Health Care Reform Legislation Imposes New Requirements on Tax-Exempt Hospitals

The Patient Protection and Affordable Care Act (the Act), signed into law last week, imposes four new requirements on non-profit hospitals in order to maintain their tax-exempt status. The new requirements apply to any organization that operates at least one facility required by a state to be licensed, registered or similarly recognized as a hospital, and any other organization the IRS determines has the provision of hospital care as the principal function or purpose for which it obtained tax-exempt status. For any tax-exempt organization that owns and operates more than one hospital facility, each facility must meet the new requirements.

With the exception of the community health needs assessment detailed below, these requirements are generally effective for taxable years beginning after March 23, 2010. Therefore, hospitals must take action to adopt policies and procedures to meet these requirements before the beginning of their next taxable year.

The Act amends the Internal Revenue Code to specify that a hospital will not be treated as tax exempt unless it meets the following requirements:

1. Community Health Needs Assessment. Each hospital must conduct a community health needs assessment at least once every three taxable years and adopt an implementation strategy to meet the community health needs identified through the assessment. The 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. According to the Joint Committee on Taxation Report (the Committee Report) issued to explain the Act's provisions, the assessment could be based on current information collected by a public health agency or non-profit organization, and it may be conducted with one or more other organizations, including related organizations. The assessment must be made widely available to the public. An excise tax penalty of $50,000 will be imposed on hospitals that fail to complete this assessment within the applicable three-year period. Unlike the other three requirements outlined below, this requirement is effective for taxable years beginning after March 23, 2012 (since hospitals must complete the community health needs assessment by the end of the taxable year beginning after March 23, 2012 however, the three-year period effectively starts running now).

The Act also requires the Secretary of the Treasury (or a delegate) to review the community benefit activities of each tax-exempt hospital at least once every three years and requires hospitals to include the following additional information on the IRS Form 990: 1) a report that describes how the hospital is addressing the needs identified in the assessment, along with a summary of needs that are not being addressed and an explanation why; and 2) audited financial statements. Note that the revised Form 990 (first filed for fiscal years beginning in 2008) includes a new Schedule H for hospitals, but that hospitals are not required to complete most of that Schedule—including a new section on community benefits—until the fiscal year beginning in 2009. Presumably, the IRS will incorporate the Act's requirements into a revised version of Schedule H.

2. Financial Assistance Policy. The Act requires hospitals to adopt, implement and publicize a policy that includes: 1) eligibility criteria for financial assistance and whether such assistance includes free or discounted care; 2) the basis for calculating amounts charged to patients; 3) the method for applying for financial assistance; and 4) 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 collections action and reporting to credit agencies. Each hospital must also adopt a written policy relating to emergency medical care that requires the organization to provide, without discrimination, care to individuals for emergency conditions regardless of their eligibility under the organization's financial assistance policy.

3. Limitations on Charges. The Act requires hospitals to limit the charges for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy to not more than the amounts generally billed to individuals who have insurance that covers such care. Hospitals also may not use gross charges when billing individuals who qualify for such care. The term "gross charge" is not defined in the Act, but is generally used to mean the full cost that a hospital charges without applying a discount negotiated with insurance providers. According to the Committee Report, the intention is that amounts billed to those qualifying for financial assistance will be based on either the best, or an average of the three best, negotiated commercial rates or Medicare rates. The impact of this provision may be lessened by 2014 when most citizens will be required to have health insurance coverage or face penalties.

4. Billing and Collections Requirements. A hospital may not engage in extraordinary collection actions before making reasonable efforts to determine whether an individual is eligible for assistance under the organization's financial assistance policy. The Committee Report indicates that extraordinary actions may include lawsuits, liens on residences, arrests, body attachments or other similar procedures. Congress has directed the IRS to issue guidance concerning what constitutes "reasonable efforts," and intends, as explained in the Committee Report, for this to include notification by the hospital of the financial assistance policy upon admission, and written and oral communications with the patient regarding the patient's bill before collection action or reporting to credit agencies is begun.

Prior to the adoption of the Act, hospitals seeking exemption from income tax had to be organized and operated exclusively for a charitable purpose, and satisfy the IRS-created "community benefit" standard, as outlined primarily in Revenue Ruling 69-545. It remains to be seen whether the IRS will continue to apply the community benefit standard as it has in the past, using the Act's requirements as a supplement, or whether the standard will be re-tooled significantly as a result of both these new requirements and other aspects of the health care reform legislation.

Contact Information

If you have any questions about the new requirements or related issues, please contact your usual Ropes & Gray attorney.

IRS Circular 230 Notice

To ensure compliance with requirements imposed by the IRS, we inform you that any U.S. tax advice contained herein is not intended or written to be used, and cannot be used by any taxpayer, for the purpose of avoiding U.S. tax penalties.