IRS Releases Proposed Regulations on Requirements for Tax-Exempt Hospitals

On June 22, only days before the Supreme Court is expected to rule on the constitutionality of the Patient Protection and Affordable Care Act ("PPACA"), the Treasury Department released proposed regulations under Internal Revenue Code section 501(r), enacted as part of PPACA. Section 501(r) requires all tax-exempt "hospital organizations" to have certain policies and procedures in place for each "hospital facility" they operate, including having a "financial assistance policy" for low income patients, written policies for the provision of emergency care, limitations on charges and collection activities for individuals eligible for the financial assistance policy, and the creation and implementation of a community health needs assessment.

The proposed regulations are detailed and prescriptive, although they do not address certain key aspects of section 501(r), including the required community health needs assessment and the sanctions for failing to comply with section 501(r).

Key Definitions Clarified

The new requirements put in place by PPACA apply to hospital facilities that are operated by hospital organizations. Hospital facilities are defined in the proposed regulations to include only entities that are required by the laws of the 50 states or the District of Columbia to be registered, licensed, or otherwise formally recognized as a hospital. Under this definition, no foreign hospitals, including those in U.S. territories, are subject to the section 501(r) requirements. While the requirements of section 501(r) apply individually to each hospital facility, including different hospitals owned or managed by the same hospital organization, the proposed regulations permit a hospital organization to treat multiple buildings or divisions as a single facility, as long as they are operated under a single state license.

Hospital organizations are defined as tax-exempt organizations under section 501(c)(3) that operate one or more hospital facilities, including organizations that operate a hospital through a "disregarded entity" – a single member limited liability company. The proposed regulations do not extend to hospital facilities operated through joint ventures or other partnerships, although future guidance in this area is expected. In addition, the preamble to the proposed regulations indicates that section 501(r) is intended to apply to governmental hospitals recognized as described in section 501(c)(3), while suggesting that a governmental hospital's "unique position" may give rise to alternative methods for complying with certain section 501(r) requirements.

Financial Assistance and Emergency Medical Care Policies

Under the proposed regulations, each hospital facility is required to have a financial assistance policy and an emergency medical care policy that are adopted by an "authorized body" of the hospital and that are consistently carried out in practice. An authorized body includes the hospital's governing board, a committee of the governing board, or other parties authorized to act by the governing board.

The emergency medical care policy must require the hospital to provide care for emergency medical conditions to all individuals, without discrimination, whether or not the individual is eligible for assistance under the financial assistance policy. This part of the policy can be met simply by requiring the hospital to comply with its existing obligations under the Emergency Medical Treatment and Labor Act. The policy must also prohibit the hospital from taking any steps that would discourage patients from seeking emergency treatment at the hospital, such as requiring payment prior to treatment for emergency services or allowing debt collection activities inside the hospital that might interfere with access to services.

Except as discussed below concerning the limitations on charges, neither section 501(r) nor the proposed regulations require a hospital to give any particular form of financial assistance to its patients, nor do they dictate any qualifications that a hospital must use in determining whether a particular patient is eligible for financial assistance. Each hospital is required, however, to describe in its financial assistance policy the type of financial assistance that is available, the eligibility criteria, how charges are calculated for eligible patients, and how the limitation on charges to "amounts generally billed," as described below, is calculated for various services. The proposed regulations give hospitals guidance on the more complicated requirements of these policies, such as the need for the financial assistance policy to be widely publicized (and to describe the publication measures in the policy itself).

To meet the requirement that a financial assistance policy be widely publicized, the proposed regulations indicate that a hospital is required to make the policy, as well as a plain language summary of the policy and an application for assistance under the policy, conspicuously available on the hospital's or another party's website. Paper copies of these same documents must also be available at the hospital and by mail, free of charge, upon request. The policy must also be publicized with signs or other displays in the hospital itself and by reaching out to the community served by the hospital in a way that is reasonably calculated to reach those who are likely to need assistance under the policy. If more than 10% of the residents of the hospital's community speak another language and have limited proficiency in English, the hospital is also required to provide the same documents, and take similar publication measures, in that language.

Examples given in the proposed regulations explain that certain elements of the financial assistance policy that are likely to change, such as the details of how amounts generally billed are calculated, can be removed from the financial assistance policy itself. Hospitals are permitted by these examples to describe in the policy the alternate location of this information, as long as the details are freely and widely available. This will permit hospitals to change elements of the policy relatively frequently, without being required to have a new financial assistance policy formally approved.

Limitations on Charges

While hospitals are generally free to determine what form of financial assistance to provide those who are eligible under the hospital's financial assistance policy, section 501(r) prohibits hospitals from charging more to eligible individuals than the "amounts generally billed" (or AGB) to insured patients for emergency or medically necessary care, and requires that charges for any other care be less than the gross charges (the full, undiscounted charge for services) for that care.

The proposed regulations require that a hospital use one of two calculation methods to determine the amounts generally billed for particular care. The simpler method allows the hospital to calculate charges as if the patient were eligible for Medicare Part A or B. A hospital applying this calculation method would use its normal coding procedures for Medicare to determine the amount that would be paid by Medicare, as well as the amount that would be paid by the Medicare beneficiary out-of-pocket. The total amount the hospital would receive from both Medicare and the beneficiary directly for the particular service is then treated as the amount generally billed for that service, and is the maximum amount the hospital is permitted to charge an individual eligible under its financial assistance policy.

Under an alternate calculation method in the proposed regulations, the hospital can take into account the amounts normally billed to patients who are insured by both Medicare and private insurers. This method requires the hospital to multiply the gross charges for its services by an "AGB percentage" which the hospital must update at least annually. The AGB percentage is the amount the hospital has received in satisfaction of

certain claims that have been paid in full over the prior 12 months, divided by the total gross charges for those same claims. The claims used in the calculation can either be those paid by Medicare Part A and B, or those paid by both Medicare Part A and B and all private health insurers who are primary payers. As with the Medicare billing method described above, the hospital can include in the calculation both the fees received directly from insurers and the amounts paid by the insured individuals in the form of co-pays, co-insurance, or deductibles. If the hospital chooses to use this method, it can calculate one ABG percentage for all services, or calculate separate percentages for different categories of services, such as a percentage for each department of the hospital. Note that the proposed regulations do not allow for an amounts generally billed calculation method based exclusively on claims paid by private health insurers, although comments have been requested on whether such a calculation method should be permitted.

When providing treatment to individuals eligible under the financial assistance policy that are not emergency or medically necessary services, the hospital is not required to limit its charges to amounts generally billed. The amount charged must nevertheless be less than the gross charges for the services.

The proposed regulations include a safe harbor for hospitals that charge more than amounts generally billed to individuals who are later determined to be eligible under the financial assistance policy. As long as the individual has not submitted an application for financial assistance at the time of the charge, and the hospital is making the reasonable efforts to determine eligibility discussed below, the hospital will not be considered to have violated the requirements under the regulations. If the individual is determined to be eligible for financial assistance after charges that exceed amounts generally billed have been issued, the hospital will be required to correct the amount charged, and issue a refund for any payment in excess of these amounts.

Billing and Collections

Section 501(r) limits the billing and collections efforts that a hospital is permitted to undertake until it has determined that a patient is not eligible for assistance under the hospital's financial assistance policy. According to the proposed regulations, these prohibited activities, referred to as "extraordinary collection actions," include measures such as selling the debt to a third party, garnishing wages, foreclosing on property or seizing accounts, filing a civil suit for collection of the debt, or making an adverse report to credit reporting agencies.

Before extraordinary collection actions can be taken, the hospital must make "reasonable efforts" to determine whether or not the patient is eligible under its financial assistance policy. Meeting the reasonable efforts standard requires the hospital to provide a plain language summary of the financial assistance policy to the patient prior to discharge and with all billing statements, to discuss the policy with the individual in any oral communications about the charges, and give at least one written notice of the types of extraordinary collection actions the hospital may take and the deadline, no earlier than 30 days from the date of the notice, after which these actions may begin. If the patient at any time submits an application for financial assistance under the policy, the hospital is no longer required to undertake these notification efforts, although certain similar requirements may apply in the case of incomplete applications for assistance.

If no application for financial assistance is submitted to the hospital after the hospital has met all of the notification requirements discussed above, the hospital can begin taking extraordinary collection actions 120 days after the first bill was sent, as long as three separate billing statements have been issued during that period. However, the patient has an additional 120 days (for a total of 240 days following the first billing statement for the care at issue) to submit the application for assistance. Once an application is received, all extraordinary collection actions must be suspended pending the hospital's determination of the individual's

eligibility. If the individual is later found to be eligible under the policy, the hospital must take steps to reverse extraordinary collection actions that have begun, even if the actions were permissible when taken. The proposed regulations do permit hospitals to use third party billing and collections agencies, including sale of the debt after the 120-day notification period has ended, as long as the hospital has a written agreement with the third parties that they will not take actions that the hospital is prohibited from taking under the proposed regulations, and that any individual eligible for financial assistance will not be required to pay more than he or she would have been required to pay if the hospital still controlled the debt.

A hospital is permitted to avoid the notification requirements if it determines that the patient is eligible for the most generous amount of assistance available under its financial assistance policy based on information provided outside of the normal assistance application process. The hospital cannot, however, make a negative determination of the patient's eligibility based on any information it believes may be unreliable, or that was obtained from the patient under duress (such as requiring the patient to give the information prior to obtaining emergency medical care). Finally, hospitals are not permitted to meet these requirements by asking patients to waive their rights to apply for financial assistance.

Further Regulations Expected

The comment period for the proposed regulations ends on September 24, 2012 and the new rules will apply to taxable years beginning on or after the regulations become final. The proposed regulations do not contain any additional information on the requirement for hospitals to perform a community health needs assessment. While waiting for these regulations, hospitals are advised to continue to rely on Notice 2011-52, which describes in broad terms the community health needs assessment. Additional regulations are also expected to explain the consequences of failing to meet the requirements of section 501(r) and the associated regulations.

If you have any questions with respect to section 501(r) or the new proposed regulations, please do not hesitate to contact Kendi Ozmon or Lorry Spitzer or your usual Ropes & Gray attorney.

****

IRS Circular 230 Notice

To ensure compliance with requirements imposed by the IRS, we inform you that any U.S. tax advice contained herein is not intended or written to be used, and cannot be used by any taxpayer, for the purpose of avoiding U.S. tax penalties.

****