers, A., White, C., and Ginsburg, P., “Addressing Hospital Pricing Leverage through Regulation: State Rate Setting,” National Institute for Health Care Reform (May 2012), available at <http://www.nihcr.org/1t192>.

<sup>39</sup> See, e.g., Meier, B., Craven McGinty, J., and Creswell, J., “Hospital Billing Varies Wildly, Government Data Shows,” *New York Times* (May 8, 2013), available at [http://www.nytimes.com/2013/05/08/business/hospital-billing-varies-wildly-us-data-shows.html?\\_r=0](http://www.nytimes.com/2013/05/08/business/hospital-billing-varies-wildly-us-data-shows.html?_r=0).

<sup>40</sup> See Daly, R., “CMS Data Show Wide Variation in Hospital Billing,” *Modern Healthcare* (May 8, 2013) for a typical cross-section of perspectives illustrating this point.

<sup>41</sup> See Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, “The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills,” (May 2011), available at [http://www.nytimes.com/2013/05/08/business/hospital-billing-varies-wildly-us-data-shows.html?\\_r=0](http://www.nytimes.com/2013/05/08/business/hospital-billing-varies-wildly-us-data-shows.html?_r=0).

<sup>42</sup> I.R.C. § 501(r)(5); Treas. Reg. § 1.501(r)-5(a)(2).

<sup>43</sup> Treas. Reg. § 1.501(r)-5(a)(1), -5(b).

<sup>44</sup> See Treas. Reg. § 1.501(r)-5(a). For elective procedures and other kinds of care that do not meet the definition of emergency care or medical necessity, hospitals must still charge less than the full price, as listed in the chargemaster, to patients who qualify for financial help. The difference here is that the regulations do not specify how much lower that price has to be, leaving the decision up to hospitals.

<sup>45</sup> Treas. Reg. § 1.501(r)-5(b)(1).

<sup>46</sup> Id.

<sup>47</sup> Treas. Reg. § 1.501(r)-4(b)(2)(i)(C).

<sup>48</sup> Treas. Reg. § 1.501(r)-5(b)(4).

<sup>49</sup> Id.

<sup>50</sup> Treas. Reg. § 1.501(r)-5(b)(3)(i) (outlining requirements for the look-back method) and 1.501(r)-1(b)(2) (defining “AGB percentage”).

<sup>51</sup> Treas. Reg. § 1.501(r)-5(b)(3)(ii). Notably, the final regulations do not allow hospitals to use *only* private health insurer data. Medicare and/or Medicaid data must always be included in the calculations.

<sup>52</sup> Treas. Reg. § 1.501(r)-5(b)(3)(iii).

<sup>53</sup> Treas. Reg. § 1.501(r)-5(b)(3)(i).

<sup>54</sup> Id.

<sup>55</sup> Id.

<sup>56</sup> Id.

<sup>57</sup> Treas. Reg. § 1.501(r)-4(b)(2)(i)(C).

<sup>58</sup> Id.

<sup>59</sup> Treas. Reg. § 1.501(r)-5(d).

<sup>60</sup> 79 Fed. Reg. at 78,983 (stating that, “If a hospital facility requires an individual to make an upfront payment for medically necessary care that exceeds the AGB for the care and the individual turns out to be FAP-eligible, the hospital facility will have failed to meet the requirements of section 501(r)(5).”).

<sup>61</sup> I.R.C. § 501(r)(6); Treas. Reg. § 1.501(r)-6(a).

<sup>62</sup> Treas. Reg. § 1.501(r)-6(b)(1)(iv).

<sup>63</sup> Treas. Reg. § 1.501(r)-6(b)(1)(ii).

<sup>64</sup> Treas. Reg. § 1.501(r)-6(b)(1)(i).

<sup>65</sup> Treas. Reg. § 1.501(r)-6(b)(2) (stating that the exception applies only where the debt purchaser has executed a legally binding agreement with the hospital that 1) prohibits the debt purchaser from engaging in any ECAs; 2) requires the purchaser to maintain low interest rates for the debt tied to IRS interest rates for underpayment of taxes; 3) allows the hospital to recall the debt if the patient is found to be eligible for financial assistance; and 4) if the hospital does not recall the debt and the patient is found eligible for financial assistance, requires the debt purchaser to ensure the patient does not pay more than the amount they would owe under the financial assistance policy.).

<sup>66</sup> Treas. Reg. § 1.501(r)-6(b)(1)(iii).

<sup>67</sup> Treas. Reg. § 1.501(r)-1(b)(3) (defining “application period” as “the period during which a hospital facility must accept and process an application for financial assistance under its FAP submitted by an individual in order to have made reasonable efforts to determine whether the individual is FAP-eligible[.]”).

<sup>68</sup> Id.

<sup>69</sup> Treas. Reg. § 1.501(r)-6(c)(3)(i). Of course, hospitals can initiate ECAs during the first 120 days in cases where a patient submits a completed application and the hospital determines he or she is ineligible for financial assistance. Treas. Reg. § 1.501(r)-6(c)(6)(iii).

<sup>70</sup> Treas. Reg. § 1.501(r)-6(c)(3)(iii), -6(c)(6).

<sup>71</sup> Treas. Reg. § 1.501(r)-6(c)(4).

<sup>72</sup> Treas. Reg. § 1.501(r)-6(c)(9).

<sup>73</sup> Treas. Reg. § 1.501(r)-4(b)(3). The exception is that hospitals are prohibited from determining eligibility based on information they “[have] reason to believe is unreliable or incorrect or on information obtained from the individual under duress or through use of coercive practices,” such as demanding upfront payment for emergency care. Treas. Reg. § 1.501(r)-6(c)(6)(ii).

<sup>74</sup> Treas. Reg. § 1.501(r)-4(b)(3).

<sup>75</sup> Id.

<sup>76</sup> Treas. Reg. § 1.501(r)-1(b)(13).

<sup>77</sup> Treas. Reg. § 1.501(r)-6(c)(6)(i).

<sup>78</sup> Treas. Reg. § 1.501(r)-6(c)(6)(iv).

<sup>79</sup> Treas. Reg. § 1.501(r)-6(c)(6)(i)(A), -6(c)(8).

<sup>80</sup> Treas. Reg. § 1.501(r)-6(c)(6)(i)(B).

<sup>81</sup> Treas. Reg. § 1.501(r)-6(c)(6)(i)(C).

<sup>82</sup> Id.

<sup>83</sup> Id.

<sup>84</sup> Treas. Reg. § 1.501(r)-6(c)(5)(i)(B).

<sup>85</sup> Treas. Reg. § 1.501(r)-6(c)(5)(ii).

<sup>86</sup> Treas. Reg. § 1.501(r)-6(c)(5)(ii) (stating that “If an individual who has submitted an incomplete financial assistance policy application during the application period subsequently completes the financial assistance policy application during the application period (or, if later, within a reasonable timeframe given to respond to requests for additional information and/or documentation), the individual will be considered to have submitted a complete financial assistance policy application during the application period, and the hospital facility will have made reasonable efforts to determine whether the individual is financial assistance policy-eligible only if it meets the requirements for complete financial assistance policy applications described in paragraph (c)(6) of this section.”).

<sup>87</sup> Treas. Reg. § 1.501(r)-6(c)(5)(i)(A).

<sup>88</sup> Treas. Reg. § 1.501(r)-6(c)(8).

<sup>89</sup> Treas. Reg. § 1.501(r)-6(c)(8)(ii).

<sup>90</sup> Treas. Reg. § 1.501(r)-6(c)(3), -6(c)(7).

<sup>91</sup> See Treas. Reg. § 1.501(r)-6(c)(4).

<sup>92</sup> Id.

- <sup>93</sup> Id.
- <sup>94</sup> Id.
- <sup>95</sup> Treas. Reg. § 1.501(r)-6(b)(iii).
- <sup>96</sup> Treas. Reg. § 1.501(r)-6(c)(4)(iii).
- <sup>97</sup> Treas. Reg. § 1.501(r)-6(c)(4)(iii)(A).
- <sup>98</sup> Treas. Reg. § 1.501(r)-6(c)(4)(iii)(B).
- <sup>99</sup> Treas. Reg. § 1.501(r)-6(c)(2).
- <sup>100</sup> Id.
- <sup>101</sup> Id.
- <sup>102</sup> Treas. Reg. § 1.501(r)-6(c)(10).
- <sup>103</sup> Id.
- <sup>104</sup> Id.
- <sup>105</sup> Treas. Reg. § 1.501(r)-6(c)(10)(i).
- <sup>106</sup> Treas. Reg. § 1.501(r)-6(c)(10)(ii).
- <sup>107</sup> Id.
- <sup>108</sup> I.R.C. § 501(r); Treas. Reg. § 1.501(r)-1(18).
- <sup>109</sup> I.R.C. § 501(r); “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,” 79 Fed. Reg. at 78,954, 78,957 (December 31, 2014) (to be codified at 26 C.F.R. pts. 1, 53, and 602).
- <sup>110</sup> “Rev. Proc. 95-48 provides that certain government entities are relieved from any requirement to file a Form 990 (and therefore are relieved from having to disclose information or documents on or with a Form 990).” 79 Fed. Reg. at 78,958.
- <sup>111</sup> IRS Schedule H (Form 990), Hospitals (2014), available at <http://www.irs.gov/uac/About-Schedule-H-Form-990>.
- <sup>112</sup> Some states require public reporting of this data. See Community Catalyst, “Free Care Compendium” (2010), available at <http://www.communitycatalyst.org/initiatives-and-issues/initiatives/hospital-accountability-project/free-care/national-snapshot#9>; and The Hilltop Institute, “Community Benefit State Law Profiles Comparison” (2015), available at [http://www.hilltopinstitute.org/HCBP\\_CBL\\_state\\_table.cfm](http://www.hilltopinstitute.org/HCBP_CBL_state_table.cfm).
- <sup>113</sup> Treas. Reg. § 1.501(r)-6(c)(10).
- <sup>114</sup> Treas. Reg. § 1.501(r)-1(b)(28).
- <sup>115</sup> McDermott, Will & Emery, “Creeping Normality: IRS Releases Final Regulations under Section 501(r),” (January 15, 2015), 13, available at <http://www.mwe.com/files/Uploads/Documents/Pubs/Creeping-Normality.pdf>.
- <sup>116</sup> Treas. Reg. § 1.501(r)-4(b)(iii)(F).
- <sup>117</sup> Id.
- <sup>118</sup> Treas. Reg. § 1.501(r)-4(b)(1)(i).
- <sup>119</sup> Treas. Reg. § 1.501(r)-1(b)(9)-(10).
- <sup>120</sup> Treas. Reg. § 1.501(r)-5(b)(8) (related to FAPs) and 1.501(r)-5(e)(related to billing and collections).
- <sup>121</sup> Id.
- <sup>122</sup> The final regulations take effect on the first taxable year beginning after December 29, 2015. Treas. Reg. § 1-501(r)-7(a).
- <sup>123</sup> Treas. Reg. § 1-501(r)-7(b).
- <sup>124</sup> Id.
- <sup>125</sup> I.R.C. § 501(r).
- <sup>126</sup> I.R.C. § 4959.
- <sup>127</sup> Treas. Reg. § 1.501(r)-2(a).
- <sup>128</sup> Treas. Reg. § 1.501(r)-2(b)(1)(ii).
- <sup>129</sup> Id.

<sup>130</sup> Treas. Reg. § 1-501(r)-2(c); Rev. Proc. 2015-21, 2015-13 I.R.B. 817 at 818.

<sup>131</sup> Treas. Reg. § 1-501(r)-2(c); Rev. Proc. 2015-21, 2015-13 I.R.B. 817 at 819.

<sup>132</sup> Note that the guidance addressing correction and disclosure is effective as of March 10, 2015, and does not apply retroactively to past years. Rev. Proc. 2015-21, 2015-13 I.R.B. 817 at 820.

<sup>133</sup> Rev. Proc. 2015-21, 2015-13 I.R.B. 817 at 819.

<sup>134</sup> Id.

<sup>135</sup> Id.

<sup>136</sup> Id.

<sup>137</sup> Rev. Proc. 2015-21, 2015-13 I.R.B. 817 at 820.

<sup>138</sup> Rev. Proc. 2015-21, 2015-13 I.R.B. 817 at 819.

<sup>139</sup> I.R.C. § 4959; Treas. Reg. § 1-501(r)-2.

<sup>140</sup> Treas. Reg. § 1-501(r)-2(a).

<sup>141</sup> Treas. Reg. § 1-501(r)-2(c).

<sup>142</sup> Treas. Reg. § 1.501(r)-2(a), -2(c).

<sup>143</sup> Id.

<sup>144</sup> See National Consumer Law Center, Collection Actions § 9.3.1 (3d ed. 2014), updated at [www.nclc.org/library](http://www.nclc.org/library), at § 9.4.6.2, *infra*.

<sup>145</sup> See Treas. Reg. § 1.501(r)-1(b)(24)(v)(B).

<sup>146</sup> Healthcare Financial Management Association, “Patient Friendly Billing Project,” available at <https://www.hfma.org/patientfriendlybilling/>.

<sup>147</sup> 79 Fed. Reg. at 78,994.

<sup>148</sup> See, e.g., Nelson, G., et al, “Hospital Community Benefits after the ACA: State Law Changes and Promotion of Community Health,” The Hilltop Institute (February 2015), available at <http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-StateLawChangesIssueBrief10-Feb2015.pdf>.