



The Hilltop Institute

analysis to advance the health of vulnerable populations

Hospital Community Benefits after the ACA Trends in State Community Benefit Legislation, January-October 2015

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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 again to reflect new community

benefit legislation enacted between January 1, 2015, and October 31, 2015.

Just two states enacted new community benefit legislation during the 2015 legislative sessions—Connecticut and North Carolina. The changes in these states' laws are discussed below. Hilltop also reviewed more than 25 community benefit bills in twelve states that were introduced but not enacted during 2015 to better understand current trends in legislative action. Bills like these are often reintroduced in subsequent sessions and inform legislative activity and policymaking in other states.

Bills Enacted

The law changes in Connecticut and North Carolina were administrative in nature. Connecticut modified its earlier statute to allow multi-hospital health systems to file one audited financial statement—reflecting, among other things, costs of free and discounted care—that includes the financial statements for each hospital within the system (HB 6987). North Carolina's new provision, contained within an

Appropriations Act, goes beyond requiring tax-exempt hospitals to annually submit all information contained in federal Form 990, Schedule H to the state health department; the new language also requires a hospital to display all of the submitted information in a conspicuous place and post it in one location on its website in a manner that is searchable (HB 97/SL 2015-241).

Bills Not Enacted

Bills related to hospital community benefit were introduced—but not enacted—in the legislatures of twelve states: California, Connecticut, Maine, Massachusetts, New Jersey, Oklahoma, Oregon, Pennsyl-

vania, Rhode Island, Vermont, Washington, and West Virginia. All of these states currently regulate various aspects of community benefit. Below are the

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more important aspects of the proposed pieces of legislation.

Community Benefit Requirement. Oklahoma Senate Bill (SB) 761 would have explicitly established for the first time that nonprofit hospitals, as a condition of tax exemption, are required to offer charity care and federal and state government-sponsored indigent health care. Connecticut SB 916 would have required each application for approval of a hospital conversion from a nonprofit to a for-profit to include a description of—and a plan for monitoring—the new hospital’s plan for community benefits and uncompensated care for the first five years.

Minimum Community Benefit Requirement. California SB 346, Oklahoma SB 761, and Washington House Bill (HB) 1946 would have established a mandatory minimum requirement for community benefits had these bills been adopted. Only five states—Illinois, Nevada, Pennsylvania, Texas, and Utah—currently require mandatory minimums. Establishing a minimum community benefit threshold is controversial (Miller, 2009) because there is no conclusive evidence that implementing minimum community benefit thresholds results in increased community benefit investments (Kennedy, Burney, Troyer, & Stroup, 2010). However, legislation proposing such mandatory minimum thresholds continues to surface.

California SB 346 would have required that nonprofit hospitals and multispecialty clinics allocate 90 percent of the total economic value of their community benefits to benefits that improve community health for vulnerable populations, further specifying that a minimum of 25 percent of the total economic value be allocated to community building activities. Among the proposed legislation reviewed, this bill appears to contain the only provisions addressing upstream social determinants.

Oklahoma SB 761 would have provided nonprofit hospitals, as a condition of tax exemption, three options for meeting charity care and indigent health care obligations: 1) expenditures for charity care and government-sponsored indigent health care must equal 100 percent of the hospital’s tax-exempt benefits (excluding federal income tax); 2) community benefit investment must be equal to 5 percent of the hospital’s net patient revenue; or 3) nonprofit hospitals must provide charity care and government-sponsored indigent health care at a “reasonable” lev-

el, as determined through a community health needs assessment (CHNA) prescribed by the state health department.

Washington HB 1946 would have required every hospital to contribute 6 percent of its revenue, less any charity care and community benefits reported for that same year, to the Washington wellness trust. Wellness trusts have been used to help finance collaborative efforts in several states (Woodcock & Nelson, 2015; Prevention Institute, 2015; McGill, 2013). The Washington bill would have created an opportunity for hospitals to invest funds in such a trust as an alternative to traditional community benefits.

Community Health Needs Assessments. California Assembly Bill (AB) 1046 would have specified the elements required to be included in a CHNA report (which would replace the currently required community benefit plan) and would have extended this requirement to small and rural hospitals. Connecticut HB 5325 would have, for the first time, required for-profit hospitals to submit data to the Office of Health Care Access to prepare a CHNA. (The bill left unclear whether responsibility for preparing CHNAs rested with the hospital or with the Office of Health Care Access.)

Financial Assistance Policies. Bills introduced in two state legislatures would have established statewide standards for eligibility for charity or discounted care. Massachusetts HB 1025 would have mandated reduced charges for uninsured or underinsured patients with family income at or below 600 percent of the federal poverty level (FPL). Oregon HB 3349 would have mandated as eligible for charity care “financially qualified persons” (self-pay patients or those with high medical costs) with income below 350 percent of the FPL. Rural hospitals, however, could establish eligibility levels for persons exceeding 350 percent of the FPL.

Bills in two other states addressed standardizing information collected from patients. HB 1504 in Washington—which had already established that all persons with family income below 100 percent of the FPL should receive charity care for the full amount of hospital charges—provided that a person may apply for charity care at any time, and hospitals must use a standardized financial assistance application form developed by the department of health.

A bill introduced in New Jersey, SB 622, was intended to strengthen charity care oversight: it would have required hospitals to use forms and to follow procedures developed by the commissioner of health to ensure uniform collection of charity care applicants' financial and demographic information. The bill would have further directed the commissioner to use these data to ensure efficient, cost-effective provision of charity care and to detect potential fraudulent charity care claims.

Financial Assistance Policy Dissemination. Oregon HB 3349 would have required charity care policies to be posted, at a minimum, in the emergency department, billing office, admitting office, and outpatient settings.

Limitations on Charges, Billing, and Collections. Bills introduced in Oregon, Rhode Island, and Vermont all specified disclosures to be made to patients regarding medical care costs. Oregon HB 2303 would have required health care professionals to disclose in writing their nonparticipation with the insurer of a patient or prospective patient and notify patients about other physicians who may bill separately from the health care professional or hospital. Rhode Island SB 325 would have required hospitals to provide written estimates of medical services within five days of request by uninsured patients or those with insurance deductibles of \$5,000 or more. Vermont HB 197 would have required providers to disclose the cost of a health care service prior to incurring any charges (except in emergency situations), as well as information about how much a health insurer is expected

to pay and any additional cost-sharing amounts to be borne by the patient.

Tax Exemption. All 50 states exempt qualifying nonprofit hospitals from paying property tax. However, states vary with respect to the levying of sales tax. This varied treatment of sales tax is reflected in bills introduced in Rhode Island and West Virginia. Rhode Island SB 466 would have extended the existing sales tax exemption for nonprofit hospitals to for-profit hospitals for a 12-year period as long as they continue to operate according to their licensing requirements. In contrast, current West Virginia law does not exempt nonprofit hospitals from sales tax. However, West Virginia's HB 2376 would have exempted from sales and service tax any nonprofit hospital that incurred uncompensated care costs equal to or greater than 4 percent of net patient revenue.

Interestingly, Pennsylvania's constitution permits the General Assembly to exempt "institutions of purely public charity" from taxation but sets forth no criteria to be used in making such determinations. In 1985, the state Supreme Court established a judicial test to determine tax-exempt status. In 1997, the Pennsylvania legislature adopted a statute creating its own criteria based, it stated, on the 1985 case. However, in 2012, a Pennsylvania Supreme Court case asserted that the courts—not the legislature—were to determine whether entities were "institutions of purely public charity" and thus tax-exempt. In an attempt to resolve this issue, Pennsylvania legislators introduced seven different bills in 2015. Because none of these bills were enacted into law, the legal questions remain unresolved.

Concluding Thoughts

The approaches incorporated in many of the above-described bills are largely in accord with existing state community benefit statutes and regulations, but it is helpful to keep in mind that hospital community benefits are initiatives, activities, and investments undertaken for the purpose of improving the health of the communities served by the hospital (Internal Revenue Service (IRS) Rev. Rul. 69-545, 1969-2 C.B.117). Today, there is broadening appreciation among researchers, government agencies, public interest organizations, foundations, and health care

providers—including hospitals—that factors other than medical care play important roles in shaping community health. At the end of 2014, IRS announced that health needs a tax-exempt hospital can consider may include "the need to address ... social, behavioral and environmental factors that influence health in the community" (IRS, 2014). State policymakers and decision makers may want to consider whether the circumstances of their respective states warrant aligning their community benefit oversight with these contemporary understandings.

*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 twelfth 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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