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Illinois Enacts Hospital Tax Exemption Standards

On June 14, 2012, Illinois Governor Patrick Quinn signed into law a measure that sets forth how much charity care nonprofit hospitals must provide and what counts toward that threshold to preserve their property and sales tax exemption.

The intention of the measure is to avoid federal and state ambiguity surrounding the test for charitable property tax exemptions for hospitals that has been a source of concern for many years. For example, in 2010, without specific guidance under Illinois law, the Illinois Supreme Court denied three state hospitals nonprofit tax-exempt status because they did not offer enough charitable care.

To qualify for a tax exemption, hospitals will now be required to use a new application form provided by the Department of Revenue that must contain verification by the hospital's CEO.

The new law will also apply retroactively to the many property and sales tax exemption applications and renewal proceedings pending as of the new law's effective date. Applicable hospitals may need to evaluate how the new law will affect existing applications—some of which may have been pending for several years.

Specifically, under the new state law, hospitals must demonstrate that the value of charity care they provide is equal to or exceeds the hospital's estimated property tax liability. Non-profit hospitals that satisfy the test for property tax exemption also will be exempt from sales tax.

The new law expands the types of activities that will count towards this threshold. The following services and activities count toward a hospital's tax exemption:

- Charity care: free or discounted services provided pursuant to the hospital's financial assistance policy, measured at cost;
- Health services to low-income and underserved individuals: includes, but not limited to, (1) subsidies for health care professionals who care for low-income patients, including financial or in-kind support to affiliated or unaffiliated hospitals, and (2) paying for or subsidizing education services to low-income individuals for disease management and prevention;
- Subsidy of state or local governments: direct or indirect financial or in-kind subsidies of state or local governments that pay for or subsidize activities or programs related to health care for low-income or underserved individuals;
- Support for state health care programs for low-income individuals: the new law provides what type of support may be included at the election of the hospital applicant for each applicable year. Unreimbursed costs will be net of fee-for-services payments, payments pursuant to an assessment, quarterly payments and all other payments included on IRS form 990, schedule H;
- Dual-eligible subsidy: the amount of subsidy provided to governments by treating dual-eligible Medicare and Medicaid patients.

Several other activities also count towards a non-profit hospital's tax exemption, including anything the state determines to relieve the burden of the government or addresses the health of low-income or underserved individuals.

For purposes of calculating a hospital's charity care, hospitals may use the value of the services or activities for the hospital year or the average value of those services or activities during a three-year period.

The aforementioned services or activities that count toward the applicable threshold, however, may not be counted more than once under any particular category.

Slow Health Care Spending Growth Predicted for 2013

Health care spending in the United States is expected to grow at a historically low rate of 7.5 percent in 2013, the fourth consecutive year of relatively low growth, according to a report by the PwC Health Research Institute. The projection continues a pattern of slower medical growth, a reflection of the sluggish economy, increased focus on cost containment by the industry, lower use of services by cost-conscious patients and efforts by employers to hold down expenses.

According to the report, employers are focused on two primary strategies to control medical costs in 2013, increasing the employee share of costs and expanding health and wellness programs. The survey also showed that plan design features with the most significant changes in 2012 were a considerable increase in in-network deductibles, emergency room co-payments and prescription drug co-payments.

The report stated one of two factors expected to "inflate" the trend in 2013 is an uptick in the consumption of health care as newly hired workers obtain coverage and patients who postponed elective procedures feel more confident about spending. Medical and technological advances that provide more specialized, sophisticated and expensive treatment also are expected to push up overall healthcare spending.

Four factors researchers expects will "deflate" the medical cost trend in 2013 are: market pressure to reduce medical supply and equipment costs; increased popularity of new methods to deliver primary care; increased availability of comparative cost information; and accelerated savings from the pharmaceutical patent cliff.

The report is available at *http://www.pwc.com/us/en/health-industries/behind-the-numbers/key-findings.jhtml*.

More than 100,000 Providers Paid for Using Electronic Health Records

More than 100,000 health care providers are using electronic health records that meet federal standards and have benefitted from the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) announced on June 19, 2012.

The EHR Incentive Programs, established by the Health Information for Clinical and Economical Health Act of 2009, provide incentive payments to eligible professionals, hospitals, and critical access hospitals as they adopt, implement, upgrade, or meaningfully use certified EHR technology in ways that improve care. As of the end of May 2012:

- More than 110,000 eligible professionals and over 2,400 eligible hospitals have been paid by the Medicare and Medicaid EHR Incentive Programs.
- Approximately 48 percent of all eligible hospitals and critical access hospitals in the U.S. have received an incentive payment for adopting, implementing, upgrading, or meaningfully using an EHR.
- One out of every 5 Medicare and Medicaid eligible professionals in the U.S. has received an incentive payment for adopting, implementing, upgrading, or meaningfully using an EHR.
- Over $5.7 billion in EHR Incentive Program payments were made.
- More than $3 billion in Medicare EHR Incentive Program payments were made between May 2011 (when the first payments were released) and the end of May 2012.
- More than $2.6 billion in Medicaid EHR Incentive Program payments were made between January 2011 (when the first states launched their programs) and the end of May 2012.

13.7 Million Young Adults Joined or Stayed on Parents' Health Plans in 2011

In 2011, 13.7 million young adults ages 19 to 25 stayed on or joined their parents' health plans, including 6.6 million who would likely not have been able to do so before passage of the Affordable Care Act, according to a new Commonwealth Fund report released on June 8, 2012.

Not all young adults have parents with health plans they can join, however, and many still go uninsured or experience gaps in coverage. Nearly two of five (39 percent) young adults ages 19 to 29 went without health insurance at some time in 2011, and more than one-third (36 percent) had medical bill problems or were paying off medical debt.

Regardless of whether they had insurance, many young adults skipped or delayed getting needed health care because of cost. Two of five (41 percent) young adults said they did not fill a prescription; skipped a medical test, treatment, or follow-up visit recommended by a doctor; did not go to a doctor when sick; or did not get needed specialist care because of cost. Those who were uninsured or who had a gap in coverage were at greatest risk: 60 percent of young adults who were uninsured when surveyed and 56 percent of those who had an insurance gap during the year did not get needed care because of cost, compared with 29 percent of young adults who were insured all year.

> Nearly two of five (39 percent) young adults ages 19 to 29, however, went without health insurance at some time in 2011.

The full report is available at *http://www.commonwealthfund.org/Publications/Issue-Briefs/2012/Jun/Young-Adults-2012.aspx*.

Did You Know?

ACA members can voluntarily commit to align their practices with ACA's *Health Care Collection, Servicing and Debt Purchasing Practices – Statement of Principles and Guidelines*. Those who are committed to the principles agree to:

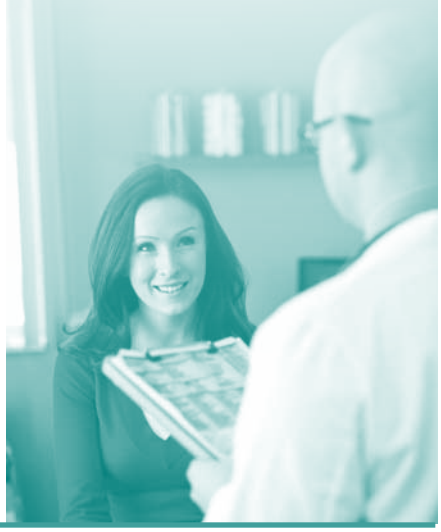
- Service all health care accounts using a process that is consistent with the expectations of their health care providers.
- Perform services or payment operations upon receipt of information necessary to comply with all applicable laws, regulations, mandates and duties as prescribed by the ACA Code of Ethics and Code of Operations.

To view other commitments set forth by the guiding principles, visit ACA's website at *http://www.acainternational.org/hcguidelines*.

Health Care Law Delivers Free Preventative Services

The Centers for Medicare & Medicaid Services (CMS) announced on June 11, 2012, that the Affordable Care Act helped 14.3 million people within original Medicare get at least one preventive service at no cost to them during the first five months of 2012. This includes 1.1 million who have taken advantage of the Annual Wellness Visit provided by the Affordable Care Act. In 2011, 32.5 million people in Medicare received one or more preventive benefits free of charge.

Prior to 2011, people with Medicare faced cost-sharing for many preventive benefits such as cancer screenings. Under the Affordable Care Act, preventive benefits are offered free of charge to beneficiaries, with no deductible or co-pay. The law also added an important new service for people with Medicare—an Annual Wellness Visit with the doctor of their choice —sat no cost to beneficiaries.



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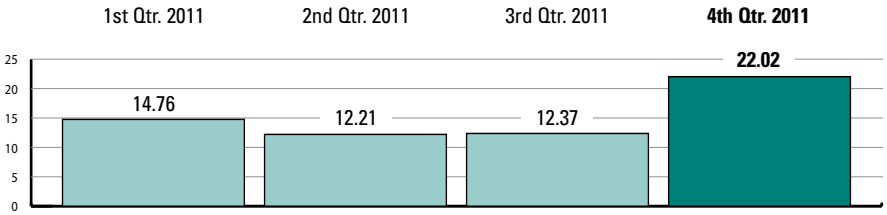
DATA WATCH

A/R Delayed in Medical Records Up

After a slight increase from the second to the third quarters of 2011, there was a major change in accounts receivable (A/R) delayed in the hospital's medical records department at the end of the year.

In the fourth quarter, hospitals reported an average of 22.20 percent of A/R delayed in the hospital's medical records department. This is up substantially from the third quarter when it was 12.37 percent of A/R.



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