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HEALTH CARE INSIDER

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RISK OF LOSS OF HOSPITAL TAX EXEMPTIONS

The Affordable Care Act (ACA) imposed a number of requirements on nonprofit hospitals in response to longstanding concerns in Congress that they are really for-profits "in disguise." The IRS created Code Section 501(r) which established certain conditions for hospitals to maintain their tax-exempt status under federal law. In order to maintain their tax exemption, among other requirements, the hospital must establish financial assistance and emergency medical care policies, limit charges to patients eligible for assistance, make reasonable efforts to identify eligible patients before engaging in extraordinary collection actions, and conduct a community needs assessment at least once every three years. The ACA encourages partnering with for-profits to reduce costs. However, recent court cases indicate that even if a nonprofit hospital operates under these terms, state and local governments may hold them to a higher standard.

In 2014, the state of Illinois shocked the nonprofit hospital industry by revoking the tax-exempt status of a prominent Catholic hospital, basing its decision at least in part on the way it treated its needy patients. The hospital filed lawsuits and used other aggressive debt collection tactics against patients who did not pay their bills. In addition, the hospital allowed several for-profit entities to fulfill key hospital functions.

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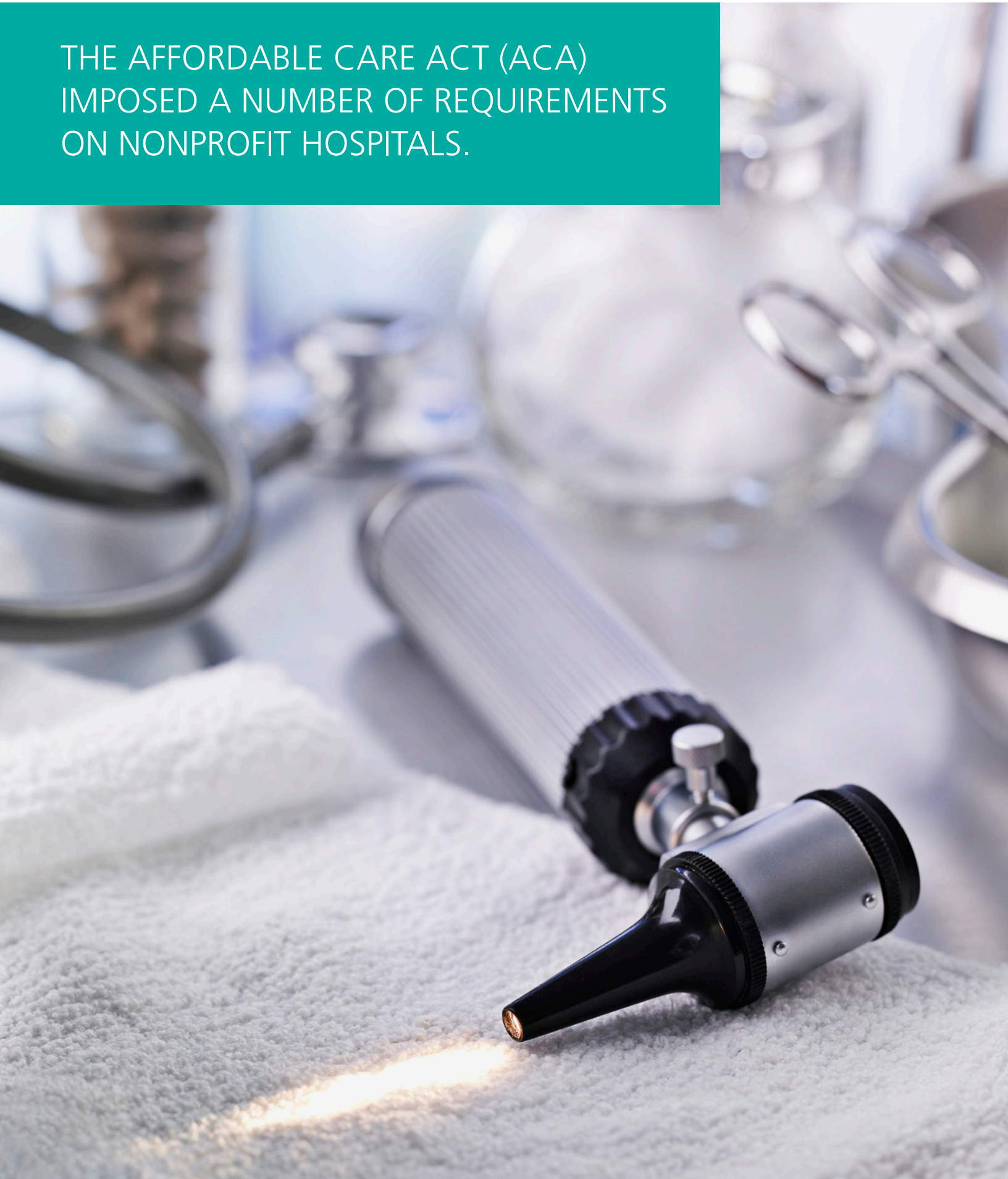
The next level of service

THE AFFORDABLE CARE ACT (ACA) IMPOSED A NUMBER OF REQUIREMENTS ON NONPROFIT HOSPITALS.



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The State alleged the hospital was not operating with a charitable purpose.

In a similar, but more far reaching decision, in 2015 a New Jersey court revoked the real estate tax exemption of Morristown Memorial Hospital. In general, New Jersey law allows for all buildings used for hospital purposes to be tax-exempt, except for portions leased to for-profit entities. Those sections would be subject to tax. In 2008, New Jersey enacted a "three criteria test" for tax-exempt hospitals, that provides that:

1. The property owner must be organized exclusively for the exempt purpose.
2. The property must be used actually and exclusively for the tax-exempt purpose.
3. Operation and use of its property must not be conducted for profit making purposes.

During the trial, the court found that Morristown Memorial Hospital met the first two tests, but failed the third test, saying a majority of the hospital's operations and use of its property were for for-profit purposes.

The court opined that over the years, a significant number of hospitals changed from being purely charitable facilities that cared for the sick, poor and mentally ill, into advanced and modern centers of care catering to self-pay and the affluent.

Based on the corporate structure of Morristown and its parent, the court noted there were various nonprofit and for-profit subsidiaries and affiliates that the hospital did business with, such as for-profit physician practices, real estate owner/operators, home care agencies and an offshore for-profit captive insurance company. The hospital also employed medical staff whose contracts included incentive compensation clauses, and contracted with physicians to provide services such as radiology, anesthesiology and emergency room services on a for-profit basis. The court said that all of these physicians practiced medicine throughout Morristown's facilities to generate medical revenue for themselves. Other businesses included for-profit captive physician practices whose staff was employed by the hospital, a for-profit management company whose employees worked at the for-profit surgical care center, and made a number of loans to for-profit physician practices that were not affiliated with the hospital. It is noted that these types of arrangements are common in the hospital industry but are now coming under attack as practices that are inconsistent with its charitable purposes.

Tax-exempt entities are permitted to have both exempt and non-exempt activities on its property, so long as the two purposes are separately described and accounted for. In Morristown's case, these exempt and non-exempt activities were co-mingled to the point that a distinction could not be made to separate them. As a result, the court decided that Morristown did not meet the "profit test" and were advancing the activities of the for-profit entities.

The New Jersey court did not stop there. It also looked at the compensation being paid to the senior executives of the hospital and employed physicians, finding that the hospital failed to meet the burden of establishing that the compensation was reasonable, and noted that the contracts with physicians contained incentive compensation provisions that were based on sharing of profits and/or cost savings.

It is likely that more municipalities will be looking to limit or eliminate real estate tax exemptions for nonprofit hospitals and other charitable organizations that are engaged in businesses not related to their charitable purposes. More challenges to tax exemptions are expected as state and local governments look to increase property tax revenue to ease budgetary issues. As noted above, this contrasts with provisions of the ACA that encourages hospitals to enter into cost saving/cost sharing arrangements with for-profit health care providers.

One inventive solution by Illinois to the court decision noted at the beginning of this article was the enactment of a law allowing hospitals to deduct expenses associated with providing charity care from their property tax bill. Some states have required nonprofit hospitals to provide free services to the community equal to the amount of tax savings they receive from their tax exemption. Still other states have set charity care spending and community benefits equal to a percentage of patient revenues.

So far the courts have focused on the hospital industry but these decisions may have far reaching effects on all health care nonprofits. It is important to review your operations to determine if you are providing services that are consistent with your charitable purposes and to make sure there are clear distinctions between your nonprofit and for-profit activities.

By Richard Lipman, CPA
National Health Care Practice Leader

"Tax-exempt entities are permitted to have both exempt and non-exempt activities on its property, so long as the two purposes are separately described and accounted for."

HOW IS THE AFFORDABLE CARE ACT DOING?

The late former mayor of New York City, Ed Koch, used to ask people on the streets of NY "How my doing?" I feel now is the time to look back on the Affordable Care Act (ACA) to see how it is doing. The one thing that needs no discussion would be the failure of the online enrollment system for the federal marketplace exchanges. Clearly there are other aspects of the ACA that need to be looked at to see if the intention of The Act came to fruition; such as coverage for dependent adults to age 26, elimination of the pre-existing condition clause on all health insurance plans, formal coverage for all US citizens and high costs.

COVERAGE FOR YOUNG ADULTS

The first item that was very popular was providing coverage for dependents to age 26 regardless of eligibility for other coverage. This allowed young adults to have medical coverage despite their status as a college student. The impact that it had to the cost of health plans was minimal since young adults typically have relatively minor cost issues when it comes to health care.

ELIMINATION OF PRE-EXISTING CONDITION CLAUSE

The next item, elimination of pre-existing conditions on all health insurance plans, was one of the main focuses of the ACA. There are horror stories galore of people who had serious medical conditions unable to buy insurance because of pre-existing conditions. The ACA gave groups and individuals the ability to purchase insurance without any concern of a pre-existing condition. This provides a person the peace of mind that they are not going to be selected against because of an illness. In order for this provision to be adopted, the government needed to indemnify insurance companies in the event their loss ratios go beyond expected levels.

In 2014, all groups and individuals were required to pay a transitional re-insurance fee to stabilize the marketplace over the next three years. In 2014, the tax was $12 billion. It is expected that taxes received in subsequent years will be reduced to $8 billion in 2015 and $5 billion in 2016. This tax as well as others, will drive the cost of coverage upward; however, this guarantees that not one person can be denied health insurance.

FORMAL COVERAGE FOR ALL

The intention of the ACA was that all citizens of the US should have formal health insurance. Prior to the ACA, it was estimated that 45 million people were uninsured. It is estimated that approximately 7-8 million people enrolled in various ACA plans in 2014. This still leaves a great many people uninsured.

In June of last year, the Congressional Budget Office estimated that even after the law has been in effect for 10 years, there will still be 31 million people uninsured in the US. Why is this the

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case when you consider the amount of money being spent to eliminate the issues of the uninsured? In part, the uninsured population is being affected by insurance carriers' future plans when it comes to the complexity of providing care. How does a carrier point the sickest and more costly patients to their competition? Will they reduce cost by eliminating the most expensive doctors from their networks?

Many insurance carriers are touting that their provider networks are producing the best medical outcomes. There is some truth to this, but realistically providers that have good outcomes at a lower cost point are likely to be recruited by the carriers. The problem with this philosophy is that patients will have to wait a longer period of time before they can get an appointment to see the doctor. In essence, doctor rationing reduces the amount of utilization a plan will incur.

Some plan sponsors and insurance companies are dis-incentivizing people from enrolling in their plans by eliminating expensive treatment centers for cancer, transplants and kidney dialysis. By eliminating these centers of excellence, individuals who need care for these diseases will not enroll in these plans. We have seen several examples of this practice, when both plan sponsors and insurance company plans have stopped offering high cost treatments that some patients were having prior to the ACA. This has forced patients to either stop their treatments or go to a more expensive plan in order to get coverage for their illness.

The high cost of prescription drugs has remained a constant for several decades. Today's "super drugs" that are known as specialty or bio-tech drugs have astronomical costs. In order to deal with these escalating costs, plan sponsors and insurance companies have greatly restricted their drug reimbursement policies. Programs such as generic only, higher deductibles and higher co-pays have become the norm. The day of a $5 generic, $20 brand and $40 non-preferred brand copay are long gone; in addition to eliminating coverage entirely for the specialty bio-tech drugs. Once again, if you require these types of expensive drugs, you will not be inclined to enroll in such a plan.

When the ACA was being drafted, quality and affordability were listed as being crucial to the plan. However, when we see what has happened with plan sponsors and insurance companies in ways to discourage people from enrolling, it is somewhat frustrating. The purpose of this law was plain and simple – everyone should have health coverage in the US – but the techniques that are employed to discourage participation are puzzling. Insurance companies will be protected against major losses for at least three years by the Federal Government. Some plan sponsors whose firms work on slim profit margins may be inclined to meet the minimum of the law, which means exposing their employees to less than adequate coverage. The one thing that is a certainty is that the ACA will continue to evolve over the next few years. Certainly some of the things in effect are positive, others are negative. It is hopeful that somewhere down the line equilibrium will be reached for the plan to reach its intended goals.

By John DePalma, MPH
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PROVIDING VALUE TO THE HEALTH CARE INDUSTRY

Today's growing and advanced health care industry is a fast-paced environment where regulatory issues, competition, and rapidly changing consumer expectations converge. Managing risks and realizing opportunities becomes a more important focus as health care organizations decide how they will adapt and evolve their business models for long-term survival.

Ensuring today's actions will lead to achieving long-term goals can be a major challenge for anyone. Many health care organizations are unable to address the issues at hand and consider the "big picture" because they are overwhelmed with urgent matters and patient care. UHY LLP's National Health Care Practice brings an understanding of the industry together with innovative solutions that have a positive impact on bottom line. We understand the challenges facing health care providers and facilities.

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