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August 04, 2010

Buried in Patient Protection and Affordable Care Act is a section entitled simply, "Additional Requirements For Charitable Hospitals." This section revokes a charitable hospital's tax-exempt status under section 501(c)(3) of the Internal Revenue Code of 1986 if the hospital fails to meet any of the following four specific requirements.

Requirements for Charitable Hospitals

1. Community health needs assessment. First, a charitable hospital must conduct a community health needs assessment once every three years (in the taxable year or in either of the two years preceding the taxable year) and must adopt an "implementation strategy to meet the community health needs identified" by the assessment. The assessment must take into account input from "persons who represent the broad interests of the community served" by the hospital, including those with a knowledge of or expertise in public health, and it must be made widely available to the public.

2. Financial assistance policy. Second, the hospital must have a financial assistance policy that includes: (i) eligibility criteria for financial assistance, and whether the assistance includes free or discounted care; (ii) the basis for calculating amounts charged to patients; (iii) the method for applying for financial assistance; (iv) if the hospital does not have a separate billing and collections policy, the actions the hospital may take in the event of non-payment, including collections actions and reporting to credit agencies; and (v) measures to widely publicize the policy within the community to be served by the hospital.

3. Limitations on charges. Third, the hospital must implement limitations on charges. The amounts charged by hospitals for emergency or other medically necessary care to patients eligible for assistance under the financial assistance policy must be limited to amounts that are not more than those charged to patients who have insurance, and hospitals are prohibited from "the use of gross charges." The staff of the Joint Committee on Taxation explains the "limitation on charge" requirement this way in its March 21, 2010 report:

Each hospital facility is permitted to bill for emergency or other medically necessary care provided to individuals who qualify for financial assistance under the facility's financial assistance policy no more than the amounts generally billed to individuals who have insurance covering such care. A hospital facility may not use gross charges (i.e., "chargemaster" rates) when billing individuals who qualify for financial assistance. It is intended that amounts billed to those who qualify for financial assistance may be based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rates. [JCT Report, p. 82]

4. Billing and collection policy that includes "reasonable efforts" to determine assistance eligibility. Fourth, and finally, the hospital must have a billing and collection policy that requires it to make "reasonable efforts" to determine whether the patient is eligible for assistance under the financial assistance policy before taking "extraordinary collection actions." For example, if an insured patient has a high deductible or coinsurance amount, the hospital must determine whether the patient qualifies for financial assistance before it bills the patient, as qualification may impact the dollar amount the hospital is permitted to bill.

Penalty for noncompliance is high: loss of tax-exempt status, compounded by a penalty (or

"excise tax") of $50,000 per year for failure to satisfy the community health needs assessment requirements. t will be up to the IRS to adopt regulations setting forth the parameters for hospital compliance with these PPACA mandates. The IRS recently published Notice 2010-39 – "Request for Comments Regarding Additional Requirements for Tax-Exempt Hospitals" (http://www.irs.gov/pub/irs-drop/n-10-39.pdf). Comments were due for submission to the IRS by July 22, 2010.

Notably, sections 501(r)(5) and (6), the sections requiring limitations on hospital charges and billing and collections policies, respectively, take effect for tax years beginning after March 23, 2010 (the date of enactment of PPACA).

The Evolution of Tax-Exemption Under §501(c)(3)

Hospitals are exempt from federal taxation if they are "organized and operated exclusively for . . . charitable . . . purposes." I.R.C. § 501(c)(3). The Internal Revenue Service first interpreted this language in 1956 to require hospitals to provide free or discounted medical services to maintain their tax-exempt status. This interpretation lasted for fourteen years before Revenue Ruling 69-545 came down. In what became known as the "community benefit" standard, the IRS ruled that hospitals maintain their tax-exempt status not by providing a required minimum level of charity care, but through promotion of health for the benefit of the community. Determinations of a hospital's tax-exempt status, therefore, were fact sensitive, requiring a case-by-case analysis. However, it appeared that, under this interpretation of the statute, hospitals could maintain their tax-exempt status without providing any specific level or quantity of charitable or discounted service.

This seemingly amorphous language plagued the IRS for years. For example, Revenue Ruling 83-157 attempted to clarify Revenue Ruling 69-545 by determining that having a fully operational emergency room was not required for tax-exemption, but was merely one of several factors that could be considered. However, it remained the IRS's position under the "community benefit" standard that charitable care was not a requisite for tax exemption.

To begin to shift that policy position, in Field Service Advice 200110030 the IRS determined that the promotion of health and mere adoption of a charity care policy is not enough to maintain tax-exempt status. The IRS identified fourteen factors to consider for a hospital to maintain its tax-exempt status; for example, the IRS determined that the hospital's charity care policy must be communicated to the public, that a reasonable amount of charity care must be provided, and that charity care patients cannot be routinely discriminated against. Furthermore, in its 2002 Healthcare Update, the IRS reaffirmed that the implementation of a charity care policy is a "highly significant factor" to satisfy the "community benefit" standard. Thus, providing free or discounted medical services remained very important to attaining or maintaining tax-exempt status.

The Genesis of the Requirements for Charitable Hospitals in PPACA

Hospitals' pricing policies began to be scrutinized in 2004. In June 2004, the House Ways and Means Subcommittee on Oversight and the Energy and Commerce Subcommittee on Oversight and Investigations held hearings reviewing the pricing and billing and collections procedures of hospitals. Spearheading the effort to reform the standards for obtaining and maintaining

tax-exempt status was Senator Charles Grassley. Given the IRS's amorphous "community benefit" standard, Grassley's goal was to encourage hospitals to proffer their own reform proposals so providers would produce a single definition of charity care and identify a requisite level of care necessary for tax exemption.

Sen. Grassley's efforts began on May 25, 2005 by writing a letter to ten non-profit hospitals asking them to justify their § 501(c)(3) tax exemptions. His several questions related to each hospital's charitable care efforts and the reasonableness of their discriminatory pricing schemes for medical care. The answers to these questions would assist Congress in "considering the issues of tax-exempt organizations and particularly the duties and requirements of public charities in relation to the billions of dollars in tax benefits that tax-exempt organizations receive at the federal, state and local level." The IRS initiated their own investigation in April 2006 by sending questionnaires to almost 600 hospitals to determine how each satisfied the "community benefit" standard.

In an effort to establish a definable standard for tax exemption, on March 8, 2006, Sen. Grassley wrote a letter to the AHA asking how Congress should define "care for the needy." Concerned for the financial well-being of hospitals and arguing that hospitals were already in compliance with Revenue Ruling 69-545, Senior Vice President for Federal Regulations Thomas Nickels expressed hesitation about any new laws further regulating requirements under § 501(c)(3).

In addition to seeking definable standards, Sen. Grassley also sought to improve transparency so the public could evaluate the charitable acts of various hospitals. On May 29, 2007, Sen. Grassley wrote a letter to Treasury Secretary Henry Paulson urging him to update Form 990 since it "has not kept up with modern practices in the charitable sector." Sen. Grassley recommended that the Form include "more detailed questions tailored to the specifics of their fields if transparency and openness are to have real value."

As a result of these recommendations, in Dec. 2007, Form 990 and its accompanying schedules were ultimately revised. Schedule H was created and applied only to tax-exempt hospitals. Specifically relevant, Part I of Schedule H requires tax-exempt hospitals to report the total amount of "Charity Care and Certain Other Community Benefits at Cost." The Instructions for Part I of Schedule H reiterate that Part I "requires reporting of . . . the cost of certain charity care and other community benefit programs." These new federal reporting standards reflecting the cost of care, as opposed to the fees charged for medical services, "establish … a uniform framework for how hospitals nationwide must report aggregate community benefit and related information on billings and collections, including data on charity care, benefits to the community, 'community building' activities, Medicare underpayments, bad debt expenses, and emergency department policies and procedures."

In 2009, Sen. Grassley converted his years of research into drafts of several legislative reforms that attempted to clarify the requirements for tax-exempt status under § 501(c)(3). Support for Sen. Grassley's legislative reforms transcended party affiliations. These same provisions were included in § 9007 of the PPACA; ironically, however, Grassley ultimately voted against PPACA.

Patients' Attempts to Enforce § 501(c)(3) in Federal Court

Several complaints have been filed in federal court by uninsured, indigent patients for monetary damages against tax-exempt hospitals that charge uninsured patients medical fees significantly exceeding the fees charged to privately insured patients or patients covered by Medicare or Medicaid. Generally, the complaints alleged:

1) Third-party breach of contract between hospitals and the federal government; 2) third-party beneficiary claims for breach of the same alleged contract; 3) breach of duty of good faith and fair dealing, based on the alleged contract; 4) breach of charitable trust for failure to provide affordable medical care to the uninsured in exchange for federal, state, and local tax exemption; and 5) unjust enrichment and constructive trust, also based on the theory that the hospitals owed a duty to provide affordable medical care to the uninsured in exchange for federal, state, and local tax exemptions.

All federal courts have held that plaintiffs fail to establish standing to sue under § 501(c)(3) (e.g., Lorens v. Catholic Health Care Partners). After finding plaintiffs failed to establish standing, courts have uniformly rejected each claim on the merits. Therefore, patients have been unsuccessful in challenging discriminatory pricing schemes in federal court.

It is worth noting that federal courts have also held that federal law does not prohibit "balance billing" Medicare patients charges for medical services after primary Medicare and Medigap coverage has been exhausted (e.g., Vencor, Inc. v. Physicians Mut. Ins. Co.). The court concluded that 42 U.S.C. § 1395cc(a)(1)(A) had "nothing to do with charges for post-Medicare services" and "So radical a scheme as imposition of price controls on medical services not covered by Medicare requires explicit language, not mere brooding purposes." On the other hand, at least one New Jersey court has held that "state[s] . . . may lawfully enact a regulatory scheme which, in part, limits the 'appropriate standard of payment' by a Medigap patient to the DRG payment" (Valley Hosp. v. Kroll). Finding the hospital;s balance billing policy constituted a contract of adhesion and therefore was unenforceable; the court ultimately determined that the amount paid to the hospital by the Medigap insurer was reasonable under state law.

States' Attempts to Quantify "Community Benefit" Under State Law

As a result of the inherent vagueness of the "community benefit" standard, several states have attempted to quantify the level of charity care required to qualify for tax-exempt status under state law. Recent case law in Illinois is illustrative. In Provena Covenant Med. Cent. v. Dep't. of Revenue, Provena Covenant Medical Center employed a pricing scheme in 2002 that charged uninsured patients "established rates, which were more than double the actual costs of care" while charging privately insured patients or patients enrolled in Medicare or Medicaid discounted rates for the same medical care. Additionally, only 302 of its approximately 110,000 total patients received charitable medical care at a reduced price. Furthermore, PCMC only waived $831,724 in actual costs (0.723% of total revenue) for medical services, yet received $1.1 million in property tax exemptions. Given these facts, among others, the Illinois Supreme Court held that PCMC failed to qualify as a tax-exempt hospital for purposes of a state property tax exemption.

Another example of an attempt to define requirements related to charity care can be found in

Texas which has, in part, codified its quantitative requirements for charity care. Under Tex. Health & Safety Code Ann. § 311.045 (a) (Vernon 2010), a tax-exempt hospital must meet the standards set forth in subsection (b) to satisfy its charity care requirements. Subsection (b) states that hospitals can satisfy the charity care requirement by providing charity care and government-sponsored indigent health care in one of three ways: 1) "at a level which is reasonable in relation to the community needs, as determined through the community needs assessment, the available resources of the hospital or hospital system, and the tax-exempt benefits received by the hospital or hospital system;" 2) "in an amount equal to at least 100 percent of the hospital's or hospital system's tax-exempt benefits, excluding federal income tax;" or 3) by demonstrating that "charity care and community benefits are provided in a combined amount equal to at least five percent of the hospital's or hospital system's net patient revenue, provided that charity care and government-sponsored indigent health care are provided in an amount equal to at least four percent of net patient revenue."

These examples of statutory provisions and case law decisions are indicative of the legal trends at the state level to quantify specific charity care requirements for local tax-exempt status.

From the Field: Billing and Collections by a For-Profit Hospital System

HCA is the largest private operator of health care facilities in the world and serves as a leader in the health care industry. HCA's pricing, billing and collection practices can serve as an example for the non-profit hospital industry. In June 2004, HCA CEO Jack Bovender, Jr. addressed the House Energy and Commerce Committee Subcommittee on Oversight and Investigations to discuss hospital billing and collection practices. Although HCA employed a pricing scheme that charged uninsured patients more than insured patients, Mr. Bovender criticized the practice, noting "the chargemaster system on which hospitals rely to set pricing and billing codes has a forty-year history of changes that has distorted the relationship between price and cost." He went on to say that "HCA is now seeking to develop a pricing structure for the uninsured that is more reflective of the actual cost of providing the care."

In 2007, HCA increased the transparency of its pricing structure by introducing the Patient Financial Resource, a pricing transparency initiative employed at HCA's several hospitals that provides a "pricing estimate for [its] most frequently used healthcare services, payment options and alternatives available to patients without healthcare coverage and contact information to call [HCA] directly for a pricing estimate." This initiative paralleled the efforts of Sen.Grassley at the federal level to increase the transparency of tax-exempt hospitals' pricing schemes.

Conclusion

Determining whether a charitable hospitals' billing and collection scheme violates federal law is fact-sensitive and depends upon several factors, including the status of the patient under the financial assistance policy, and the type of medical service rendered. It is clear from PPACA that patients must be informed of the existence of the hospital's financial assistance policy and that qualified patients may qualify for free or discounted medical services. Not only must hospitals comply with PPACA by making "reasonable efforts" to determine if patients qualify for financial assistance before pursuing "extraordinary collection actions," the amount hospitals may charge qualified patients for emergency or medically necessary care is limited. Discriminatory pricing schemes may also jeopardize a hospital's tax-exempt status if the

government determines that the hospital has failed to satisfy its charitable mission under the "community benefit" standard set forth in Revenue Ruling 69-545.

The trend toward price transparency efforts, led in part by HCA, may help further ensure not only that uninsured and underinsured patients are not unfairly charged by tax-exempt hospitals, but that hospitals receive fair revenue for medical services necessary to allow the hospitals to continue to operate in a manner that benefits the community.

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[1] Note also that Section 2719A of PPACA, "Patient Protections," provides that emergency services must be covered by insurers in a manner that does not discriminate against a patient using an out-of-network hospital. The patient's "cost-sharing requirement (expressed as a copayment amount or coinsurance rate) … [must be] the same requirement that would apply if such services were provided in-network."

2 Hospitals that routinely screen patients for charity care or government-sponsored program eligibility may believe they meet (or may, in fact, actually meet) the requirement that they make "reasonable efforts" to determine whether patients qualify for financial assistance, but a hospital should evaluate its financial assistance policy to see whether patients who do not qualify for government assistance or government-sponsored programs may still be eligible for discounted or free care. If a "reasonable effort" is not made to communicate the parameters of the hospital's financial assistance policy to each and every patient (for example, if "reasonable efforts" are only made for patients thought to be eligible for government assistance or government-sponsored programs), the hospital should be wary of sending any patient's account to a collection agency.

3 See Rev. Rul. 56-185, 1956-1 C.B. 202.

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

5 See Lisa Kinney Helvin, Caring for the Uninsured: Are Not-For-Profit Hospitals Doing Their Share? 8 Yale J. Health Pol'y L. & Ethics 421, 442 (2008).

6 Rev. Rul. 83-157, 1983-2 C.B. 94.

7 Note that FSAs have no precedential value.

8 Leah Snyder Batchis, Comment, Can Lawsuits Help the Uninsured Access Affordable Hospital Care? Potential Theories for Uninsured Patient Plaintiffs
, 78 Temp. L. Rev. 493, 511 (2005).

9 See Carol Pryor et al., Access Project & Cmty. Catalyst, Best Kept Secrets: Are Non-Profit Hospitals Informing Patients About Charity Care Programs?
6 (2010). The goal of this project was to randomly survey 99 hospitals to determine if hospitals were generally complying with the American Hospital Association's ("AHA") voluntary guidelines to make their financial assistance policies public, communicate the policies to patients in a meaningful and easily understandable way, and have easily understandable written policies for patients to determine if they qualify for financial assistance.
See
Pryor et al.,
supra
, at 2. It was found that: 1) 85 hospitals mentioned the availability of charity care; 2) 42 hospitals provided application forms; 3) 26 hospitals provided information regarding eligibility criteria for charity care; and 4) 34 hospitals provided information in a language other than English.
Id.
at 3.

10 See John M. Quirk, Turning Back the Clock on the Health Care Organization Standard for Federal Tax Exemption , 43 Willamette L. Rev. 69, 89 (2007) (attempts to quantify charity care under state law).

11 See Press Release, Senator Chuck Grassley, Grassley Asks Non-Profit Hospitals to Account for Activities Related to Their Tax-Exempt Status
(May 27, 2005).

12 Marilyn E. Phelan, Nonprofit Organizations: Law and Taxation §21:13 (2010).

13 See Press Release, Senator Chuck Grassley, Sen. Grassley Works to Build Confidence in Nonprofits With Greater Transparency (May 29, 2007).

14 See Press Release, Senator Chuck Grassley, Grassley's Provisions for Tax-Exempt Hospital Accountability Included in New Health Care Law (Mar. 24, 2010).

15 Representative Bobby Rush (D-Ill.) and Senator Max Baucus (D-MT) have both publicly supported Grassley's initiatives. Senator Baucus co-wrote the letter sent to Treasury Secretary Paulson regarding reforms to Form 990 and accompanying schedules. See Press Release, Senator Chuck Grassley, Sen. Grassley Works to Build Confidence in Nonprofits With Greater Transparency (May 29, 2007). Rush, initially outraged by the practice of "patient dumping," has joined Grassley in legislative reforms to keep tax-exempt hospitals accountable under § 501(c)(3). See Jay Heflin, Politics Makes Strange Bedfellows in Fight Against Nonprofit Hospitals , http://thehill.com/homenews/house/89541-politics-makes-strange-bedfellows-in-fight-against-nonprofit-hospitals (last visited June 9, 2010). However, both Rush and Baucus voted for PPACA.

16 Prior legislative efforts to reform tax exemption standards for hospitals had failed; for example, the Tax Exempt Hospitals Responsibility Act of 2006 introduced by Representative Bill Thomas (R-CA). See Helvin, supra, at 449-50.

17 For an in-depth analysis of the cases, see Helvin, supra, at 433-40 (2008).

18 Plaintiffs are not foreclosed from bringing claims under various state law statutes more protective of patients' rights. However, such claims have not been entirely successful. See, e.g. , Galvan v. Nw. Mem'l Hosp. , 888 N.E.2d 529 (Ill. App. Ct. 2008). More research would be helpful to 1) examine how different state courts have interpreted their state statutes, and in what states such claims are more successful than in others; and 2) whether discriminatory pricing schemes may have a disparate impact on any protected class.

19 This case has never been cited by any federal court.

20 Steven T. Miller, Commissioner of the Tax Exempt and Government Entities Division of the IRS, commented in a 2009 speech that "[m]ore than a dozen states have adopted written standards involving community benefit." Steven T. Miller, Comm'r, Tax Exempt and Gov't Entities, Internal Revenue Serv., Charitable Hospitals: Modern Trends, Obligations and Challenges (Jan. 12, 2009).

21 To date, Tex. Health & Safety Code Ann. § 311.045 has not been cited in any state or federal case law.

22 Tex. Health & Safety Code Ann. § 311.045 (c) (Vernon 2010) provides "guidelines" for the hospital in determining the amount of care required. Community needs, available hospital resources, tax-exempt benefits received, and other factors unique to the hospital, are among the factors to be considered.

23 Tex. Health & Safety Code Ann. § 311.045 (b)(1)(A)-(C) (Vernon 2010).

24 A Review of Hospital Billing and Collection Practices: Hearing Before the H. Energy & Commerce Comm. Subcomm. on Oversight and Investigations, 108th Cong. 4 (2004) (statement of Jack Bovender, CEO of HCA).

25 HCA, Welcome to the Patient Financial Resource, http://www.hcahealthcare.com/CustomPage.asp?guidCustomContentID={C7403AAF-2EFC-4CC9-BEC9-3D5815D11C45} (last visited June 16, 2010).