501(c)(3) Hospitals: Proposed IRS Rules under Section 9007 of the Affordable Care Act

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Summary

The Affordable Care Act (§9007) created several additional requirements for organizations that operate one or more hospital facilities seeking to maintain or achieve 501(c)(3) tax-exempt status. Specifically, current and future hospital facilities and organizations will have to (1) regularly perform a community health needs assessment, (2) create and publicize a financial assistance policy, (3) impose limitations on charges, and (4) adopt certain billing and collections policies. The Internal Revenue Service (IRS), Department of the Treasury, recently released proposed regulations providing guidance regarding these new requirements.

This report discusses these new requirements and regulations for hospitals in the context of the current standards for tax-exempt status. The discussion begins with an examination of the "charity care" and "community benefit" standards as tools to interpret the "charitable" requirement under Section 501(c)(3). The report next examines the four new requirements for tax-exempt hospitals: community health needs assessment, financial assistance policy, limitations on charges, and billing and collections conditions, as defined by the statute and the proposed regulations. The report concludes with a discussion about the enforcement of these new requirements and specific areas for which the Treasury Department and IRS are currently soliciting comments.

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Introduction

Adding Section 501(r) to the Internal Revenue Code (IRC), the Affordable Care Act (§ 9007) created several additional requirements for 501(c)(3) organizations that operate one or more hospital facilities. Each current and future hospital facility and organization will have to meet these requirements in order to maintain or achieve 501(c)(3) tax-exempt status. The Internal Revenue Service (IRS), Department of the Treasury, recently released proposed regulations providing guidance regarding these new requirements.[1]

This report discusses these new requirements and regulations for hospitals in the context of the current standards for tax-exempt status. The discussion begins with an examination of the "charity care" and "community benefit" standards as tools to interpret the "charitable" requirement under Section 501(c)(3). The report next examines the four new requirements for tax-exempt hospitals: community health needs assessment, financial assistance policy, limitations on charges, and billing and collections conditions, as defined by the statute and the proposed regulations. The report concludes with a discussion about the enforcement of these new requirements and specific areas for which the Treasury Department and IRS are currently soliciting comments.

Qualifications for 501(c)(3) Status

In order to qualify as a 501(c)(3) charitable organization, the organization must be "organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, educational purposes, or to foster national or international amateur sports competition, or for the prevention of cruelty to children or animals."[2] While the tax code does not provide a per se exemption for hospitals, a hospital tends to qualify for tax-exempt status as a "charitable" entity.[3]

In order to identify which organizations qualify as "charitable," the IRS has used the "community benefit standard" since 1969. According to Rev. Rul. 69-545, a hospital provides a community benefit if it "promot[es] the health of a class of persons that is broad enough to benefit the community."[4] The community benefit standard was formulated in response to problems regarding the scope and enforcement of the earlier "charity care standard."[5]

Established by Rev. Rul. 56-185, the charity care standard required hospitals to provide medical care services for free or at discounted cost to individuals unable to pay for those services.[6] A

[1] 77 Fed. Reg. 38147, 38151 (June 26, 2012). This is not the first guidance issued by the IRS regarding the Affordable Care Act's new requirements for tax-exempt hospitals. Notice 2010-39, 2010 IRB 24 (June 14, 2010) addressed the new requirements and solicited comments. Notice 2011-52, 2011 IRB 30 (July 25, 2011) described the community health needs assessment requirements (§501(r)(3)).

[2] IRC §501(c)(3).

[3] Technical Explanation of the Revenue Provisions of the Reconciliation Act of 2010, as amended in combination with the Patient Protection and Affordable Care Act, JCX-18-10, March 21, 2010.

[4] Rev. Rul. 69-545, 1969-2 C.B.117.

[5] *See* Rev. Rul. 69-545, 1969-2 C.B.117.

[6] Rev. Rul. 56-185, 1956-1 C.B.202.

contemporaneous House Report to Rev. Rul. 69-545 reflected the deliberate movement away from the charity care standard because of the "significant uncertainty [under that standard] as to the extent to which a hospital must accept patients who are unable to pay, in order to retain its exempt status."[7]

"Community Benefit Standard" Today

Before the enactment of the Affordable Care Act, Members of Congress, the health care community, and the IRS have expressed a common concern for the diminishing distinction between non-profit and for-profit hospitals and the corresponding difficulty of defining "community benefit." The IRS has attributed this trend to Medicare and Medicaid, because of which hospitals, both nonprofit and for-profit, are required to treat emergency care patients regardless of their ability to pay.[8] Similarly, a 2008 Government Accountability Office (GAO) report revealed that several of the factors presented in Rev. Rul. 69-545 to define "community benefit" were frequently exercised by both nonprofit and for-profit hospitals.[9] The report also concluded that variations in the definition of community benefit exercised by tax-exempt hospitals have led to differences in the types of benefits which they report.[10] The IRS has attempted to address these problems with the community benefit standard by quantifying the community benefit activities with the redesigned Schedule H and Form 990.[11]

These new statutory requirements established by the Affordable Care Act, however, seem to reflect a possible return to the "charity care standard" with the focus on providing financial assistance for those unable to pay for health care. While the new provisions stop short of requiring hospitals to provide free health care, the new policy requirements encourage hospitals to provide more transparency concerning the benefits offered to the community.

Explanation of Proposed Regulations

This section examines the guidance regarding the four new requirements for tax-exempt hospitals. The discussion begins with a brief description of the scope of the regulations relating to the definitions of "hospital facility" and "hospital organization." The section then analyzes the

[7] H. Rept. 91-413, pt. 1, at 43 (1969) (relating to the Tax Reform Act of 1969).

[8] Statement by Steven T. Miller, Commissioner, Tax Exempt and Government Entities, Internal Revenue Service, (Jan. 12, 2009), *available at* http://www.irs.gov/pub/irs-tege/miller_speech_011209.pdf.

[9] The factors are "(1) the operation of an emergency room open to all members of the community without regard to ability to pay; (2) a governance board composed of independent civic leaders; (3) the use of surplus revenue for facilities improvement, patient care, and medical training, education, and research; (4) the provision of inpatient hospital care for all persons in the community able to pay, including those covered by Medicare and Medicaid; and (5) an open medical staff with privileges available to all qualifying physicians." Government Accountability Office, "Nonprofit Hospitals, Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements," September 2008, at 14-15, *available at* http://www.gao.gov/new.items/d08880.pdf.

[10] Government Accountability Office, "Nonprofit Hospitals, Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements," September 2008, at 7, *available at* http://www.gao.gov/new.items/d08880.pdf.

[11] *See* Internal Revenue Service, *Draft Form 990 Redesign Project – Schedule H*, June 14, 2007, *available at* http://www.irs.gov/pub/irs-tege/draftform990redesign_schh_instr.pdf; Statement by Steven T. Miller, Commissioner, Tax Exempt and Government Entities, Internal Revenue Service, (Jan. 12, 2009), *available at* http://www.irs.gov/pub/irs-tege/miller_speech_011209.pdf.

four new requirements as presented in the proposed regulations: (1) community health needs assessment, (2) financial assistance policy, (3) limitation on charges, and (4) billing and collections policies.

Scope: Definition of Hospital Facility and Hospital Organization

The statute defines a hospital organization as "an organization which operates a facility which is required by a state to be licensed, registered, or similarly recognized as a hospital, and any other organization which the Secretary determines has the provision of hospital care as its principal function or purpose constituting its basis for its exemption under subsection (c)(3)."[12] The proposed regulations adapt this definition by distinguishing between a "hospital facility" and "hospital organization." The proposed regulations define "hospital facility" using the first half of the statute's definition: "a facility that is required by a state to be licensed, registered, or similarly recognized as a hospital."[13] A "hospital organization," under the proposed regulations, follows the second half of the statute's definition as an "organization recognized (or seeking to be recognized) as described in section 501(c)(3) that operates one or more hospital facilities."[14] The proposed regulation's definitions of "hospital facility" and "hospital organization" parallel those used by Schedule H of Form 990.[15] This distinction is significant, as the regulations assign certain responsibilities to either hospital facilities or organizations.

A hospital organization may consider multiple buildings operating under a single state license as a single hospital facility.[16] Future guidance will address whether a single hospital building operating under multiple state licenses should be treated as one or multiple hospital facilities.

The following requirements for tax-exempt status must be met on a facility-by-facility basis. Section 501(r)(2)(B) requires a hospital organization to meet the Section 501(r) requirements for each facility which it operates.[17]

Requirement #1: Community Health Needs Assessment

Under Section 501(r)(3), a hospital organization must conduct a community health needs assessment (CHNA) at least once every three taxable years.[18] The assessment should solicit input from persons who represent the broad interests of the community served by the hospital facility and those with specialized knowledge or expertise in public health.[19] In addition to the assessment, the hospital organization must then create and adopt an implementation strategy to address the needs identified through the assessment.[20] The statute also requires that the hospital

[12] IRC §501(r)(2)(A)(i)-(ii).

[13] Prop. Treas. Reg. §1.501(r)-1(b)(15), 77 Fed. Reg. 38147, 38161 (June 26, 2012).

[14] Prop. Treas. Reg. §1.501(r)-1(b)(16), 77 Fed. Reg. 38147, 38161 (June 26, 2012).

[15] Instructions for Form 990 Return of Organization Exempt from Income Tax, *available at* http://www.irs.gov/pub/irs-pdf/i990.pdf.

[16] 77 Fed. Reg. 38147, 38150 (June 26, 2012).

[17] IRC §501(r)(2)(B); Technical Explanation of the Revenue Provisions of the Reconciliation Act of 2010, as amended in combination with the Patient Protection and Affordable Care Act, JCX-18-10, March 21, 2010.

[18] IRC §501(r)(3)(A).

[19] IRC §501(r)(3)(B)(i).

[20] IRC §501(r)(3)(A)(i).

organization widely publicize the results of the CHNA to the public served by the hospital facility.[21] The Affordable Care Act added Section 4959, which imposes a $50,000 excise tax on a hospital organization that fails to meet the CHNA requirements.[22]

The recently proposed regulations defer to Notice 2011-52, which addresses the CHNA specifically. Future regulations will provide additional guidance regarding CHNA requirements; however, hospital organizations may rely on the provisions in the notice until further guidance is issued.[23] While the IRS plans to clarify the statutory requirements regarding the identity of "those who represent broad interests of the community," Notice 2011-52 outlines three groups whose view the CHNA must take into account: persons with specialized knowledge in public health, other agencies with current data regarding the community, and representatives or leaders of low-income and minority populations served by the hospital facility.[24]

The IRS is currently considering different methods regarding the documentation and administration of the CHNA to ensure flexibility so that the assessment matches the specific needs and resources of the individual communities served by the hospital facilities.[25] The IRS intends to require the documentation of a CHNA to include a prioritized description of the community needs identified as well as details of the assessment process to provide more accessibility and transparency.[26] The hospital organization must also report in its annual information return (i.e., Form 990) the CHNA results and a discussion of how the organization is addressing the needs identified by the assessment.[27] The IRS is also considering whether to permit public health agencies or non-profit organizations to conduct the community health needs assessment for the hospital organization.[28]

Requirement #2: Financial Assistance Policy

Section 501(r)(4) requires a hospital organization to establish for each hospital facility it operates a written financial assistance policy (FAP).[29] The FAP must include

> eligibility criteria for financial assistance and whether such assistance includes free or discounted care; the basis for calculating amounts charged to patients; the method for applying for financial assistance; in the case of an organization which does not have a separate billing and collections policy, the actions the organization may take in the event of non-payment, including collections action and reporting to credit agencies; and measures to widely publicize the FAP within the community served by the organization.[30]

[21] IRC §501(r)(3)(B)(ii).

[22] IRC §4959.

[23] 77 Fed. Reg. 38147, 38151 (June 26, 2012).

[24] Notice 2011-52, IRB 30 (July 25, 2011).

[25] Id.

[26] Id.

[27] Notice 2010-39, IRB 24 (June 14, 2010).

[28] Notice 2011-52, IRB 30 (July 25, 2011); Technical Explanation of the Revenue Provisions of the Reconciliation Act of 2010, as amended in combination with the Patient Protection and Affordable Care Act, JCX-18-10, March 21, 2010.

[29] IRC §501(r)(4).

[30] IRC §501(r)(4)(A)(i)-(v); Prop. Treas. Reg. §1.501(r)-4(b)(1)(i)-(v), 77 Fed. Reg. 38147, 38161 (June 26, 2012).

Eligibility criteria. The statute and regulations do not require particular eligibility criteria, but the FAP must specify whether discount, free care, or other assistance is available and the criteria an individual must satisfy to receive each type of assistance.[31] The IRS is considering whether a requirement is necessary for the FAP eligibility criteria to reflect the specific needs of the hospital facility's community.[32]

Amounts Charged. Regarding the basis for amounts charged to patients, the FAP should include a statement indicating that, following a determination of FAP-eligibility, an individual who is eligible for financial assistance will not be charged more for emergency or other medically necessary care than the amounts generally billed to individuals who have insurance covering such care.[33] Following the statement, the FAP should describe the method the hospital facility uses to determine the amounts generally billed to individuals who have insurance.[34] For example, the FAP, if applicable, must state the percentage of gross charges the hospital facility considers when determining the amounts generally billed to the individuals without health insurance.[35]

Application methods. The FAP must also discuss the application process, including information or documentation that an individual must submit as part of a financial assistance application.[36] The regulations prohibit the denial of financial assistance because of omission of information or documentation which the FAP does not specifically require.[37]

Nonpayment events. If the hospital facility does not have a separate billing and collections policy, the FAP should outline actions that the hospital organization may take in an event of nonpayment.[38] Beyond the specific actions responding to nonpayment, the proposed regulations also require the FAP to include the time frames and the authority which will determine whether extraordinary collections are necessary.[39] The IRS and Treasury Department have proposed to include definitions of "billing and collections policy" and "actions a hospital organization may take in the event of nonpayment" in the final regulations.

FAP publication. After the completion of the FAP, the hospital facility should publicize the policy widely within the community served by the facility.[40] The proposed regulations dictate four measures which must be included in the FAP regarding its publication. These requirements include measures ensuring the availability of paper copies of the FAP, the notification of visitors about the FAP through public displays, the notification of the community (specifically targeting those who are most likely to require financial assistance), and the availability of a plain language summary of the FAP in both hard copy and digital formats.[41]

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[31] Prop. Treas. Reg. §1.501(r)-4(b)(2), 77 Fed. Reg. 38147, 38161 (June 26, 2012).

[32] 77 Fed. Reg. 38147, 38151 (June 26, 2012).

[33] Prop. Treas. Reg. §1.501(r)-4(b)(2)(i)(C), 77 Fed. Reg. 38147, 38161 (June 26, 2012).

[34] Id.

[35] 77 Fed. Reg. 38147, 38151 (June 26, 2012).

[36] Prop. Treas. Reg. §1.501(r)-4(b)(3), 77 Fed. Reg. 38147, 38162 (June 26, 2012).

[37] 77 Fed. Reg. 38147, 38151 (June 26, 2012).

[38] Prop. Treas. Reg. §1.501(r)-4(b)(4), 77 Fed. Reg. 38147, 38162 (June 26, 2012).

[39] 77 Fed. Reg. 38147, 38152 (June 26, 2012).

[40] Prop. Treas. Reg. §1.501(r)-4(b)(5), 77 Fed. Reg. 38147, 38163 (June 26, 2012).

[41] 77 Fed. Reg. 38147, 38152-53 (June 26, 2012).

In addition to the financial assistance policy, Section 501(r)(4) also requires a hospital organization to establish an emergency medical care policy that ensures its hospitals will provide emergency medical care to individuals regardless of their eligibility under the organization's FAP.[42] The purpose of the emergency care policy is to "prevent discrimination in the provision of emergency medical treatment, including the denial of service, against those eligible for financial assistance."[43] The hospital facility's current emergency medical care policy may be considered sufficient if it prohibits such activities as demanding emergency department patients to pay before receiving treatment, conducting collection activities in the emergency department, or other actions that may discourage individuals from seeking emergency care.[44]

Previous comments on the regulations have expressed concern with the overlap of the new emergency medical care policy and the Emergency Medical Treatment and Active Labor Act (EMTALA).[45] The proposed regulations clarify that an emergency medical care policy will satisfy Section 501(r)(4) if it requires the same nondiscriminatory emergency medical care that would be required under the regulations implementing EMTALA.[46]

Requirement #3: Limitation on Charges

Section 501(r)(5) requires a hospital organization to limit amounts charged for medical care provided to those eligible for financial assistance under the FAP.[47] In the case of emergency medical care, the hospital organization cannot charge a FAP-eligible individual more than the amounts that would be generally billed to individuals covered by insurance for the same services.[48] In the case of other medical care, the hospital organization must charge less than gross charges for that care.[49]

The regulations outline two methods to determine amounts generally billed to individuals covered by insurance: the look-back method[50] and the prospective method.[51] The "look-back" method examines past Medicare only claims or Medicare and private insurance claims paid to the hospital facility to determine the amounts generally billed.[52] The "prospective" method requires the hospital facility to estimate the amount that would be paid by Medicare for that particular service if the FAP-eligible patient were a Medicare beneficiary.[53] Because these two methods are mutually exclusive, the hospital facility must choose a particular method and continue to use that

[42] IRC §501(r)(4).

[43] Technical Explanation of the Revenue Provisions of the Reconciliation Act of 2010, as amended in combination with the Patient Protection and Affordable Care Act, JCX-18-10, March 21, 2010.

[44] Prop. Treas. Reg. §1.501(r)-4(c)(2), 77 Fed. Reg. 38147, 38164 (June 26, 2012).

[45] The Emergency Medical Treatment and Active Labor Act (42 USC §1395dd) requires hospitals accepting federal Medicare funds to provide a medical screening examination and appropriate stabilizing treatment to all patients that come to the hospital's emergency department, regardless of the patients' ability to pay.

[46] 77 Fed. Reg. 38147, 38153 (June 26, 2012).

[47] IRC §501(r)(5)(A).

[48] Prop. Treas. Reg. §1.501(r)-5(a)(1), 77 Fed. Reg. 38147, 38165 (June 26, 2012).

[49] Prop. Treas. Reg. §1.501(r)-5(a)(2), 77 Fed. Reg. 38147, 38165 (June 26, 2012).

[50] Prop. Treas. Reg. §1.501(r)-5(b)(1), 77 Fed. Reg. 38147, 38165 (June 26, 2012).

[51] Prop. Treas. Reg. §1.501(r)-5(b)(2), 77 Fed. Reg. 38147, 38165 (June 26, 2012).

[52] 77 Fed. Reg. 38147, 38154 (June 26, 2012).

[53] 77 Fed. Reg. 38147, 38154 (June 26, 2012).

method.[54] The IRS and Treasury Department are requesting comments concerning more practical details relating to calculating amounts generally billed.

Section 501(r)(5) also prohibits the use of gross charges: the hospital facility's full price for medical care which the facility charges all patients before applying any deductions or discounts.[55] This blanket prohibition applies to any medical care, not just emergency care, received by FAP-eligible individuals.[56]

The proposed regulations acknowledge the possible timing difficulties coordinating the determination of FAP eligibility and billing for hospital care by providing a safe harbor for hospital facilities. If the FAP-eligible individual has not submitted a complete FAP application at the time of the billing and the hospital facility has made and continues to make reasonable efforts to determine whether the individual is FAP-eligible, a hospital facility will not have violated Section 501(r)(5) if it charges a FAP-eligible individual more than amounts generally billed for emergency care.[57] However, once the individual has been determined to be FAP-eligible, the hospital facility must reduce its charges for the excess amount the individual is later determined to owe as a FAP-eligible individual.[58]

Requirement #4: Billing and Collections

Section 501(r)(6) requires hospital organizations to make reasonable efforts to determine whether a person is FAP-eligible before engaging in extraordinary collection actions against the individual.[59] The notice proposed rule would define "reasonable efforts" to entail notifying relevant individuals about the FAP, providing sufficient information for the applicant in completing the FAP application, and documenting the determination process regarding whether the applicant is FAP-eligible.[60]

The proposed regulations provide a timeline in which these "reasonable efforts" may be conducted. The "notification period," during which the hospital facility must notify the patient about the FAP, ends on the 120th day after the hospital facility issues the first billing statement to the patient for the care. If by the end of this 120-day period the patient has not submitted a FAP application, the hospital facility may conduct extraordinary collection actions against the patient.[61] The "application period" when the hospital facility must accept and process a FAP application ends on the 240th day after the hospital facility issues the first billing statement to the patient for care.[62] The IRS and Treasury Department are considering shortening both these periods to ensure efficiency in the billing process for hospital facilities.

[54] 77 Fed. Reg. 38147, 38154 (June 26, 2012).

[55] Prop. Treas. Reg. §1.501(r)-1(b)(14), 77 Fed. Reg. 38147, 38161 (June 26, 2012).

[56] 77 Fed. Reg. 38147, 38155 (June 26, 2012).

[57] Prop. Treas. Reg. §1.501(r)-5(d), 77 Fed. Reg. 38147, 38166 (June 26, 2012).

[58] Prop. Treas. Reg. §1.501(r)-6(b)(4), 77 Fed. Reg. 38147, 38167 (June 26, 2012).

[59] IRC §501(r)(6).

[60] 77 Fed. Reg. 38147, 38156 (June 26, 2012).

[61] Id.

[62] Id.

Moving Forward: Enforcement and Future Guidance

Effective Dates

These new standards for tax-exempt hospital facilities and organizations will apply to taxable years beginning after the enactment of the Affordable Care Act (after March 23, 2010).[63] However, the requirements relating to the community health needs assessment (§501(r)(3)) will apply to taxable years beginning after March 23, 2012.[64]

Enforcement

Beyond the possible revocation of a hospital's tax-exempt status and the excise tax levied on hospital organizations that fail to meet the CHNA requirements, the regulations currently do not provide any guidance on the specific consequences or sanctions for failing to meet one or more of the Section 501(r) requirements.[65] The IRS and the Treasury Department are currently considering comments regarding enforcement and will address the issue in future guidance. Form 990 will continue to serve as a tool for the IRS to enforce accountability and transparency for tax-exempt hospitals.

Future Guidance

The Treasury Department and IRS are currently seeking comments concerning the following:

- Whether the definition of "hospital organization" includes the operation of hospital facilities through partnerships and disregarded entities.[66]
- Whether non-profit government hospital organizations may be exempted from the Section 501(r) requirements.[67]
- Additional community health needs assessment requirements.[68]
- The "look-back" and "prospective" methods, in particular relating to Medicare and gross percentage charges.[69]
- Whether a hospital facility may retain sufficient control over the collection actions when it sells a patient's debt to a third party.[70]
- The notification and application periods for the FAP and how to balance the patient's need to seek financial assistance and the hospital organization's interest in efficiency.[71]

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[63] Prop. Treas. Reg. §1.501(r)-7(a)(1), 77 Fed. Reg. 38147, 38169 (June 26, 2012).

[64] Prop. Treas. Reg. §1.501(r)-7(a)(2), 77 Fed. Reg. 38147, 38169 (June 26, 2012).

[65] 77 Fed. Reg. 38147, 38150 (June 26, 2012).

[66] *Id.* at 38150.

[67] *Id.* at 38150.

[68] Notice 2011-52, IRB 30 (July 25, 2011).

[69] 77 Fed. Reg. 38147, 38154 (June 26, 2012).

[70] *Id.* at 38156.

- How to provide flexibility regarding the FAP application and the hospital facility's financial management.[72]

Conclusion

Section 501(r) and corresponding regulations require more transparency and accountability on behalf of hospitals in order to maintain their tax-exempt status. The community health needs assessments obligate hospitals to recognize the health needs of the community and also to implement a strategy to address these needs. While the financial assistance policy itself does not automatically provide patients with financial aid for hospital services, it provides more transparency regarding the application process for financial assistance by ensuring that information relating to eligibility criteria, the basis for determining costs, the application methods, and actions for nonpayment is more accessible and available to patients and the community. Similarly, the imposition of a limit on charges for FAP-eligible individuals and an obligation to undertake reasonable efforts to determine whether an individual is FAP-eligible before conducting extraordinary collection actions are intended to support a tax-exempt hospital's commitment to community benefit and service.

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(...continued)

[71] Id.

[72] *Id.* at 38158.

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