PROSKAUER ROSE LLP®

Health Law Alert

A report
for clients
and friends
of the Firm

May 2009

What's on the Horizon for Hospital Income Tax-Exemption?

Congress and the Internal Revenue Service (the "IRS") are focusing once more on the question of what tax-exempt hospitals must do to maintain their exemption from federal income tax, especially as the prospects for health reform with universal coverage become clearer. This Client Alert outlines recent events, provides some background on the tax-exempt standard for hospitals, and summarizes what may be coming in the near future and what tax-exempt hospitals can do in these unprecedented financial times to be ready to address these events.

Just this past Monday, May 18, 2009, Sen. Max Baucus (D-MT), Chairman of the Senate Finance Committee, and Sen. Charles Grassley (R-IA), the ranking member of the Committee, released policy options for financing comprehensive health care reform, which were slated for discussion at a Committee hearing on Wednesday, May 20, 2009, and which are open to public comment until Tuesday, May 26, 2009. The policy options paper explores three areas of potential funding: (i) savings achieved from within the health care system from reductions in current levels of spending; (ii) reevaluating current health tax subsidies; and (iii) changes to non health tax provisions. These policy options are the third and final round of policy options for discussion before the Committee marks up legislation in June, 2009.

The policy option that should be of particular interest to hospitals in this latest round is the option to modify the requirements for tax-exempt hospitals by codifying organizational and operational requirements. Specifically, such requirements include generally, among other things, that tax-exempt hospitals (i) regularly conduct a community need analysis; (ii) provide a minimum annual level of charitable patient care; (iii) not refuse service based on a patient's inability to pay; and (iv) follow certain procedures before instituting collection actions against patients. In addition, the policy option provides for excise taxes designed to encourage compliance with the operational requirements. If chosen, this option could clearly impact a hospital's ability to care for its patients.

The question of what tax-exempt hospitals must do to maintain their tax-exemption, often posed as whether and how tax-exempt hospitals differ from for-profit hospitals, has arisen periodically since the IRS first articulated the "community benefit" standard in 1969. The "community benefit" standard was a move away from basing hospital tax-exemption on assistance to the poor; specifically, the community benefit standard eliminated the previous requirement that tax-exempt hospitals provide medical care to patients without charge or at rates below cost.

During this time, factors indicating that the hospital was operating exclusively to benefit the community included: (i) having a full-time emergency room where no one requiring emergency care is denied treatment; (ii) having a community board of directors; (iii) having an open medical staff; (iv) treatment of Medicare and Medicaid beneficiaries; and (v) the application of any surplus funds to improving facilities, equipment, patient care, and medical training, education, and research. For these purposes, medical education constitutes community benefit when it is directed at providing knowledge or training to professionals in the community at large as opposed to professional training for those specifically rendering services for the hospital, and medical research constitutes community benefit when it includes clinical and community health research, as well as studies on health care delivery that are generalizable, shared with the public, and funded by the government or a tax-exempt entity (including the hospital itself). The community benefit standard was prompted in part as a response to enactment of the Medicare and Medicaid programs and the expectation that the entire population would have

private or governmental insurance coverage, thus eliminating the need for charity care altogether. Obviously, this expectation did not materialize.

Still, this universal coverage expectation never fully disappeared, and in the 1970's, there were several failed attempts to pass health care reform legislation in the form of national health care. Health care measures in the 1970's that did succeed were focused instead on controlling the growing costs of Medicare and Medicaid programs, not on community needs. In the 1980's, the IRS clarified the community benefit standard by acknowledging that, while the operation of an emergency room for all members of the community was strong evidence of community benefit, in certain situations, operating an emergency room could be duplicative of services already offered by nearby hospitals. In these cases, community benefit would be demonstrated by other factors already articulated in the standard, including having a community board of directors, having an open medical staff, serving Medicare and Medicaid beneficiaries, and investing surplus funds in hospital resources. In short, by the 1980's, tax-exempt hospitals had moved from being required to serve all the medical needs of indigent populations to being able, in certain circumstances, to deny medical services to those unable to pay for their medical care. Interestingly, this meaningful evolution of the IRS's position towards tax-exempt hospitals had taken place over a span of less than thirty years.

A decade later in 1993, the Clinton administration health reform plan again aimed for universal coverage. The plan addressed the tax-exempt status of hospitals by requiring them to develop and implement, with community input, plans to meet the community's health care needs. This proposal was consistent with trends already evident at the state and national levels to monitor and document the special role of tax-exempt hospitals and their responsiveness to their communities. The proposed reform legislation required hospitals (on a periodic basis, but no less frequently than annually), with the participation of community representatives, to: (i) assess the health care needs of their communities and (ii) develop a plan to meet those needs in order to retain their tax-exempt status. The underlying assumption of this proposed legislation was that the hospital, together with the surrounding community and its natural constituencies, would best determine the community's needs, and thus the hospital was vested with the authority to essentially choose among the public goods to be offered. Of course, this proposed health reform was not enacted.

Over the past decade, the IRS's approach to determining tax exemption for nonprofit hospitals, as evidenced through IRS pronouncements, has refocused on the importance of providing free or subsidized care to needy populations, stressing that providing services to all, regardless of ability to pay, is strong evidence that the hospital is in fact operating for the benefit of the community.

Now, against this fluid backdrop of the standard of tax-exemption for hospitals, and as health reform and universal health coverage move to the front of the legislative agenda, what exactly tax-exempt hospitals must do in order to maintain their tax-exemption is part of that debate. This question is of particular interest to tax-exempt hospitals, even those that are "in the red," because the numerous benefits afforded to tax-exempt hospitals include access to tax-exempt financing and the ability to receive deductible charitable contributions, as well as income tax-exemption.

The conversation about what hospitals must do to maintain their tax-exemption, including a review of their community benefit practices, charity care and billing policies and care of the indigent and uninsured, has been gathering strength in this decade. In 2004, Senate Finance Committee staff proposed sweeping changes in the law affecting tax-exempt charities. Variants of some proposals became law with the Pension Protection Act of 2006, but the changes were not focused on health care organizations. However, Committee hearings in 2005 and 2006 did focus on whether hospitals were providing charity care and what the standard for tax-exemption should be. Moreover, in 2005, the IRS examined the executive compensation processes of a large number of nonprofit organizations, including hospitals. In 2006, the IRS distributed a Compliance Check Questionnaire to several hundred tax-exempt hospitals, focusing primarily on the community benefit standard and executive compensation, but also asking about the hospitals' billing and collection practices, and their governance, among other matters. The IRS published preliminary results from this project in 2007 and a final report, with extensive analysis of reported charity care and community benefit amounts, in February, 2009. This report is discussed in further detail here.

In 2007, Senate Finance Committee staff floated a proposal that would require hospitals to meet numerical standards for providing charity care and community benefit, as well as other specific requirements, including joint venture requirements, governance requirements and curtailing unfair billing and collection practices, in order to maintain tax-exempt status. Also in 2007, the IRS began rebuilding its Form 990, or exempt organization return, from the ground up. A new Schedule H of the redesigned Form 990 will now gather extensive data on tax-exempt hospitals' charity care and other activities. Unfortunately, data from the Schedule H will not be available until 2011 at the earliest, and change may not wait for the data to catch up.

On Friday, May 8, 2009, tax staff for Sen. Grassley indicated that a proposal for revamping hospital tax-exemption standards could be expected in two to three weeks. On Tuesday, May 12, 2009, at a Senate Finance Committee roundtable on financing health reform, Sen. Grassley questioned witnesses about whether hospitals should continue to be tax-exempt, particularly if the need for uncompensated care were reduced through universal coverage, and suggested that hospitals be taxed, but receive deductions or credits for their charitable activities.

Based on past IRS guidance and rulings, it is unlikely that the IRS will revoke tax-exemption for nonprofit hospitals that are providing community benefit. Moreover, based on IRS guidance in this area which does not focus on providing quantitative standards or require that community benefits be commensurate with the amount of benefits that a hospital receives, it also is very unlikely that the IRS would now discard its facts-and-circumstances historical measurement and instead pursue a quantitative/numerical standard for measuring charity care and community benefit. Indeed, whether hospitals should receive tax-exemption is one of the many items in the long list of changes suggested to raise health care-related revenue, which list also includes miscellaneous items such as modifying or repealing the itemized deduction for medical expenses and modifying the FICA Tax exception for students. Health reform financing is instead primarily targeted at two main components: (i) health systems savings, which include proposals to reform the health care delivery system; and (ii) modification of the exclusion for employer-provided health coverage to limit the value of such coverage that is excludible from gross income. Moreover, measuring community benefit is a very complicated task, as evidenced by Schedule H, and this complexity will likely prevent Congress from proposing any real or meaningful change to the basis for hospital exemption, particularly any proposals to impose quantitative minimums in the area of charity care, before it can fully review the community benefit reports from the various Schedules H, especially if health coverage becomes universal. As stated above, community benefit data from Schedule H will not be available until 2011 at the earliest.

Still, whether or not health reform with universal coverage moves forward, we can expect further debate on tax-exemption standards for hospitals. Indeed, if universal coverage becomes a reality, many will question whether hospitals which provide care only to the insured should continue to be tax-exempt. Similarly, if health reform does not move forward or does not expand coverage to all, pressure will undoubtedly continue for tax-exempt hospitals to meet their communities' needs on their own.

To position themselves most efficiently and effectively for this debate, tax-exempt hospitals may consider adopting the following practices:

- Hospitals will need to file a complete Schedule H for the calendar year 2009 or their fiscal year beginning in 2009, and should complete a mock Schedule H for the calendar year 2008 or their fiscal year beginning in 2008. Hospitals should evaluate and discuss that mock Schedule H with counsel to determine how to report their information on the actual Schedule H and whether they should file a Schedule H for the 2008 reporting year — earlier than required.

- Hospitals should minimize the burden of collecting and checking data for Schedule H, and avoid duplication of their efforts by immediately planning to integrate Schedule H information collection with other community benefit tabulation activities already in place (or which they will create).

- Hospitals should prepare community benefit reports, describing in detail the community benefits that they provide, if they do not already prepare such reports.

- Hospitals should aim to have their patient accounting processes reviewed with the assistance of staff who work in all levels of the process to determine whether they can collect data more efficiently and avoid duplication.

- Hospitals should, if they do not already do so, begin to assess how they can increase the amount of community benefit that they already provide to their communities and how they can better fill vital community needs.

- Perception and process are as important as the care actually delivered to patients. Board and committee meetings that do not discuss community benefit, board minutes that document only discussions on financial results, and incentive compensation goals that primarily focus on financial performance can give the impression – whether or not accurate – that community benefit is not the hospital's mission. Having a community benefit board committee or subcommittee, building community benefit reports into board meetings, and implementing similar steps demonstrate that the hospital's commitment to community benefit starts at the top.

Client Alert

Proskauer Rose LLP has one of the leading health care law practices in the world. We combine an intimate knowledge of the health care industry with the resources and depth of an international law firm with more than 700 lawyers in twelve cities across the U.S., South America and Europe. This unique blend of capabilities has enabled us to become an effective, trusted advisor to both well-established and emerging health care companies.

For more information, please contact:

Stuart L. Rosow	212.969.3150	srosow@proskauer.com
Elizabeth M. Mills	312.962.3538	emills@proskauer.com
Lee A. Barkan	212.969.3115	lbarkan@proskauer.com
Ellen H. Moskowitz	212.969.3232	emoskowitz@proskauer.com
A. Nicole Spooner	212.969.3623	aspooner@proskauer.com

Proskauer Rose is an international law firm that handles a full spectrum of legal issues worldwide.

You can also visit our Website at **www.proskauer.com**