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Health Reform Act Includes Additional Tax Exemption Requirements: What Tax-Exempt Hospitals Need to Do Now

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The Affordable Care Act (the "Act")[1] establishes, for the first time, specific statutory requirements that hospitals must meet to qualify as organizations described in Section 501(c)(3) of the Internal Revenue Code and exempt from federal income tax. These requirements are included in a new Section 501(r) of the Internal Revenue Code. For the most part, these requirements are effective for tax years beginning on or after the date of the Act's enactment – March 23, 2010. Thus, they are effective now for hospitals with tax years beginning in April, May, or June and will shortly be effective for the many hospitals whose tax years begin in July. The codification of these requirements has been under discussion for some time. Read our analysis of possible actions from one year ago.

One important point is that the requirements will be applied separately to each hospital operated by an entity, a significant difference from the general rule that federal income tax exemption is evaluated on an entity-wide basis. In addition, one of the requirements is that hospitals periodically conduct and report on a community health needs assessment; how the term "community health needs assessment" is interpreted by the IRS will determine whether this is a requirement that many hospitals will meet with minor tweaking of current activities. The IRS has now asked for comments on how these provisions can be implemented, along with comments on implementation of the requirements in general. Comments are requested by July 22, 2010. IRS Notice 2010-39 (the "Notice"), which summarizes the new law and asks for comments, is at http://www.irs.gov/pub/irs-drop/n-10-39.pdf.

Hospitals should review their operations to confirm that they comply with the new requirements and should prepare to report their compliance on a facility-by-facility basis on the Form 990, Schedule H. The specific requirements are as follows.

Definition of Hospital. The new requirements are applicable to any organization that operates as a hospital under state licensure rules and any other organization that the Treasury Secretary determines has the provision of hospital care as its principal function or purpose. (No such additions have been proposed to date.) The statute provides that if a hospital organization has more than one hospital facility, the organization must meet the new requirements separately with respect to each hospital, and that the organization will not be treated as a Section 501(c)(3) tax-exempt organization with respect to any facility not meeting the requirements. Beyond that, the statute does not specify what will happen if one or more of several hospital facilities operated by one entity fail to meet the requirements. The Notice asks for comments on what the consequences should be in this situation and the proper tax treatment for future periods.

Financial Assistance Policy. The first requirement specified in the Act is that the hospital must implement a written financial assistance policy. The Act does not impose a requirement that charity care be provided, but simply that the hospital must have a policy. The policy is to include: (i) eligibility criteria for financial assistance, and whether such assistance includes free or discounted care; (ii) the basis for calculating amounts charged to patients; (iii) the method for applying for financial assistance; (iv) in the case of an organization that does not have a separate billing and collections policy, the actions the organization may take in the event of non-payment, including collection actions and reporting to credit agencies; and (v) measures to widely publicize the policy within the community to be served by the organization.

In addition, the hospital needs a written policy that requires the provision, without discrimination, of care for emergency medical conditions to individuals regardless of the individuals' eligibility for assistance under the hospital's financial assistance policy. While most tax-exempt hospitals already have financial assistance policies and provide emergency care without consideration of ability to pay (consistent with their obligations under the Emergency Medical Treatment and Active Labor Act), hospitals should review their policies to make sure the required elements are clearly stated and conveyed to the public.

Limitation on Charges to Patients Receiving Partial Financial Assistance. The second requirement specified in the Act is that the hospital must limit the amounts charged for care provided to individuals eligible for assistance under the hospital's financial assistance policy to not more than the amounts generally billed to insured patients. (This requirement refers to patients who have qualified for partial financial assistance but are still responsible for a part of their bill.) The legislative history indicates that this requirement can be met by charging the best (lowest) negotiated commercial rates, an average of three best negotiated commercial rates, or Medicare rates. This is a ceiling; patients can of course be charged a lower amount for their remaining balance. Many hospitals already have some method to charge less than chargemaster rates for patients receiving partial financial assistance, in response to state law or otherwise. These methods should be reviewed to confirm that they are consistent with the Section 501(r) rule.

Billing and Collection Requirements. The third requirement is that the hospital must not engage in extraordinary collection actions before it has made reasonable efforts to determine whether the individual is eligible under the financial assistance policy. The legislative history indicates that reasonable efforts may include notifying patients concerning the financial assistance policy upon admission and in written and oral communications with patients before collection action or credit rating agency reporting is initiated. The legislative history gives lawsuits, liens on residences, arrests, and body attachments as examples of extraordinary collection actions. The Act provides that the IRS is to issue regulations as necessary to provide guidance on what are "reasonable efforts" to determine whether a patient is eligible under the hospital's financial assistance policy, and the Notice asks particularly for thoughts on this issue. Of possible relevance is that the Act provides that, beginning in 2014, hospitals will be able to qualify individuals for Medicaid coverage for a period of presumptive eligibility (regardless of whether the state Medicaid plan provides for presumptive eligibility); presumptive eligibility procedures for Medicaid now in place may provide some guidance.

Financial Statement. Another requirement is that the hospital must attach its audited financial statement, or the consolidated financial statement in which it is included, to its Form 990.

Community Health Needs Assessment. The final requirement specified in the Act is that the hospital must conduct and implement a community health needs assessment at least every three years. Such community health needs assessment must take into account input from persons who represent the broad interests of the community served, including those with expertise in public health. The community health needs assessment must be made widely available to the public. The hospital must report in the Form 990 how it is addressing the needs identified in the community health needs assessment and a description of the needs that are not being addressed together with the reasons why such needs are not being addressed.

Because a community health needs assessment need be conducted only every three years, this requirement is not effective until tax years beginning after March 23, 2012.

Further, the community health needs assessment requirement is the only requirement with a specific penalty for failure to comply. Under the newly added Section 4959 of the Internal Revenue Code, a hospital which fails to satisfy the community health needs assessment requirement is subject to a $50,000 excise tax for each tax year in which the requirement is not met.

The Notice particularly requests comments as to what may be appropriate requirements for a community health needs assessment. Many tax-exempt hospitals already prepare community service or community benefit plans under state law or participate in communitywide health planning. Practical comments to the IRS indicating current efforts and how they can be used to fulfill this requirement will undoubtedly be helpful to the IRS.

Agency Review and Reports. The Treasury Secretary is required to review at least once every three years the community benefit activities of each tax-exempt hospital. Presumably, this will be accomplished through a review of the information on Schedule H of the Form 990, with revisions to the Schedule H to accommodate separate reporting for each of the entity's hospitals.

Finally, the health reform legislation mandates the submission to Congress of certain agency reports by the Treasury Secretary, in consultation with the Secretary of Health and Human Services. One report, required annually, concerns levels of charity care, bad debt expense, and certain reimbursed costs of taxable, tax-exempt, and government hospitals. In addition, the Treasury Secretary must conduct a study and report on the trends of charity care not later than five years following enactment of the legislation.

With the expanded charity care and community benefit reporting required of hospitals on the new Schedule H to Form 990, tax-exempt hospitals have already been developing means to collect the required information. This information should be compiled on a facility-specific level as well. In addition, tax-exempt hospitals should review and, to the extent necessary, revise their financial assistance and other policies so that they can readily demonstrate that they meet the new requirements.

[1] "Affordable Care Act" means The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA).

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