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IRS Rules Will Not Stop Unfair Hospital Billing and Collection Practices

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When Keith Herie could not afford the $14,000 bill for his wife Katie's emergency appendectomy, the debt collector for Heartland Regional Medical Center sued him and garnished his wages [1]. Herie is not alone—hospitals throughout the country have sued tens of thousands of patients for unpaid medical bills [2]. Unmanageable medical bills push millions of Americans into financial distress, ranging from damaged credit to bankruptcy [3].

On December 31, 2014, the Internal Revenue Service (IRS) issued final rules for tax-exempt hospitals that ostensibly limit these harsh hospital billing practices [4]. The IRS rules implement additional requirements for a hospital's maintenance of federal tax exemption status enacted by the 2010 Patient Protection and Affordable Care Act and codified in section 501(r) of the Internal Revenue Code [5]. These IRS rules, however, provide inadequate and unpredictable protection for many patients, leaving them vulnerable to financial and health-related consequences of hospital billing abuses.

Unfair Hospital Prices and Harsh Debt Collection Practices

The IRS rules for tax-exempt (generally speaking, nonprofit) hospitals address the twin problems of unfair hospital prices and harsh debt collection practices. Hospitals routinely charge uninsured patients undiscounted "chargemaster" prices, the "rack rates" or list prices of the health care industry, while government and commercial payers receive substantial discounts of 50 percent or more of the chargemaster prices for their members [6]. Increasingly, insured patients are also paying inflated prices for out-of-network care, that is, care from hospitals or physicians who are not part of an insurer's network and therefore have not negotiated discounts with those insurers [7]. Even if the patient's health plan pays for part of the care, the patient is often billed for the difference between the amount paid by the insurer and the hospital's or clinician's full charges. The proliferation of narrow-network health plans with few in-network hospitals, clinics, and physicians makes it more likely that patients will find themselves unwittingly out of the network with high out-of-pocket bills.

The problem of unmanageable hospital bills is exacerbated by harsh debt collection practices [8]. These practices include assigning the debt to collection agencies [9], suing patients [2], seeking foreclosure or liens on patients' homes [10], garnishing wages [1], charging high interest rates [11], requiring upfront payment before providing additional

care [12], and even seeking arrest for failing to appear in court for a debt collection hearing [13].

Aggressive hospital debt collection practices inflict significant financial, emotional, and health-related hardship upon patients. Patients may lose their wages, homes, or creditworthiness or be pushed into bankruptcy. Unmanageable medical debt has been associated with higher levels of stress and anxiety and poorer health [14]. Indebted patients may have difficulty securing future health care because hospitals and clinicians may not serve those with outstanding medical debt [3]. Further deleterious health problems may ensue as patients self-ration medically necessary care, prescription drugs, or other necessities like food or shelter to pay their medical bills.

Although the IRS rules aim to protect vulnerable patients from unfair hospital billing and collection practices, the rules are distressingly underinclusive and create unjustifiable gaps in protection.

The IRS's Billing and Collection Rules for Tax-Exempt Hospitals

The IRS rules prescribe fair billing and collection requirements for tax-exempt hospitals. First, hospitals must maintain and widely publicize financial assistance policies, including eligibility criteria. Second, hospitals must limit the amounts charged to patients who are eligible for financial assistance to "amounts generally billed" to insured patients for emergency or medically necessary care. Hospitals may not charge such patients their undiscounted chargemaster rates. Third, the rules bar hospitals from using "extraordinary collection actions" unless the hospital has made reasonable efforts to determine whether the patient is eligible for financial assistance [4].

There are two main gaps in the IRS rules' protections. First, they do not apply to for-profit or government-run hospitals, which make up more than 40 percent of all hospitals in the US [15]. Second, the rules give hospitals complete discretion to determine eligibility for financial assistance, which is the trigger for the rules' protections. Under the rules, for example, a hospital could adopt a narrow financial assistance policy with very restrictive income requirements, exclude all patients with any form of insurance regardless of out-of-pocket expenses, or make applying for financial assistance so onerous that few are able to complete the process.

Although a growing number of hospitals are for-profit, ownership or tax status is difficult for patients to discover. Of a sample of 140 hospitals across fourteen states, I discovered that more than half did not have information on ownership or tax status readily available on their websites. If a hospital was for-profit, it was significantly less likely to provide ownership information on its website than if it was nonprofit or government-run. Moreover, for-profit hospitals were also less likely to post financial assistance

information. With a few exceptions, for-profit hospitals do not appear to have voluntarily adopted the financial assistance, billing, and collection policies required of nonprofits.

Furthermore, hospital financial assistance policies vary significantly in terms of generosity and terms. Among the sample of financial assistance policies from 140 hospitals, eligibility cutoffs for financial assistance ranged from an income of 100 percent of the federal poverty level (FPL) to 600 percent of the FPL. Many hospitals with financial assistance policies offered free care to those with incomes up to 100-200 percent of the FPL and sliding scale discounts above that threshold. However, some hospitals did not offer any free care and only offered moderate discounts even to the poorest patients. Of the hospitals in the sample that provided eligibility information based on insurance status, a quarter excluded those with insurance from their financial assistance policies altogether.

Hospitals' debt collection practices also vary significantly. One investigation compared the number of medical debt collection lawsuits filed in 2013 by the two dominant nonprofit health systems in Springfield, Missouri [16]. CoxHealth or its assignee debt collector had filed 701 lawsuits, while Mercy or its assignee had filed only 40 in the same period. Many of the patients sued were ineligible for financial assistance as defined by the two health systems and thus were unprotected by the IRS requirements. These data were published because investigators from ProPublica compiled and analyzed court records for all medical debt lawsuits in the state [16], but information about most hospitals' debt collection practices is not generally available.

Even if information about a hospital's tax status, financial assistance, or bill collection practices were readily ascertainable, the uneven protections of the IRS rules remain problematic because these factors do not drive a patient's choice of hospital. Most patients choose their hospitals based on their physicians' referral or because it is the closest in an emergency [17]. This means that whether or not a patient is protected by the IRS's fair billing and collection rules is a matter of luck and fiat. Although the financial consequences for the patient may be dire, the current rules requiring fair prices and collection practices of some hospitals and not others creates a system of financial roulette.

A Better Approach: Fair Hospital Pricing and Collection for All

There is no good reason to limit fair pricing and collection requirements to tax-exempt hospitals. Requiring hospitals to charge fair prices to patients paying out of pocket and to refrain from the most onerous debt collection practices is not mandating that they engage in charitable acts—nothing is being given away for free or at a loss—and, therefore, the requirements could be appropriately applied to for-profit hospitals. Hospitals are still able to charge a fair market rate (i.e., the rate they generally charge

insured patients) with commercially reasonable expectations of getting paid for services rendered.

The model for broadening these protections to all hospitals regardless of tax status already exists in various state fair pricing and collection laws: at least ten states have passed laws that limit the amount hospitals may charge to patients who fall below defined income levels and restrict hospital collection practices for these patients [18-27]. The strongest example is California's Hospital Fair Pricing Act, which limits how much California hospitals may charge uninsured patients who earn less than 350 percent of the FPL or insured patients whose medical bills exceed 10 percent of household income [18]. The California law also substantially restricts hospitals' collection activities against these patients. It has leveled the field for financial assistance for patients. California's experience with its fair pricing and collection law has been positive; it has not resulted in widespread financial strain on hospitals. Indeed, most hospitals have voluntarily adopted policies that go beyond the requirements of the law [28].

Taking laws like California's as a model, a better national approach would be to decouple fair pricing and collection rules from hospital tax status and make compliance with these rules a condition of participation in Medicare. (Nearly all hospitals participate in Medicare as a financial necessity.) This proposal would require all Medicare-participating hospitals to limit the amounts charged to self-pay patients with incomes less than a defined threshold, say 350 percent or 400 percent of the FPL, as well as any patients whose out-of-pocket medical bills exceed 10 percent of their annual household income. The protections would thus extend not only to uninsured patients but also to insured patients with high out-of-pocket expenses. By defining the income and affordability thresholds, the policy would replace hospitals' discretion in determining eligibility for fair billing and collection with level and predictable standards across all hospitals. Hospitals could receive further financial enhancements to their Medicare payments if they offered, for example, free emergency and medically necessary care to all self-pay patients with incomes less than 200 percent of the FPL. As with California's laws, there could be some flexibility in the requirements as applied to rural or critical access hospitals that might struggle to comply with the general rule.

The proposal would also expand debt collection protections. Under the current IRS rules, hospitals may continue to use aggressive debt collection practices as long as they have made "reasonable efforts" (e.g., providing notice and time for the patient to apply for financial assistance) to determine the patient's eligibility for financial assistance. Again, state laws [18-27] provide a more rigorous model for fair debt collection practices. First, the hospital would have to offer eligible patients an option for an extended payment plan with no or limited interest. Second, a hospital pursuing debt collection would be prohibited from attaching a lien to or forcing the sale of a person's primary residence while it is occupied by the patient, his or her spouse, or any dependent. Third, the

hospital would be prohibited from seeking wage garnishment while a person is making a good-faith effort to pay the debt. Fourth, the hospital would be allowed to assign a debt to a collection agency and report nonpayment to a credit reporting agency only if the patient has stopped making any payments for a defined period of time (e.g., 90 or 120 days past due), the hospital has made reasonable efforts to contact the patient, and the collection agency agrees to the same limits on collection to which the hospital is subject under the law.

Conclusion

The IRS rules for tax-exempt hospitals took a step toward ensuring fairness in hospital billing and debt collection, but the rules' gaps—allowing hospitals to determine eligibility for financial assistance and excluding for-profit hospitals—create a harsh system of financial roulette for patients. Patients ought to be treated fairly by all hospitals, which have a duty to avoid inflicting not only physical harms on their patients but also unjustifiable financial harms. It is time to broaden the protections of fair hospital billing and collection practices to all hospitals and financially vulnerable patients.

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Disclosure

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