

STATEMENT OF VHA INC.

OVERSIGHT SUBCOMMITTEE OF THE COMMITTEE ON WAYS AND MEANS  
UNITED STATES HOUSE OF REPRESENTATIVES

IN CONNECTION WITH THE HEARING ON

"TAX-EXEMPT ORGANIZATIONS: OPERATIONS AND IRS OVERSIGHT"  
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VHA Inc. (formerly Voluntary Hospitals of America) appreciates the opportunity to deliver this testimony on the current operations and challenges of tax-exempt community hospitals, the impact of the new statutory requirements for hospital tax exemption enacted as part of the Accountable Care Act, and certain concerns and policy priorities of nonprofit hospitals regarding comprehensive tax reform

My name is Michael Regier, and I am senior vice president of legal and corporate affairs, general counsel and compliance officer for VHA Inc. In this position, I am also responsible for overseeing VHA's public policy office. Prior to joining VHA in 2007, I served for twelve years as senior vice president and general counsel of the Seton Healthcare Family, a non-profit hospital system based in Austin, Texas.

Founded in 1977, VHA is dedicated to the success of nonprofit, community-based health care. VHA is a national alliance of over 1,400 not-for-profit hospitals and more than 23,000 non-acute health care organizations. VHA helps its members deliver safe, effective and cost-efficient health care through both national and local support. VHA has 15 regional offices covering 47 states, as well as a public policy office in Washington, D.C.

For many years, VHA has undertaken a leadership role in the field of community benefit for not-for-profit hospitals. VHA supports its members in their task of assessing and meeting community health needs by providing tools, best practices and other resources. The Guide for Planning and Reporting Community Benefit, developed through VHA's longstanding collaboration with the Catholic Health Association (CHA), has become an industry standard resource for non-profit hospitals and health systems. Most recently, VHA and CHA have developed a new community benefit planning resource entitled Assessing and Addressing Community Health Needs. VHA has also provided its members with resources and best practices in the areas of corporate governance and whole hospital joint ventures.

## Introduction

Under federal tax law prior to its amendment by the Affordable Care Act, tax exemption for nonprofit community hospitals was governed by a handful of Internal Revenue Service (IRS) administrative rulings and judicial decisions. In the context of enacting a comprehensive health care reform bill, Congress determined that specific statutory rules and more oversight by both Congress and the IRS were appropriate.

## Prior Law Governing Hospital Tax Exemption

Since 1969, the IRS used the "community benefit" standard for determining whether a hospital is charitable.<sup>1</sup> In Revenue Ruling 69-545, the IRS ruled that community benefit included:

- Maintaining an emergency room open to all persons regardless of ability to pay;
- Having an independent board of trustees composed of representatives of the community;
- Operating with an open medical staff policy, with privileges available to all qualifying physicians;
- Providing charity care; and
- Utilizing surplus funds to improve the quality of patient care, to expand facilities, and to advance medical training, education and research.<sup>2</sup>

In 2009, the IRS began requiring hospitals to submit detailed information on their community benefit activities and expenditures on their annual information returns filed with the IRS.<sup>3</sup> VHA, working together with other hospital associations and industry groups, advised the IRS on the development of the new Schedule H (Hospitals).

## Overview of New Tax-Exempt Hospital Provisions

The provisions enacted as part of the Affordable Care Act include the following:

- Section 9007(a) of the Act added new statutory requirements that must be met by all hospitals seeking exemption from federal income tax and other tax benefits as 501(c)(3) organizations.<sup>4</sup> These requirements are now contained in new Internal Revenue Code ("Code") Section 501(r).
- Section 9007(b) added a new penalty excise tax (new Code Section 4959) to help enforce the new requirements.
- Section 9007(c) mandated IRS review of each 501(c)(3) hospital and its community benefit activities at least once every three years.

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<sup>1</sup> See Rev. Rul. 69-545, 1969-2 C.B. 117 and the Restatement (Second) Trusts (1959). See generally Bruce R. Hopkins, *The Law of Tax-Exempt Organizations*, sec. 6.3 (discussing various forms of health-care providers that may qualify for exemption under section 501(c)(3)).

<sup>2</sup> Rev. Rul. 69-545.

<sup>3</sup> See IRS Form 990, Schedule H (Hospitals).

<sup>4</sup> Organizations qualifying for federal income tax exemption pursuant to Code Section 501(c)(3) are eligible to receive tax deductible contributions, have access to tax-exempt financing through State and local governments, and are generally exempt from State and local taxes.

- Section 9007(d) imposed new reporting and disclosure requirements on 501(c)(3) hospitals filing the annual information return known as the IRS Form 990.

The requirements are entitled, "Additional Requirements for Section 501(c)(3) Hospitals," and the legislative history makes it clear that the new requirements are in addition to, and not in lieu of, the requirements otherwise applicable to 501(c)(3) organizations. As detailed below, new Code Section 501(r) imposes the following new requirements that a hospital must satisfy to obtain or maintain its status as a 501(c)(3) organization:

- prepare and widely publicize a community health needs assessment ("CHNA") every three years, and adopt an implementation strategy to meet the health needs in the CHNA
- adopt, implement and widely publicize a financial assistance policy (providing for free or discounted medical care for those who qualify) as well as a written policy for the provision of emergency medical care
- abide by a limitation on charges for medical care when such care is provided to those qualifying for financial assistance
- refrain from engaging in "extraordinary" collection efforts before making reasonable attempts to determine whether a patient qualifies for financial assistance.

The new requirements are generally effective for taxable years beginning after March 23, 2010. Thus, for a calendar year hospital, the new requirements became effective on January 1, 2011. However, the new CHNA requirement is not mandatory until taxable years beginning two years after March 23, 2010. Thus, for a calendar year hospital, the CHNA requirement must be fulfilled in the taxable year starting on January 1, 2013.

### **IRS Guidance Related to the new Statutory Requirements under Section 501(r)**

Since Section 501(r) was enacted in 2010, the IRS has issued no proposed or final regulations, but it has issued various forms of informal guidance (specifically, Notice 2010-39, Notice 2011-52, Announcement 2011-37 and Notice 2012-4). It has also amended the IRS Form 990 Schedule H to incorporate over 20 new questions with over 60 different subparts. These new questions are principally found in Part V, Section B (Facility Policies and Practices) and must be filled out separately by each hospital facility that is subject to the new statutory requirements. While most of these questions are designed to measure hospital compliance with the new requirements, the IRS has stated that some of the questions are merely informational in nature.

In **Notice 2010-39**, 2010-39 IRB 24 (June 14, 2010), the IRS described each of the new tax-exempt hospital requirements and solicited public comment on how they should be interpreted. Other than setting forth the statute and legislative history relevant to each

requirement, Notice 2010-39 did not provide guidance to the hospital community on the new requirements.

VHA, like all of the major hospital groups and other stakeholders, submitted comments to the IRS on July 21, 2010. VHA's comments on Notice 2010-39 are available on its website at:

[https://www.vha.com/AboutVHA/PublicPolicy/Advocacy/Advocacy%20Letters/2010/IRS/VHA\\_Comment\\_Ltr\\_PPACA\\_Provisions\\_07\\_21\\_2010.pdf](https://www.vha.com/AboutVHA/PublicPolicy/Advocacy/Advocacy%20Letters/2010/IRS/VHA_Comment_Ltr_PPACA_Provisions_07_21_2010.pdf)

**Release of Revised Schedule H.** After soliciting initial comments from the hospital community on the new requirements as well as conducting several meetings with hospital representatives in 2010 and early 2011, the IRS on February 23, 2011, released a substantially revised version of the Form 990 Schedule H along with revised instructions to Schedule H. Much to the surprise of the hospital community, the revised Schedule H appeared to incorporate or predetermine many of the issues relating to the new requirements on which the IRS had sought public comment through Notice 2010-39. Several hospital membership organizations and associations protested that the numerous detailed revisions to the Schedule H appeared to supplant the process of issuing regulatory guidance pursuant to notice and public comment standards. Initially, the IRS responded that "nothing in it [the revised Schedule H] depends on the regulatory process that we are currently engaged in with the community..." See "Schedule H Implements Tax-Exempt Hospital Guidance Before Rules are Out, Some Say," 54 BNA Daily Tax Report G-7 (March 21, 2011) (quoting IRS Tax Exempt and Government Entities Commissioner Sarah Hall Ingram).

**Announcement 2011-37**, 2011 IRB 27 (July 5, 2011). After the tax-exempt hospital community continued to press its specific concerns about the new Schedule H, the IRS announced that it "decided to make the entire Part V, Section B [of the revised Schedule H] optional for the 2010 tax year to give the hospital community more time to familiarize itself with the types of information the IRS will be collecting related to compliance with section 9007 [of the Accountable Care Act]...and to address any ambiguities arising from the extensive revisions of the form and instructions." The IRS also stated that it "continues to invite comments on how to improve the clarity and reduce the burden of reporting the information related to these additional requirements on the Form 990 and Schedule H." An IRS Memorandum attached to Announcement 2011-37 stated that "the Service does not intend the new Schedule H to serve as a substitute for any regulations or guidance that may be necessary to carry out the provisions of Section 501(r) " It also contended that "many of the questions asked in Section V and responses elicited are informational in nature, and thus a "negative" answer should not be interpreted as indicating non-compliance with specific requirements under Section 501(r)."

Following the release of the revised Schedule H, VHA continued to work actively with other hospital groups, such as the American Hospital Association (AHA) and the Healthcare Financial Management Association (HFMA) to identify ways in which the Schedule H could be revised to eliminate redundancies and reduce burdensome paperwork. VHA, AHA and HFMA also identified for the IRS those questions on the

revised Schedule H that appeared to reach beyond the scope of the statute or were inconsistent with Section 501(r) and its legislative history. See VHA-AHA-HFMA Joint Letter to IRS Commissioner Sarah Hall Ingram (April 20 2011), posted at <http://www.aha.org/advocacy-issues/letter/2011/110420-cl-schedh.pdf>. Subsequently, VHA joined AHA and HFMA in developing line by line comments on the Schedule H. See VHA-AHA-HFMA Joint Letter to IRS Commissioner Sarah Hall Ingram (August 24, 2011), posted at <http://www.aha.org/advocacy-issues/letter/2011/110824-let-aha-hfma-vha-shall.pdf>.

**Notice 2011-52**, 2011 IRB 30 (July 25, 2011) set forth in significant detail the guidance that IRS is considering with respect to the specific requirement that each hospital conduct a community health needs assessment (CHNA) at least once every three years. While VHA has consistently urged its members to conduct regular assessments of community health needs as a critical component of community benefit planning, VHA expressed serious concerns about the overly prescriptive nature of the IRS guidance relating to CHNAs. It lodged particular objection to the many procedural requirements described in the Notice 2011-52, some of which IRS has already incorporated into the questions in Part V, B of the revised Schedule H. VHA's articulated concerns about IRS's proposed approach include the following:

- Requiring each hospital facility in a multi-hospital system to issue a separate written report on its CHNA, as opposed to allowing the system to issue a consolidated report.
- Imposing excessively detailed mandates regarding consultation with public health agencies and representatives of specific populations within a community (i.e., populations with chronic health needs).
- Imposing excessive CHNA documentation requirements, particularly those focused on the process of conducting the CHNA (e.g., describe the process and methods used to conduct the assessment (including sources and dates), specify how and when the hospital consulted with community leaders (including specific names and titles of individuals consulted, and whether such consultation involved meetings, focus groups, interviews, surveys or written correspondence), and specify "information gaps" that may have affected the hospital's ability to assess community health needs).
- Requiring each hospital to attach its most recently adopted CHNA implementation strategy to its Form 990 (as opposed to allowing the hospital the option of either attaching the strategy or reporting how the hospital is addressing the health needs identified through its CHNA--as the statute requires).

### **Hospital challenges in complying with the new requirements**

VHA expects that hospitals will have a number of challenges complying with the new requirements, particularly in light of current health insurance trends and reimbursement

shortfalls. At the same time, VHA believes that Congress needs to make sure that hospitals are able to direct their limited resources toward meeting their communities' most significant health needs as opposed to complying with excessively burdensome paperwork requirements.

Some of the specific areas which VHA has identified as needing further guidance from IRS include the following:

- Applicability of the statutory requirements to hospital joint ventures (including those not operated as charitable hospitals generating exempt income)
- Calculating permissible charges in compliance with the limitation in Code Section 501(r)(5) on amounts hospitals may charge for emergency or other medically necessary treatment provided to individuals who qualify for financial assistance (i.e., did Congress intend this requirement to apply and be calculated on a procedure-by-procedure basis or may hospitals calculate an average effective discount rate received from each commercial insurance company across all covered procedures and services?)
- Whether hospital reporting of delinquent patient accounts to credit agencies is to be considered an "extraordinary collection" measure
- What constitutes "reasonable efforts" to determine whether an individual is eligible for financial assistance

Some of the areas that IRS has already clarified--at least through the informal mechanism of the IRS Schedule H and its Instructions--including the following:

- Defining what type of "hospital facility" is generally required to comply with the new requirements and to report its compliance on the Schedule H
- Describing what is involved in "widely publicizing" the required financial assistance policy
- Clarifying that the "best" commercial rate means the "lowest" rate for purposes of the limitation on charges
- Defining the scope of the mandate to provide emergency medical care without "discrimination"

### **What matters to tax-exempt hospitals in the context of comprehensive tax reform**

VHA supports efforts to make the tax code fairer, simpler and more efficient. We agree with the many members of this Committee who have recognized that the economy loses substantial amounts of productivity each year because of our burdensome tax system. Even tax-exempt organizations are not exempt from having to spend millions of dollars to comply with IRS documentation and filing requirements. These requirements, some

of which have not been mandated by Congress, appear to have grown exponentially in recent years. A good example is the redundant and overly prescriptive Schedule H.

Not-for-profit health care organizations play a critical role in community health needs, and more is being asked of them every day because of the growth in our uninsured (or underinsured) populations. Federal tax benefits are important in helping such organizations carry out their missions and meet their needs for capital.

As the Ways & Means Committee continues its efforts toward comprehensive tax reform, it should avoid taking any action that would jeopardize the following core benefits:

- income tax exemption for charitable hospitals
- tax-exempt financing for hospital facilities
- deductibility of charitable contributions and bequests for hospital donors

All three of these are needed by nonprofit hospitals in order to provide the maximum amount of community benefit, including charity care and other financial assistance on behalf of uninsured and low-income persons, subsidized health services, community health improvement services, community building activities, research and education.

The exemption from income tax of charitable and other not-for-profit organizations is longstanding. While most nonprofit hospitals operate on very slim margins and thus have little net income subject to tax, the exemption permits not-for-profit organizations to retain earnings for future capital improvement. It also provides a uniform foundation for many state tax exemptions, including exemption from sales and property taxes.

A second tax provision is the exclusion for tax-exempt bond interest. Charitable organizations like hospitals have significant capital needs and rely on tax-exempt financing to obtain much needed capital. Since not-for-profit hospitals by law cannot raise money by issuing stock to investors, debt and retained earnings are their only sources of capital to make the investments in staff, facilities and technology that are required to deliver the safe, high-quality care their communities need and deserve. While the markets for tax-exempt financing by hospitals are fairly well established at present, many hospitals and other not-for-profit entities would be severely hampered in obtaining debt financing at all if these markets were disrupted through significant changes to the tax treatment of interest paid on tax-exempt bonds.

A third tax provision that directly benefits charitable organizations is the deduction for charitable contributions. In the health care context, both individual and corporate contributions are essential funding sources for medical research and education, capital improvements and community health activities and organizations. The Obama Administration has proposed a reduction in the value of charitable contribution deductions for taxpayers in the 33 and 35 percent brackets. VHA opposes any such a limitation, and believes that it would have a particularly negative impact on significant gifts by individual donors.

## Conclusion

Not-for-profit hospitals and health systems provide essential services efficiently and compassionately every day in communities throughout the United States. Their work in further of their charitable missions contributes significantly to the public good and lessens the burdens of government. In view of anticipated cuts in Medicare funding under the Affordable Care Act and the Budget Control Act, and in light of the great financial demands many state Medicaid programs face, nonprofit community hospitals and health care organizations will be challenged to do more than ever before to maintain access to quality health care for all Americans.

In the Affordable Care Act, Congress saw fit to codify some of the specific community benefit obligations of tax-exempt hospitals. VHA has long encouraged its members to take their community benefit obligations seriously, and will now work to facilitate their full compliance with the codified requirements, which include

- Conducting a community health need assessment at least once every three years
- Adopting and publicizing a financial assistance or "charity care" policy
- Limiting hospital charges for medical care payable by individuals qualifying for financial assistance, and
- Refraining from taking "extraordinary" collection actions before making reasonable efforts to determine whether the patient qualifies for financial assistance.

As we work with our members, however, we will also continue our advocacy aimed at assuring that the implementation of these new requirements is not unduly burdensome or overly prescriptive and does not go beyond Congressional intent. In particular, the revised Schedule H--with its confusing mix of compliance inquiries and informational questions--needs to be streamlined and simplified. VHA looks forward to working with the Oversight Subcommittee as well as with the IRS toward this goal.

***For further information regarding any of the topics discussed herein, please contact Michael J. Regier, Senior Vice President of Legal and Corporate Affairs, VHA Inc., at (972) 830-6810 or [mregier@vha.com](mailto:mregier@vha.com) or Cidette Perrin, Senior Director Governmental Relations, VHA Inc. at (202) 354-2608 or [cperrin@vha.com](mailto:cperrin@vha.com).***