Hospital Community Benefit Program

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Hospital Community Benefits after the ACA

Trends in State Community Benefit Legislation, November 2015-May 2016

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Introduction

The Hilltop Institute first published the Community Benefit State Law Profiles in March 2013. The Profiles present a comprehensive analysis of each state's community benefit landscape viewed through the lens of major categories of federal community benefit requirements articulated in §9007 of the Affordable Care Act (§501(r) of the Internal Revenue Code). In January 2015, Hilltop updated the Profiles to reflect laws and regulations adopted between March 1, 2013, and December 31, 2014. In October 2015, Hilltop updated the Profiles to reflect new community benefit legislation enacted between January 1, 2015, and October 31, 2015. Hilltop updated the Profiles again in June 2016 to reflect new community benefit legislation enacted or proposed between November 1, 2015, and May 31, 2016. This issue brief reports legislative changes during this period. Just three states enacted new community benefit legislation: Florida, New Hampshire, and Vermont. The changes in these states' laws are discussed below. To better understand current trends in legislative action, Hilltop also reviewed community benefit bills in eight states that were introduced but not enacted or are still pending. Bills like these are often reintroduced in subsequent sessions and inform legislative activity and policymaking in other states.

Bills Enacted

As of May 31, 2016, Florida, New Hampshire, and Vermont were the only states that enacted community benefit state laws during the 2016 legislative session. New Hampshire's House Bill (HB) 1316 was a nonsubstantive change that added a definition of self-pay to the statute.

Florida passed two bills—both relating to hospital billing and financial transparency—aimed at helping patients and their families know what to expect and how to plan their finances when they seek nonemergent care at a hospital. Senate Bill (SB) 1442 requires a hospital facility to disclose to patients, in writing, that some providers delivering services in the hospital may separately bill the patient; some providers practicing in the hospital may not participate with the same health insurers as the hospital; and prospective patients should contact the provider to determine whether the provider participates as a network provider or preferred provider of the hospital. Hospitals must make the following available: contact information for providers with whom the hospital contracts and instructions on how to contact nonparticipating providers. HB 1175 goes further by requiring a facility to provide, on its website, financial information and quality of service measures disseminated by the Florida Agency for Health Care Administration. The facility must disclose, in plain language, average payments and payment ranges, that

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these are estimates, that actual costs will be based on services rendered, and that the patient can request a more personalized good faith estimate of charges. The facility is also required to disclose its financial assistance policy, payment plans, discounts, and the facility's charity care policy and collection procedures.

Vermont passed one bill related to community needs assessments. S 255 requires each hospital to have a protocol for meaningful public participation in its strategic planning process for identifying and addressing health care needs that the hospital provides or could provide in its service area. Hospitals must post, on their websites, a description of the needs, strategic initiatives developed to address the needs, and opportunities for public participation.

Bills Pending

Bills related to hospital community benefits were introduced in the legislatures of seven states: Massachusetts, New Hampshire, New Jersey, North Carolina, Vermont, Virginia, and West Virginia. Only Massachusetts and New Jersey are currently still in session. As such, it is possible that they may propose additional legislation. The pending bills, which relate to tax exemption and preventing medical debt, are discussed below.

Tax Exemption. In New Jersey, four bills were introduced in response to a tax court decision in June 2015. A judge decided that Morristown Medical Center was not entitled to its property tax exemption because profit-making medical services were provided throughout the hospital and there was no separate accounting of nonprofit and for-profit medical activities to delineate exempt property from non-exempt property. After that ruling, a number of local jurisdictions added hospitals to their tax rolls. Twenty-two of the state's 62 nonprofit hospitals subsequently filed lawsuits against the local jurisdictions. There is currently a four-year backlog in state tax court, so the new hospital cases will likely not be resolved in the near future.

In March 2016, Governor Christie proposed a two-year freeze on tax lawsuits involving nonprofit hospitals and the appointment of a nine-member panel to study the issue. Two bills, A 1797 and S 1878, have been introduced that would create this panel, but no bill has been introduced to freeze the tax lawsuits. A 1797 would set an expiration date for the study panel at 90 days after the issuance of the report, while S 1878 would not set an expiration date. Both bills would require an annual community service contribution from hospitals to maintain their tax-exempt status.

A 2907 and S 1306 address nonprofit hospitals' tax-exempt status. A 2907 would maintain the property tax exemption for nonprofit hospitals with for-profit medical providers as long as the hospital is tax-exempt under the federal Internal Revenue Code. S 1306 would maintain a nonprofit hospital's property tax exemption if the average of its reported community benefit expense percentages of total expense for a three-year period is 5 percent or greater or if the average of its combined community benefit expense and community building activities percentages of total expense is 10 percent or greater. None of these bills have been heard in committee, but the legislative session runs until January 2017.

Preventing Unnecessary Medical Debt. Aimed at preventing unnecessary medical debt through hospital and affiliate charity care policies, Massachusetts' HB 1025 would require each hospital to have a written financial assistance policy that, at a minimum, reduces charges for underinsured and uninsured individuals and, at the hospital's discretion, reduces co-pays and deductibles for underinsured and uninsured individuals with a gross household income at or below 600 percent of the federal poverty level. Hospitals would also be required to notify patients about public assistance programs during the registration process and provide clear billing information that includes a statement indicating how the patient may obtain applications for public assistance or the hospital's financial assistance program.

Bills Not Enacted

Virginia, West Virginia, North Carolina, and Maryland introduced bills relating to hospital community benefits that were not enacted.

Virginia's HB 1083 would have required a review of the definition of charity care and charity care requirements and imposed greater transparency in public reporting on the provision of charity care.

West Virginia's HB 4288 would have exempted any nonprofit hospital that incurred uncompensated care costs equal to or greater than 4 percent of the hospital's total net patient revenue from the state sales tax for each taxable year.

North Carolina's SB 825 would have required nonprofit hospitals and healthcare systems to make their charity care policies accessible on their websites. It would also have required hospitals to annually report key fiscal information directly to the state Department of Health and Human Services rather than providing a link to the hospital's federal 990 tax forms. This bill was part of an ongoing debate that began in 2013 when Republican legislators introduced a bill that would have lowered the cap on the amount of sales tax refunds that these hospitals could receive. The concern was that hospitals are spending too much of the refund on capital projects instead of charitable and community benefits. Bill sponsors stated that, by requiring hospitals to disclose financial information, this bill would have helped provide context if legislators attempt to lower the sales tax refund cap again.

Nonprofit hospitals in Maryland are currently required to submit an annual community benefit report detailing, among other things, the community benefit initiatives undertaken by the hospital. HB 1189/SB 601 would have required hospitals to include an itemization of the value of all tax exemptions received by the hospital in the annual report. In both the House and the Senate, these bills received immediate unfavorable reports.

Concluding Thoughts

In the wake of the Morristown Medical Center decision in New Jersey, it is likely that more states will debate state and local tax exemptions for hospitals. For example, the Illinois Supreme Court just announced that it will review a case that focuses on the constitutionality of exempting nonprofit hospitals in Illinois from paying property taxes.

Many argue that, with the transformation from a system once dominated by locally owned and managed nonprofit community hospitals to a system of regional and interstate multi-hospital systems with extensive business interests, substantial investment capital, and fewer ties to local communities, it is time to reexamine the property tax exemption afforded to nonprofit hospitals by local communities. Others maintain that hospital systems still provide a valuable public or charitable purpose by providing health care services that might not otherwise be available in the community and that these local institutions rely on tax exemptions to keep their doors open.

As these debates continue, it is important not to lose sight of the broader vision for the health needs of the community articulated in the final regulations for charitable hospitals issued by the Internal Revenue Service (IRS) on December 31, 2014. The IRS (2014) stated that the "health needs of a community … include not only the need to address financial and other barriers to care but also the need to prevent illness, to ensure adequate nutrition, or the need to address social, behavioral, and environmental factors that influence health in the community." Moving forward, it is important for policymakers, hospitals, and communities to leverage hospital community benefit policy to address these needs.

The information in this brief is provided for informational purposes only and is not intended as legal advice.
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About The Hilltop Institute

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a non-partisan health research organization dedicated to improving the health and wellbeing of vulnerable populations. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations, and nonprofit organizations at the national, state, and local levels. Hilltop is committed to addressing complex issues through informed, objective, and innovative research and analysis. To learn more about The Hilltop Institute, please visit **www.hilltopinstitute.org**.

Hilltop's Hospital Community Benefit Program is a central resource created specifically for state and local policymakers who seek to ensure that tax-exempt hospital community benefit activities are responsive to pressing community health needs. The program provides tools to state and local health departments, hospital regulators, legislators, revenue collection and budgeting agencies, hospitals, and community-based organizations to use as these stakeholders develop approaches that will best suit their communities and work toward a more accessible, coordinated, and effective community health system. This is the thirteenth issue brief in the series, *Hospital Community Benefits after the ACA*, published by the program. Funding for this brief was made possible by the generous support of the ***Kresge Foundation***.

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