Tax Update 2014
Agenda

IRS Update

Affordable Care Act Provisions

501 (r) Regulations

Trends in Healthcare Tax
IRS Update
The IRS EO group will not publish a 2013 Annual Report & 2014 Work Plan.
SEVERANCE PAYMENTS

• Supreme Court Case:  *United States v. Quality Stores, Inc.*  
  U.S. No. 12-1408, 3/25/14  
  Supreme Court decision; 8-0  
  Refund claims denied

*Severance payments are subject to FICA*
FLEXIBLE SPENDING ACCOUNTS

• IRS Notice 2013-71--IRC Section 125 plans
• Modification of “Use-or-Lose” Rule For Health Flexible Spending Arrangements (FSAs)
  o Difficulty for employees of predicting future needs for medical expenditures
  o Minimize incentives for unnecessary spending at the end of a year
  o Employees are reluctant to participate because of aversion to forfeitures of their salary reductions
  o Simplify administration of Health FSAs
<table>
<thead>
<tr>
<th>FLEXIBLE SPENDING ACCOUNTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>Use it or lost it</strong></td>
</tr>
<tr>
<td>• <strong>Grace period</strong></td>
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<tr>
<td>• <strong>Modification to carryover rule</strong></td>
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PHYSICIAN RECRUITMENT ARRANGEMENTS

• **Vancouver Clinic, Inc. v. United States – April 8, 2013**
  o Physician loans are taxable compensation when paid if there is no intention of repayment
  o Physician recruitment loans reported as W-2 wages not 1099 income

• **Considerations for structuring advances**
  o Use a separate employment agreement to detail the physician’s compensation & other employment details
  o Execute a promissory note that requires periodic payment of the principal & interest on the loaned amount over the course of the physician’s employment
  o Allow the physician to repay the loan, plus interest, once the length of service requirement is met
• Significant period of time from the date of taxpayer filing until tax exemption is granted in most instances.

• IRS TE/GE expects a “significant” decrease in the IRS backlog of 80,000 applications by the end of 2014; announced February 2014

• Form 1023 EZ released (June 2014)
  - Organizations with anticipated annual gross receipts < $50,000 & total assets < $250,000
  - 3-page form; $400 filing fee
“Today’s tax code is once again a broken Mess. The 26,000-page tax code of 1986 has grown to more than 70,000 pages. In the last decade alone, there have been more than 4,400 changes to the code – more than one a day.”

-House Ways & Means Committee Report

• Tax Exempt Provisions
  • Unrelated business income calculated separately for each activity
  • Introduction of manager-level penalty when exempt organization is subject to accuracy-related penalty for a substantial understatement of unrelated income (5%, $20,000 Cap)
  • Imposing a 25% excise tax on compensation paid over $1,000,000 by exempt organizations to their five highest-paid employees
  • Eliminating future tax-exempt private activity bonds
  • Repeal of the law authorizing Type II & Type III supporting organizations
  • Elimination of safe harbor for professional advice
  • Charitable contributions
Affordable Care Act Provisions
Eligibility

• Available in individual coverage exchange (not in small employer exchange).

• Household income = 100% to 400% of federal poverty level.

  2013 Federal Poverty Levels
  ➢ Individual ($11,490 to $45,960)
  ➢ Family of four ($23,550 to $94,200)

• Individual is not eligible for credit if eligible for other government-sponsored coverage such as Medicare or Medicaid.

• Not eligible if enrolled in employer-sponsored plan or eligible for employer-sponsored plan that meets affordability & minimum value requirements. Test the self-only premium for affordability.
**Amount of the Credit**

- Example of a Premium Tax Credit
  
  Family of four in Louisville, Kentucky
  - 40-year old father, 39-year old mother & two children under age 21
  - Family income $47,100 (200% of Federal Poverty Level)

Monthly premium for second lowest cost silver plan

$636.00  (KY Health Cooperative Plan)

$247.27  Required monthly contribution

$383.73  Monthly subsidy
**Advance Payments & Reconciliation**

- Advance payments go directly to insurance company each month.
- Taxpayer reconciles the advance payments with the actual credit on new Form 8962 when filing a tax return for the coverage year.
- Will receive an additional refundable credit or if advance payment exceeds actual credit, excess is owed back as additional tax subject to caps.

<table>
<thead>
<tr>
<th>Dollar Caps on repayment</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 200%</td>
<td>$600</td>
</tr>
<tr>
<td>At least 200% but less than 300%</td>
<td>$1,500</td>
</tr>
<tr>
<td>At least 300% but less than 400%</td>
<td>$2,500</td>
</tr>
</tbody>
</table>
INDIVIDUAL COVERAGE REQUIREMENT

- Effective date January 1, 2014
- Must have “minimum essential coverage” qualify for one of nine exemptions or pay tax penalty
- Minimum essential coverage includes
  - Employer-sponsored coverage
  - Medicare, Medicaid, Tricare, CHIP, VA
  - Coverage purchased in the individual market (including coverage purchased on the exchanges)
- Minimum essential coverage does not include
  - Specialized coverage such as coverage only for dental or vision insurance, disability policies
  - Coverage for only a specific disease or condition
  - Health coverage provided by a foreign insurance company
Exemptions

1. Religious conscience
2. Health care sharing ministry
3. Indian tribes
4. No U.S. income tax filing requirement
5. Short coverage gap (less than three consecutive months)
6. Hardship (certified by state health insurance exchange)
7. Unaffordable coverage options (more than 8 percent) of your household income
8. Incarceration
9. Not lawfully present
INDIVIDUAL COVERAGE REQUIREMENT

**Liability for Penalty**

- Beginning with 2014 1040 filing, individuals will need to account for coverage, exemptions & any penalties they may owe
- Parent is liable for penalty if dependent claimed on the return lacks coverage or exemption
- Penalty is computed month by month
- Penalty is the greater of 1% of your household income that is above the tax return filing threshold for your filing status or your family’s flat dollar amount
  - Flat dollar amount per individual = $95 in 2014, $325 in 2015 & $695 in 2016
  - Penalty is capped at the cost of national average premium for bronze coverage
**Liability for Penalty**

- Penalty calculation – greater of
  - Applicable percentage of income
  - Flat dollar amount
- Determined monthly
- Penalty amount for minors is ½ adult amount
- Penalty for entire family limited to three times the flat dollar amount for an adult
- No penalty if coverage gap three months or less
## INDIVIDUAL COVERAGE REQUIREMENT

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Penalty</th>
<th>Percent of Income**</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$95</td>
<td>1.0%</td>
</tr>
<tr>
<td>2015</td>
<td>$325</td>
<td>2.0%</td>
</tr>
<tr>
<td>2016 and afterwards</td>
<td>695*</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

* Indexed to rate of inflation after 2016 rounded to next lowest $50

** Based on household income in excess of taxpayer’s threshold amount of income required to file an income tax return
Penalty for NO coverage

- Large employers subject to penalty if minimum essential coverage not provided to at least 95% of full-time employees
- Penalty is equal to $2,000 x full-time employees in excess of 30 and is not deductible
- Effective 2015
EMPLOYER SHARED RESPONSIBILITY – “PLAY OR PAY” MANDATE (IRC § 4980H)

• Large employer defined
  ➢ Average of 50 or more full-time employees in preceding year
  ➢ Full-time employee defined as working an average of 30 hours per week
  ➢ Full-time equivalent rule for counting part-time workers
    ➢ Total hours of service by part-time employees for the month divided by 120
  ➢ Special rule for seasonal workers
Penalty related to large employers that DO offer coverage

- Large employers that offer coverage to at least 95% of full-time employees that:
  - IS NOT affordable*
  - DOES NOT meet minimum value requirements**

Penalty is equal to the lesser of $3,000 per full-time employee receiving premium assistance through a marketplace or $2,000 per full-time employee in excess of 30

* if the employer share of the premium is in excess of 9.5% of their household income
** the health plan doesn’t cover at least 60% of total allowed costs of benefits provided under the plan
EMPLOYER/EMPLOYEE PROVISIONS

• Information reporting on coverage (IRC § 6055)
  ○ Submitted on IRS Form 1095-C
    ▪ Employer name, address & EIN
    ▪ Name, address & TIN of the employee as well as name & TIN (or date of birth) of each dependent covered under the plan
    ▪ For each individual listed on Form 1095-C, the months during which the individual was covered

*Effective for 2015 calendar year, due to employees by February 1, 2016 & to the IRS by March 31, 2016
EMPLOYER/EMPLOYEE PROVISIONS

• Reporting related to Employer Mandate (IRC § 6056)
  o Submitted on IRS Form 1095-C
    ▪ Number of full time employees, by month
    ▪ For each full-time employee, months when coverage was available
      for each full-time employee, the employees share of the lowest-cost
      monthly premium for self-only coverage

*Effective for 2015 calendar year, due to employees by February 1,
2016 & to the IRS by March 31, 2016
FEES ON HEALTH PLANS

- *Health Care Act* created the Patient-Centered Outcomes Research Trust Fund (PCORTF)
  - Created to conduct comparative clinical effectiveness research
- PCORTF to be funded by annual fee on health insurance policies & self-insured health plans
- Effective for policy or plan years beginning on or after October 1, 2012 & before September 30, 2019
FEES ON HEALTH PLANS

• Fee equal to specified dollar amount times average number of lives covered under policy
  o $1 for plan years ending before October 1, 2013
  o $2 for years beginning after September 30, 2013
  o Increased based on projected per capita amount of national health expenditures for years beginning after September 30, 2014

• Fee is calculated by one of three methods
  o Actual Count Method
  o Snapshot Method
  o 5500 Method

• Excise tax is reported on IRS Form 720-Quarterly Federal Excise Tax Return

http://www.irs.gov/uac/Newsroom/Patient-Centered-Outcomes-Research-Institute-Fee
501 (r) Regulations

Prepare for Section 501(r) requirements

- Prepare the board for its role in approving updated financial assistance, billing and collections, and emergency medical care policies
- Revisit financial assistance policy eligibility requirements
- Conduct an analysis of your polices and identify gaps
- Review how the current financial assistance policy is publicized and determine what changes need to be made
IRC SECTION 501(R)(4)

- Financial Assistance Policy (FAP)
  - Eligibility criteria for financial assistance
  - Basis for calculating amounts charged
  - Description of the process for patient to apply for financial assistance
  - If no separate billing & collection policy exists, actions organization may take in event of nonpayment
  - Measures to widely publicize policy
IRC SECTION 501(R)(4)

- Financial Assistance Policy (FAP)
  - May publicize summary of FAP as certain information may change regularly (such as federal poverty references)
  - No mandate for particular eligibility criteria
  - Must state amounts, such as gross charges, to which any discount percentages will be applied
• Must state FAP-eligible patient will not be charged more than amounts generally billed (AGB) for emergency or other medically necessary care
• Must state which of IRS permitted methods will be used to determine AGB
• Must either state percentage of gross charges hospital facility applies to determine AGB & how these AGB percentages were calculated or how members of public may readily obtain this information in writing free of charge
METHOD FOR APPLYING & ACTIONS TAKEN FOR NONPAYMENT

- Financial assistance may not be denied based on omission of information not specifically required by FAP or FAP application form
- Must describe actions that may be taken in event of nonpayment if no separate billing & collections policy exists
- Must describe process & time frames hospital will use in taking these actions, including reasonable efforts to determine if individual is FAP eligible
- Must describe who has final authority for determining hospital has made reasonable efforts
Four types of measures required

- Measures taken to make paper copies of FAP, FAP application & plain language summary available (in English & language of minority populations comprising > 10% of hospital’s community)
  - One commenter suggested a 5% or 500 patient threshold
- Public display measures
- Measures to inform & notify members of hospital’s community
- Measures to make FAP, application form & plain language summary available on website
• Authorized body must adopt policy & hospital must implement policy

• Authorized body includes
  o Governing body
  o Committee of governing body permitted under state law to act on behalf of governing body
  o Other parties authorized by governing body of hospital to act on its behalf
IRC SECTION 501(R)(5)

- 501(r)(5) – Limitation on Charges
  - Limits amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under FAP to not more than amounts generally billed to individuals having insurance covering such care
  - Prohibits use of gross charges
GROSS CHARGES

- May use gross charges as starting point to which discounts are applied
- Safe harbor provided for situations where individual does not complete FAP application before time of charges
LIMITATIONS ON CHARGES

• Must limit charges to FAP-eligible patients to not more than AGB to individuals with insurance covering that care & charges must be less than gross charges

• Two methods for computing AGB
  - Look-back method
  - Prospective method

• A hospital facility may use only one of the methods to determine AGB

• After choosing a particular method, a hospital facility must continue to use that method

• Claims paid under Medicare Advantage are treated as claims paid by private insurance
LOOK-BACK METHOD

• Based on actual claims paid to hospital by either Medicare fee-for-service only or Medicare fee-for-service together with all private health insurers paying claims

• Must calculate AGB percentages no less than annually by dividing sum of certain claims paid by sum of associated gross charges

• Calculated by multiplying gross charges by one or more AGB percentages
LOOK-BACK METHOD

• Must begin applying AGB percentages by 45\textsuperscript{th} day after end of 12-month period used in calculation (one commenter suggested a 75 - 90 day window to more closely coincide with revenue cycle)

• May calculate one average AGB percentage for all emergency & medically necessary care or multiple AGB percentages for separate categories of care as long as the hospital facility calculates an AGB percentages for all emergency & other medically necessary care
PROSPECTIVE METHOD

• Determine AGB by using same billing & coding process hospital would use if individual were Medicare fee-for-service beneficiary
IRC SECTION 501(R)(6)

- 501(r)(6) – Billing & Collection Requirement
  - May not engage in extraordinary collection actions (ECA) before organization has made reasonable efforts to determine whether individual is eligible for assistance
BILLING & COLLECTION

• Must engage in reasonable efforts to determine FAP eligibility before engaging in ECA

• ECAs include
  o Any action that requires legal or judicial process
  o Reporting to credit agencies
  o Sale of individual’s debt to another party
NOTIFICATION PERIOD

• Period in which hospital must notify individual about FAP
• Begins on date care is provided & ends on 120th day after hospital provides first billing statement
• Notify individual about FAP
• If individual provides incomplete application, provide them with information relevant to complete application
• Make & document determination as to whether individual is FAP eligible
NOTIFICATION ABOUT FAP

- Must distribute plain language summary of FAP & offer an application before discharge.
- Must distribute plain language summary of FAP with all (& at least three) billing statements during notification period.
- Must inform individual of FAP in all oral communications during notification period.
- Must provide at least one written notice about ECAs. Hospital may initiate if individual does not submit FAP application or pay amount due by last day of notification period.
• Brief description of eligibility requirements & assistance offered
• Direct website address & physical location copies may be obtained
• Instructions on how to obtain free copy by mail
• Contact information
• Statement of availability of translations if applicable
• Statement that no FAP-eligible patient will be charged more than AGB
APPLICATION PERIOD

- Must accept & process FAP applications during longer period that ends on 240\(^{th}\) day after hospital provides individual with first billing statement
- Many comments suggest this is too long
INCOMPLETE FAP APPLICATIONS

• If received during application period, hospital must
  o Suspend ECAs when received
  o Provide written notice that describes additional information needed
  o Provide at least one written notice describing ECAs that may be initiated or resumed if individual does not complete by deadline
COMPLETE FAP APPLICATIONS

- If received during application period, hospital must
  - Provide billing statement indicating amount owed
  - Refund any excess payments made by individual
  - Take all reasonably available measures to reverse any ECA
Trends in Healthcare Tax
TAX TRENDS IN HEALTH CARE

Increased scrutiny

- More challenges to maintain tax-exempt status post ACA (UPMC & Ascension)
- Both federal & state officials will be challenging tax-exempt status
- Compliance efforts will become increasingly more difficult
- Mandatory IRS review at least once every three years
- Senator Grassley status of IRS’s work on not-for-profit hospitals (April 4, 2014)

Reconsidering state property tax & sales tax exemptions

- Charity care requirements – (Illinois, Nevada, Pennsylvania, Texas, Utah)
- PILOT Programs
Health care Reform

- Changes to payment & delivery model
- Impact of increasing insured patient population
- Consolidation of health systems
- Increase in Joint Ventures
- Proactive planning & structuring of future arrangements
TAX RISK REVIEW

- Maintenance of Tax Exempt Status
- Compensation & Benefits
- Taxable Subsidiaries & Joint Ventures
- Tax Exempt Bonds
- State & Local Taxes
- Unrelated Business Income
- Physician Transactions
- Int’l Tax/Alternative Inv.
IRS EXAMINATION ACTIVITY

• Unrelated business income
  o Triggered by reporting of losses
  o Time to revisit expense allocations
  o Potential for transfer pricing studies

• Payroll tax exams
  o IRS very aggressive in challenging independent contractor status of medical directors & other individuals

• Client self-prepared 990s with no external review
  o Incorrect answers led to several exams

• Foreign activity
  o Foreign activity triggered exam, but it quickly expanded into other areas
Questions?

bkd.com
DISCLOSURES

• These discussions & conclusions are based on facts as stated & existing authorities as of date of this communication. Our advice could change as a result of changes in applicable laws & regulations. We are under no obligation to update this communication if such changes occur. Any advice should be based on your unique facts & circumstances as you communicated them to us & should not be used or relied on by anyone else.

• Tax professionals that practice before IRS are required to adhere to certain professional standards prescribed by Department of Treasury & IRS. These standards require us to include the following statement in certain written federal tax advice: This advice is not intended or written to be used & it cannot be used, for the purpose of avoiding penalties that may be imposed.
Thank You!

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