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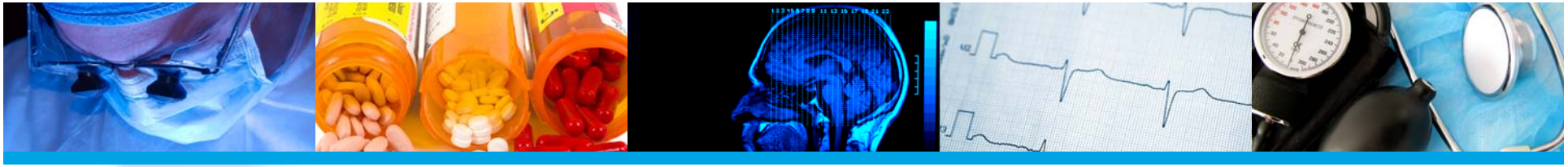
HEALTH CARE REFORM LEGISLATION: What Does It Mean for Exempt Organizations?

Taxation Section/Exempt Organizations Committee

District of Columbia Bar
Wednesday, April 28, 2010
Washington, D.C.



PRESENTERS

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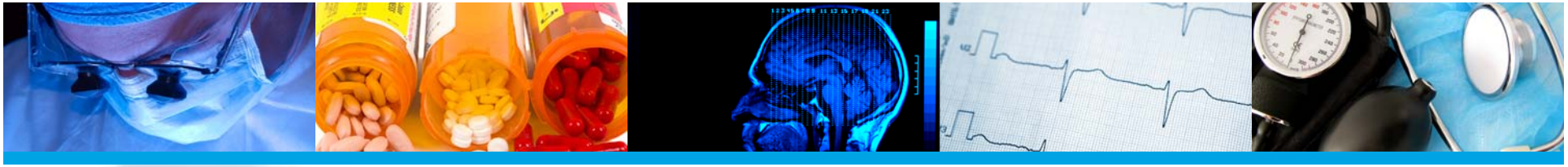
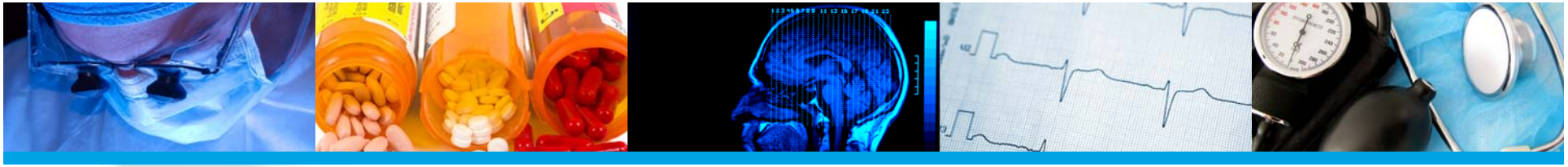


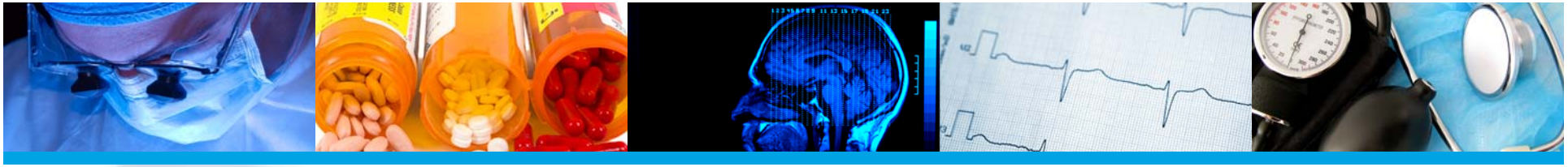
SUMMARY and OVERVIEW

- On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law.
- PPACA imposes four new substantive requirements that a hospital must satisfy to maintain its tax exemption.
  - Conduct a community health needs assessment once every three years
  - Adopt financial assistance policy
  - Limit charges for those qualifying for financial assistance
  - Refrain from extraordinary collection actions before making reasonable efforts to determine whether a patient qualifies for financial assistance



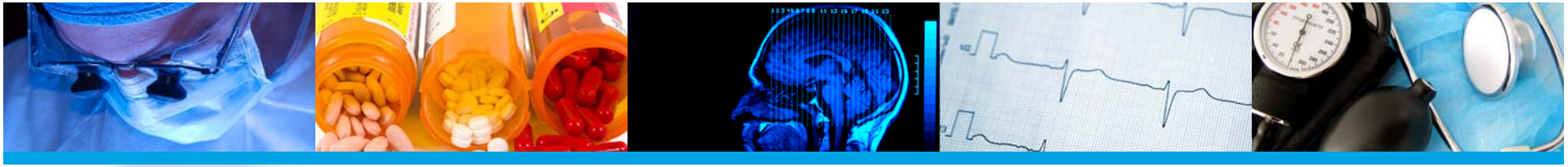
SUMMARY and OVERVIEW (continued)

- In addition, PPACA imposes three new mandates that will increase the flow of data from tax-exempt hospitals to the IRS, and from IRS/Treasury to Congress:
  - Tax-exempt hospitals must include and disclose additional information on Form 990 Schedule H (community needs assessment implementation and financial audits)
  - IRS must review every exempt hospital's community benefit activities as reflected on its Form 990/Schedule H at least once every three years
  - Treasury Secretary must report annually to Congress on comparative levels of hospital charity care and complete a Congressional study on emerging trends after five years



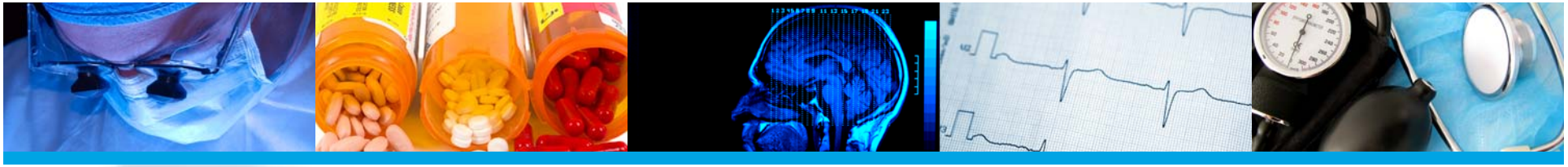
SUMMARY and OVERVIEW (continued)

- These new provisions are generally effective for taxable years beginning after the date of enactment.
  - E.g., if a hospital's fiscal/tax year begins on July 1, the new requirements go into effect 68 days from now
  - Effective date for completion of community needs assessment is delayed (consistent with the "once-every-three-years" requirement) to taxable years beginning two years after the date enactment
- What should you be doing now to assure that your organization/clients will meet the new requirements?
- What are the implications for the future of tax exemption?



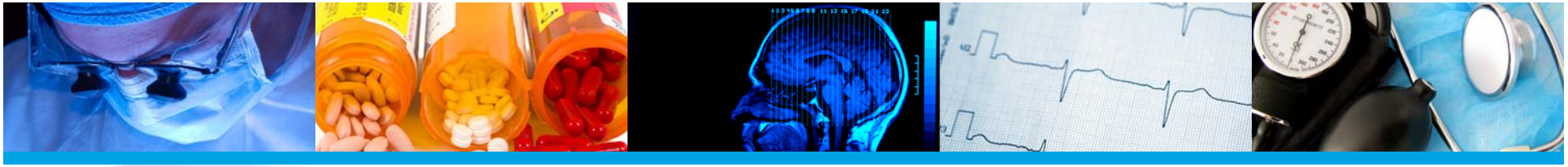
THRESHOLD ISSUES

- What organizations are subject to the new additional requirements?
  - Any 501(c)(3) organization which operates a facility which is required by a State to be “licensed, registered or similarly recognized as a hospital”
  - Any other organization which the Treasury Secretary determines “has the provision of hospital care as its principal function or purpose constituting the basis” for its tax status
- What about organizations that operate more than one hospital facility?
  - Organizations must meet the requirements “separately with respect to each such facility”
  - An organization shall not be treated as a 501(c)(3) with respect to any facility for which these requirements are not met



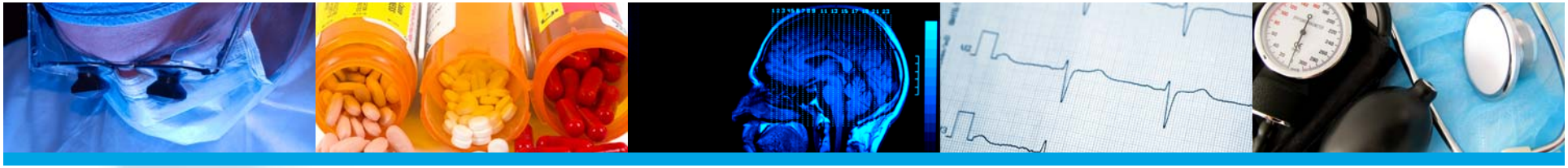
COMMUNITY NEEDS ASSESSMENT

- New Code Section 501(r)(3) requires each hospital to conduct a community needs assessment every three years and adopt implementation strategy to meet identified needs.
- Section 501(r)(3)(B) specifies that the needs assessment must "take into account" input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise in public health.
- Section 501(r)(3)(B) also specifies that the assessment be made widely available to the public.
- Under new Code Section 4959, failure to comply results in an excise tax penalty of up to $50,000.



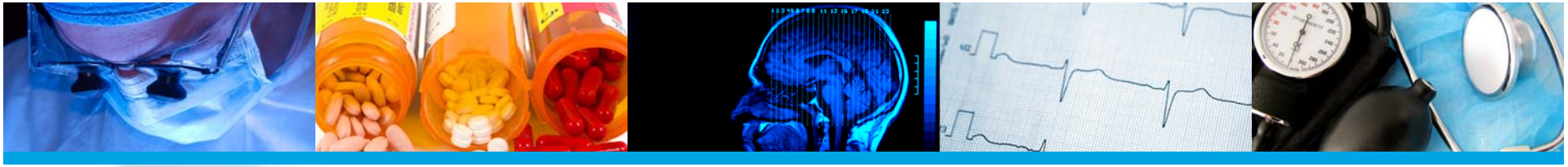
COMMUNITY NEEDS ASSESSMENT

- Legislative history of the PPACA clarifies that:
  - A community needs assessment may be based on current information collected by a public health agency or nonprofit organization
  - Two or more related or unrelated hospitals may jointly conduct a community needs assessment
  - No further specifics on what is included or how assessment is conducted or on how to make widely available to public
- Legislative history also clarifies how the $50,000 penalty will apply to an organization that consistently fails to satisfy the requirement (i.e., the three-year period rolls forward resulting in an additional penalty $50,000 each year).



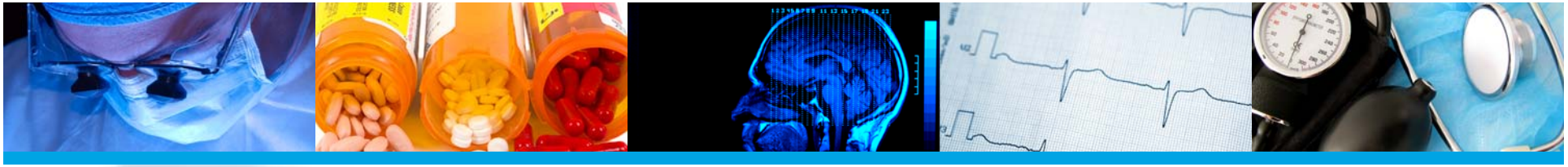
FINANCIAL ASSISTANCE POLICY

- The PPACA requires each tax-exempt hospital to adopt, implement and publicize a financial assistance policy.
- Under new Code Section 501(r)(4)(A), the policy must include the following:
  - eligibility criteria for such assistance, and whether it includes free or discounted care
  - the basis for calculating the amounts charged to patients
  - the method for applying for financial assistance
  - collection actions that will be taken in the event of non-payment (including reporting to credit agencies)
  - measures to widely publicize the policy within the hospital community



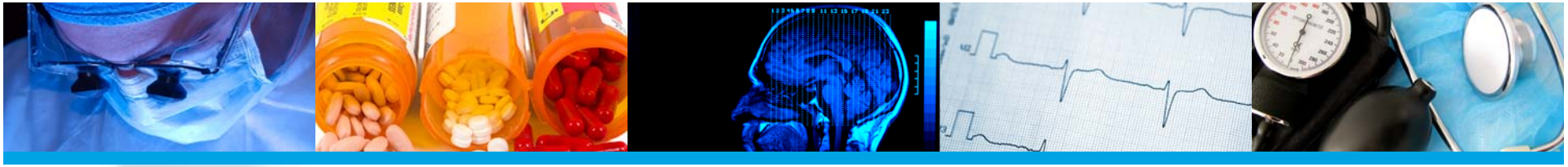
FINANCIAL ASSISTANCE POLICY

- New Code Section 501(r)(4)(B) also requires the hospital to adopt a written Emergency Medical Care (EMC) policy.
  - requiring organization to provide, without discrimination, care for "emergency medical conditions" (within the meaning of 42 U.S.C. 1395dd)
  - to individuals regardless of their eligibility under the organization's financial assistance policy
- This provision is in effect for taxable years beginning after March 23, 2010 (date of enactment).



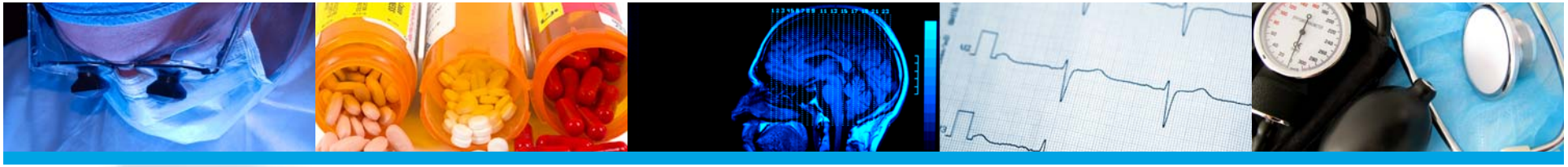
FINANCIAL ASSISTANCE POLICY

- 42 U.S.C. 1395dd sets forth the EMTALA standards for providing medical screening and necessary stabilizing treatment for emergency medical conditions and labor, as well as a definition of the term “emergency medical condition.”
- The PPACA legislative history states that the adopted EMC policy must prevent discrimination in the provision of medical treatment, including denial of service, against those eligible for financial assistance and those eligible for government assistance.
- Concern is whether this will functionally expand EMTALA obligations for non-profit hospitals.



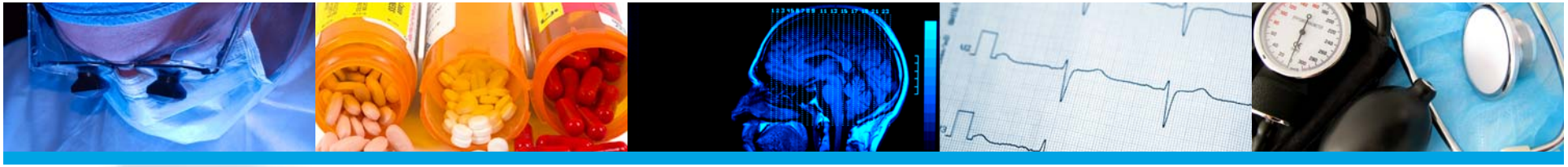
LIMITATIONS ON CHARGES

- New Code Section 501(r)(5)(A) (as amended by Section 102902 of the PPACA) requires organizations to limit charges for emergency or "other medically necessary care" provided to individuals who qualify for financial assistance to "the amounts generally billed" to individuals with insurance.
- New Code Section 501(r)(5)(B) requires hospital organizations to "prohibit the use of gross charges."
- These provisions are effective for taxable years beginning after March 23, 2010 (date of enactment).



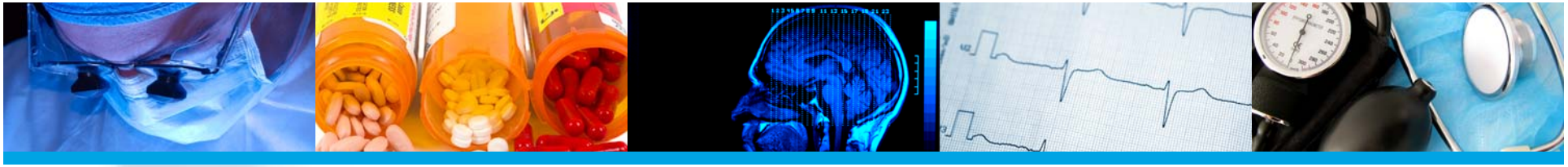
LIMITATION ON CHARGES

- The legislative history, in explaining the term “generally billed,” states that amounts billed to those who qualify for financial assistance may be based on:
  - (a) the best (or an average of the three best) negotiated commercial rates, or
  - (b) Medicare rates
- The legislative history further states that a hospital facility may not use gross charges (i.e., charge master rates) when billing individuals who qualify for financial assistance.



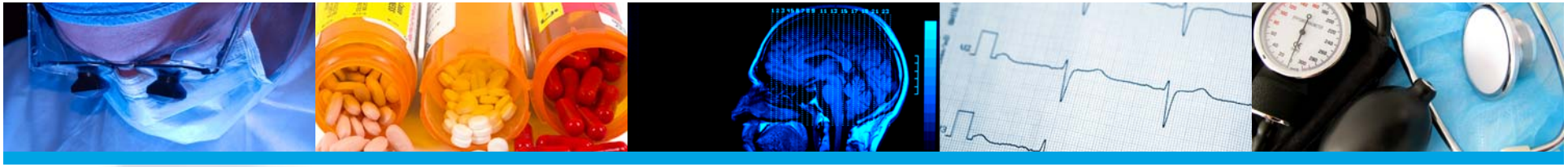
COLLECTION PROCESS

- New Code Section 501(r)(6) requires hospitals to refrain from engaging in "extraordinary collection actions" without first making "reasonable efforts" to determine whether the individual is eligible for financial assistance.
- This provision is effective for taxable years beginning after March 23, 2010.
- The legislative history gives the following examples of "extraordinary collection" actions: lawsuits, liens on residences, arrests, body attachments or other similar collections practices.



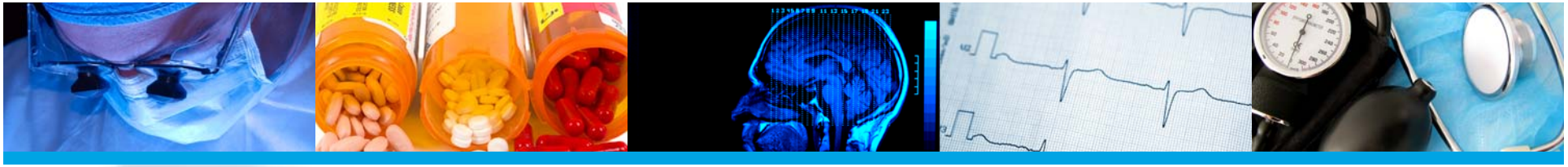
COLLECTION PRACTICES

- The legislative history states that "reasonable efforts" (to determine an individual's eligibility for financial assistance) include:
  - Notification by the hospital of its financial assistance policy to a patient upon admission
  - Notification regarding financial assistance in written or oral communications with the patient regarding the patient's bill (including invoices and telephone calls) before collection action or reporting to credit rating agencies is initiated
- Need for further regulatory clarification regarding what else might be considered "reasonable efforts."



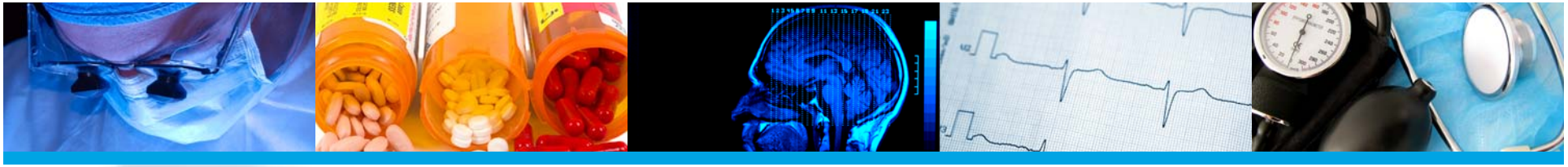
HOSPITAL REPORTING/DISCLOSURE

- Hospitals are already required to file a Form 990 (including the Schedule H) with the IRS annually.
- Section 9007(d) of PPACA imposes two new requirements on tax-exempt hospitals filing Form 990 and Schedule H:
  - Hospitals must now describe how they are addressing the needs identified in the community health needs assessment, as well as describe any identified needs that are not being addressed (and explain why not)
  - Hospitals must also include a copy of their audited financial statements with the tax return
- This provision goes into effect for taxable years beginning after March 23, 2010 (generally, for returns to be filed starting in late 2011 and 2012).



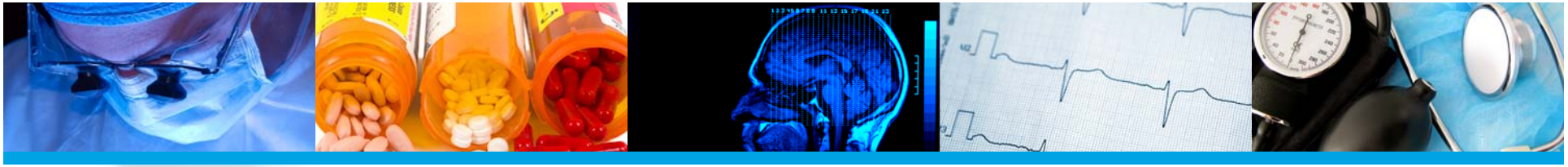
MANDATORY IRS REVIEW

- Section 9007(c) of the PPACA contains a rather unusual provision: It mandates Treasury/IRS to review the "community benefit activities" of every applicable 501(c)(3) hospital at least once every three years.
- The legislative history suggests that the mandated periodic review will focus on "information about a hospital's community benefit activities (currently reported on Form 990, Schedule H)."



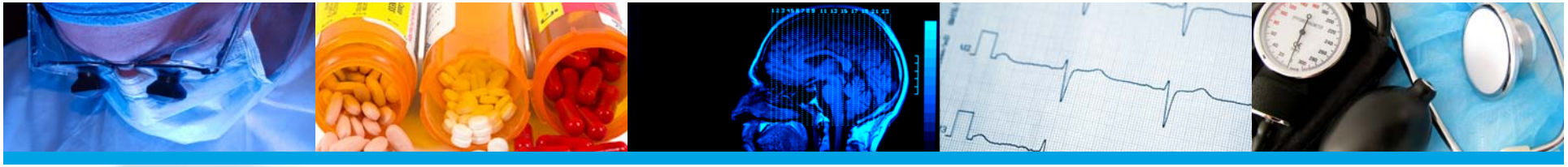
TREASURY REPORTS and STUDY

- Section 9007(e) of the PPACA requires the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, to provide an annual report to Congress that includes the following information for tax-exempt hospitals, taxable hospitals, and government hospitals:
  - levels of charity care
  - bad debt expenses
  - unreimbursed costs for services provided with respect to means-tested government programs
  - unreimbursed costs for services provided with respect to non-means-tested government programs



TREASURY REPORTS and STUDY

- The annual reports must also include information on costs incurred by tax-exempt hospitals for community benefit activities.
- The Secretary must also prepare a study on the trends emerging in the annual reports and submit it to Congress within 5 years.
- Query: How will Treasury obtain information on taxable hospitals that is in any respect comparable to the Form 990/Schedule H data it will have received on tax-exempt hospitals? Without comparable data, won't the results be skewed?



ANY QUESTIONS?

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