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Emerging Issue: The Dynamic Role of States in Nonprofit Healthcare

The Affordable Care Act and State Charities Regulators

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I. INTRODUCTION

The Patient Protection and Affordable Care Act of 2010 (the "Affordable Care Act") was enacted almost three years ago in March 2010. Certain of its provisions became effective shortly after enactment, and others have been ramping up in advance of the full implementation of most of the remaining provisions of the Affordable Care Act on January 1, 2014. The Affordable Care Act is probably one of, if not the most, comprehensive reform of the healthcare sector, which represents the largest percentage of this nation's gross domestic product. Because of the extent of the reforms, the depth of impact on the entire healthcare system, and the costs and increased revenues associated with the Affordable Care Act, numerous challenges will be presented to state charities regulators as implementation of the Affordable Care Act continues to take place.

This paper will focus on the intersection between the federal healthcare reforms enacted as part of the Affordable Care Act and state charities regulators.¹ Part II discusses the duty of care and oversight issues concerning compliance with the new section 501(r)² requirements applicable to nonprofit and governmental hospitals that are or seek tax exemption under section 501(c)(3). Part III focuses on the dynamics of a consolidating marketplace for hospitals and health systems and the expected mergers, acquisitions and other transactions that are taking place and will take place in the coming years in response to or as a result of the law changes contained in the Affordable Care Act. Finally, with the increased funding that will result from full implementation of the Affordable Care Act, there will be greater competition for an increasingly scarce commodity – physicians. Part IV discusses how nonprofit hospitals may be compelled to push the limits of the anti-kickback and self-referral laws, thereby creating financial exposures for the hospitals and concomitant questions about compliance with fiduciary duties of oversight as the Delaware Supreme Court spelled out in the CareMark litigation.³

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¹ Other State regulators will be affected, including State health and insurance departments.

² Section 501(r) is now part of the Internal Revenue Code of 1986, as amended.

³ In re Caremark International Inc. Derivative Litigation, 698 A.2d 959 Del. Ct. of Ch. 1996).

II. SECTION 501(r) REQUIREMENTS FOR SECTION 501(c)(3) HOSPITALS

Nonprofit hospitals have for decades had to satisfy one of two operational tests to obtain or retain their Federal income tax-exempt status as organizations described in section 501(c)(3). A nonprofit hospital either must provide free or low-cost care “to the extent of its financial ability” under the “relief of poverty” test set forth in Revenue Ruling 56-185, 1956-1 C. B. 202, or must treat all persons able to pay or who have insurance, participate in the Federal Medicare and the Federal-State Medicaid programs, and operate an open emergency room when appropriate under the “promotion of health” (often referred to as the “community benefit”) test set forth in Revenue Ruling 69-545, 1969-2 C.B.117.

One of the many tax law additions to the Internal Revenue Code made by the Affordable Care Act was section 501(r), which applies specifically to “hospital organizations” that are (or seek to be) recognized as charitable organizations described in section 501(c)(3). The IRS has identified almost 3400 nonprofit and governmental hospitals that are subject to these requirements.

Section 501(r) imposes four additional operational requirements on section 501(c)(3) hospitals. Section 501(r)(1) provides that a “hospital organization,” as defined in section 501(r)(2), will not be treated as a charitable organization described in section 501(c)(3) unless the hospital organization (i) satisfies the community health needs assessment and implementation strategy requirements prescribed in section 501(r)(3), (ii) complies with the financial assistance policy requirements described in section 501(r)(4), (iii) observes the restriction on charge requirements described in section 501(r)(5), and (iv) employs collection practices that satisfy the requirements in section 501(r)(6).

If a hospital organization fails to comply fully with any requirement of section 501(r), it will lose its exemption as a charitable organization described in section 501(c)(3) either at the entity level (if it operates only one hospital facility) or at the hospital facility level (if it operates more than one hospital facility). In addition, a hospital organization will incur a \$50,000 monetary penalty⁴ if a hospital organization’s hospital facility fails to comply with the community health needs assessment and implementation strategy requirements. Section 501(r) is discussed comprehensively in the article attached to this paper that was published in the January/February 2013 issue of the journal *Taxation of Exempts*. The focus of this paper, rather, is to discuss the nature of the duties of care that a board of directors of a nonprofit hospital or health system must fulfill in connection with compliance with section 501(r)’s requirements.

Under most State law configurations of the director’s duty of care, a director is required to discharge his or her duties in good faith, with ordinary care, and in a manner that the director reasonably believes to be in the best interests of the corporation. In general, a person seeking to establish liability of a director must prove that the director did not act in good faith, with ordinary care, and in a manner the director reasonably believed to be in the best interest of the

⁴ This \$50,000 penalty imposed by new section 4959 of the Code, which is part of Chapter 42.

corporation. The enactment of section 501(r) and its imposition of new specific and highly detailed requirements presents new challenges for those individuals who govern nonprofit hospitals and health systems.

Unlike the general principles of law applicable to determining whether a nonprofit hospital is entitled to obtain or retain its tax-exempt status that pre-date the Affordable Care Act, section 501(r) is highly prescriptive and creates many opportunities for foot faults or worse. Because these foot faults may result in loss of exemption or the imposition of a substantial fine, board members can no longer be content to operate as if business is as usual. Rather, it is this author's view that boards of directors of nonprofit hospitals and health systems have a heightened duty of oversight to ensure that the persons with day-to-day responsibility for ensuring that a nonprofit hospital is taking all appropriate steps to satisfy all these requirements are, in fact, doing so and the board should periodically monitor compliance with these requirements.

In Notice 2011-52, 2011-30 I.R.B. 60 released in 2011, and in proposed regulations issued in 2012, the Treasury Department and Internal Revenue Service have made it clear that they expect fiduciary-level decision makers, *i.e.*, full boards or committees of boards, to take ownership for the adoption of policies and procedures that comply with section 501(r). Given this express requirement, State charities regulators should in turn be monitoring compliance with section 501(r) from the standpoint of following up when the IRS notifies the charities regulator under section 6104 of the Code of a loss of exemption of a nonprofit hospital or the imposition of the \$50,000 excise tax.⁵ By the same token, board members should be fully cognizant of the fact that if, through their action or inaction, a hospital loses its tax exemption or incurs the \$50,000 excise tax, they may bear some personal responsibility for the monetary losses that result to the hospital. In fact, the monetary losses to a hospital that loses its tax exemption could be quite substantial.

This potential for personal exposure is heightened by the fact that larger hospitals and health systems are increasingly adopting the practice of compensating non-management members of their boards of directors because of the increased responsibilities that are placed upon them given the complexity of the marketplaces in which they operate. Thus, State and Federal volunteer protection statutes that limit monetary liability of volunteer directors will not be available for those directors.

⁵ According to the IRS Exempt Organizations FY 2012 Annual Report & FY 2013 Workplan released in January 2013, eight State tax and charity agencies in seven different States have met the eligibility requirements for information and in FY 2011 the IRS made approximately 27,000 disclosures to these eight agencies. These disclosures include proposed and final revocations of exemption and proposed and final notices of deficiency for Chapter 42 taxes.

III. MERGERS, ACQUISITIONS AND CONSOLIDATIONS

A significant byproduct of the changes that will be implemented beginning in 2014 pursuant to the Affordable Care Act will be the increased margin pressure that will be facing nonprofit hospitals and health systems. This pressure will come from various sources. It will come from insurers, who will see their enrollments increase and, correspondingly, their market power increase. This will allow insurers to negotiate lower prices and demand alternative pricing strategies such as package pricing, thereby placing topline revenue pressure on nonprofit hospitals. In addition, it should be fully expected that both Federal and State governments will place topline pressure on nonprofit hospitals and health systems through rate reductions for Medicare and Medicaid beneficiaries.

At the same time, nonprofit hospitals and health systems will be faced with the need to expend significant amounts for new capital items such as technology and information systems and incur higher operating costs to meet the increased demand resulting from expanded access to health insurance for more than 40 million previously uninsured or under-insured individuals.

The combination of topline pressure and increased costs should cause any board of a nonprofit hospital or health system to evaluate its near- and longer-term strategy for survival. Mergers and affiliations are one strategy that will allow hospitals and health systems to increase their scale and thereby increase their economic efficiencies. By way of example, in just one transaction on which I am currently working that involves an affiliation of two large multi-hospital health systems, the cost savings projected from just the consolidation of supply chain amount to approximately \$650 million. Other hospitals and health systems may simply decide to “hang it up” and sell their facilities to another nonprofit organization or to a for-profit management company. These raise State law issues concerning compliance with State change-of-control requirements overseen by State charities regulators as well as potential heightened fiduciary duty of care (so-called “*Revlon*” duties) in connection with a sale transaction to a for-profit purchaser.

Finally, there will be those hospitals and their boards who simply don’t “get the memo” and begin the spiral into insolvency and bankruptcy. This will raise to the forefront an issue that has been facing for-profit companies for decades -- to whom is a board member’s duty of care owed, the organization or its creditors?⁶

Each of these scenarios -- mergers or affiliations, outright sales, or insolvency and bankruptcy -- presents its own unique issues for board members and the State charities regulators that provide oversight of them. In some instances, such as in California, the State charities regulators (in California, the Attorney General) will be able to evaluate many of these options in advance because of State law requirements that apply to transactions between a nonprofit hospital and either another nonprofit hospital or health system or a for-profit hospital or health

⁶ See, e.g. *Trenwick Am. Litig. Trust v. Ernst & Young LLP*, 906 A.2d 168, 2006 Del. Ch. LEXIS De. Ct. Ch. 2006).

system. However, in the insolvency or bankruptcy context, charities regulators may simply be left with looking in the rear-view mirror, so to speak, to evaluate the conduct of the boards of directors of nonprofit hospitals and health systems that spiral into bankruptcy or insolvency.

IV. NONCOMPLIANCE AND FRAUD

It is well recognized in both governmental circles as well as in the private sector that whenever there are large sources of private and governmental money available, there is also widespread opportunity for fraud and abuse. Healthcare is perhaps the poster child of that reality. The President and the Congress have made no secret of the fact that one of the ways expected to pay for the expansion of coverage and benefits under the Affordable Care Act is the aggressive pursuit of those who would engage in fraud and abuse in the healthcare sector.

From a State charities regulator's perspective, this raises interesting oversight and enforcement issues. For example, one of the additions in the Affordable Care Act was to accelerate the self-disclosure requirements to the Office of Inspector General for potential violations of the Stark self-referral law. Another example is compliance with the anti-kickback statutes. With expanded coverage under the Affordable Care Act, hospitals and health systems will face increasing pressure to recruit and retain physicians, especially those in primary care specialties such as family medicine, internal medicine and pediatrics.

Under traditional interpretations of the State law duty of care, directors are not expected to ferret out wrongdoing in their organizations. The classic description of this duty is from *Graham v. Allis-Chalmers, Manufacturing Company*.⁷ There, the Supreme Court of Delaware famously said, of a director, "If he has recklessly reposed confidence in an obviously untrustworthy employee, has refused or neglected cavalierly to perform his duty as a director, or has ignored either willfully or through inattention obvious danger signs of employee wrongdoing, the law will cast the burden of liability upon him."⁸ The Court went on to state: "[W]e know of no rule of law which requires a corporate director to assume, with no justification whatsoever, that all corporate employees are incipient law violators who, but for a tight checkrein, will give free rein to their unlawful propensities."⁹ The Court concluded, that "absent cause for suspicion there is no duty upon the directors to install and operate a corporate system of espionage to ferret out wrongdoing which they have no reasonable cause to suspect exists."¹⁰

On the other hand when there is evidence that there may be wrongdoing, they have a heightened duty to put in place processes and procedures and compliance plans to provide a reasonable level of assurance that the organizations will be and remain in compliance with

⁷ 188 A.2d 125, 41 Del. Ch. 78 (Del. Sup. Ct. 1963).

⁸ 188 A.2d at 131.

⁹ 188 A.2d at 131-132.

¹⁰ 188 A.2d at 130.

applicable laws. Given the incredible focus that will be placed on weeding out fraud and abuse in order to pay for expanded coverage under the Affordable Care Act, the boundaries of this duty of care will be stretched to their limits and tested.

V. CONCLUSION

Regardless of your political viewpoint concerning the efficacy of the changes made by the Affordable Care Act, implementation of various provisions has already begun and will only accelerate in 2013 with a full rollout beginning on January 1, 2014. Nonprofit hospitals and health systems have had to comply with Section 501(r)'s requirements since the first day of their fiscal year commencing after the date of enactment, March 23, 2010. Other requirements are phased in and the biggest impact will occur on January 1, 2014 when, through exchanges and other means, expansion of access will occur dramatically. These factors will challenge the oversight and governance capacities of every nonprofit hospital and health system in the United States and, correspondingly, place increased responsibilities on State charities regulators.