



IRS Issues Notice of Proposed Regulations on New Federal Tax Exemption Requirements for Hospitals

July 2, 2012

Section 9007 of the Patient Protection and Affordable Care Act (PPACA) imposes additional requirements on tax-exempt hospitals to receive and maintain their Section 501(c)(3) federal tax-exemption status. The new requirements are codified in the Internal Revenue Code at Section 501(r). The Internal Revenue Service (IRS) has issued a notice of proposed regulations that provide guidance regarding the Section 501(r) requirements published in the Federal Register at <http://federalregister.gov/a/2012-15537>. The comment period ends on September 24, 2012. Hospitals may rely on these proposed regulations until final or temporary regulations are issued.

This *Health Law Alert* addresses the proposed regulations for the limitation on charges required in Section 501(r)(5). This Section requires a hospital facility to limit charges for emergency or other medically necessary care provided to financial-assistance-policy-eligible (FAP-eligible) individuals to not more than the amounts generally billed (AGB) to individuals who have insurance covering such care. Previously, the Joint Committee on Taxation's statement in the Technical Explanation of the PPACA and amended Schedule H for tax year 2011 suggested that a hospital may calculate the maximum amounts that can be charged to FAP-eligible individuals using the average of its three lowest negotiated commercial insurance rates. The U.S. Treasury Department and the IRS concluded that the three lowest commercial rates may be difficult to determine because different commercial insurers may negotiate the lowest rates for different items and services. As a result, they are proposing a single federal regulatory definition that determines AGB on the basis of claims paid by Medicare or, in the alternative, Medicare and all private health insurers.

The proposed regulations provide two mutually exclusive methods for hospitals to use to determine AGB. After selecting one of the proposed methods, a hospital facility must continue to use that method. The first method is a "look-back" method based on actual claims paid to the hospital by either Medicare fee-for-service only (Part A and Part B) or Medicare fee-for-service together with all private health insurers paying claims to the hospital. The second method is "prospective" and requires the hospital to estimate the amount it would be paid by Medicare and a Medicare beneficiary for the emergency or other medically necessary care at issue if the FAP-eligible individual were a Medicare fee-for-service beneficiary.

Under the look-back method, a facility may calculate one average AGB percentage for all emergency and other medically necessary care. A facility also has the option of calculating multiple AGB percentages for separate categories of care provided by different departments or for separate items or services, as long as the facility calculates AGB percentages for all emergency and other medically



necessary care provided. The proposed regulations provide the following methodology for the look-back method:

Under the look-back method for determining AGB, a hospital facility must determine AGB for any emergency or other medically necessary care provided to a FAP-eligible individual by multiplying the gross charges for that care by one or more percentages of gross charges, called AGB percentages. The hospital facility must calculate its AGB percentage(s) no less frequently than annually by dividing the sum of certain claims paid to the hospital facility by the sum of the associated gross charges for those claims. More specifically, these AGB percentages must be based on all claims that have been paid in full to the hospital facility for emergency and other medically necessary care by either Medicare fee-for-service alone or by Medicare fee-for-service and all private health insurers together as the primary payer(s) of these claims during a prior 12-month period. For these purposes, a hospital facility may include in “all claims that have been paid in full” both the portions of the claims paid by Medicare or the private insurer and the associated portions of the claims paid by Medicare beneficiaries or insured individuals in form of co-insurance, copayments, or deductibles. A hospital facility must begin applying its AGB percentage(s) by the 45th day after the end of the 12-month period the hospital facility used in calculating the AGB percentage(s).

The proposed regulations provide the following methodology for the prospective method.

Under the prospective Medicare method, a hospital facility may determine AGB for any emergency or other medically necessary care that the hospital provides to a FAP-eligible individual by using the same billing and coding process the hospital facility would use if the individual were a Medicare fee-for-service beneficiary. The hospital facility may then set AGB for that care at the amount the hospital facility determines would be the amount Medicare and the Medicare beneficiary together would be expected to pay for the care.

A hospital’s FAP must identify which of the permitted methods the hospital uses to determine AGB. If applicable, the FAP must state the percentage(s) of gross charges the hospital applies to determine AGB (the AGB percentage(s)) and how these AGB percentage(s) were calculated, or explain how the public may easily obtain this information in writing and free of charge. Finally, the proposed regulations provide that if a hospital charges more than AGB to a FAP-eligible individual who has not submitted a completed FAP to the hospital at the time of the charge, the hospital does not violate the Section 501(r)(5) limitation on charges, so long as the hospital made and continues to make reasonable efforts to determine whether the individual is FAP-eligible *and* refunds any amounts overcharged to an individual subsequently found to be FAP-eligible.

A second *Health Law Alert* will address the proposed regulations directed to the requirements for written financial assistance policies (Section 501(r)(4)), and billing and collection policies (Section 501(r)(6)). In July 2011, the Treasury Department and the IRS issued Notice 2011-52, which addressed the Community Health Needs Assessment (CHNA) requirements under Section 501(r)(3). Hospital organizations may continue to rely on the anticipated regulatory provisions described in Notice



2011-52 with respect to any CHNA made widely available to the public, and any adopted implementation strategy, until six months after the date further guidance regarding the CHNA requirements is issued.

For further information, please contact [Victoria R. Glidden](#) or your regular [Hinshaw attorney](#).

Hinshaw & Culbertson LLP prepares this publication to provide information on recent legal developments of interest to our readers. This publication is not intended to provide legal advice for a specific situation or to create an attorney-client relationship. We would be pleased to provide such legal assistance as you require on these and other subjects if you contact an editor of this publication or the firm.

Copyright © 2012 Hinshaw & Culbertson LLP. All Rights Reserved. No articles may be reprinted without the written permission of Hinshaw & Culbertson LLP, except that permission is hereby granted to subscriber law firms or companies to photocopy solely for internal use by their attorneys and staff.

ATTORNEY ADVERTISING pursuant to New York RPC 7.1. The choice of a lawyer is an important decision and should not be based solely upon advertisements.