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*Tax-Exempt Section 501(c)(3) Hospitals: Community Benefit
Standard and Schedule H*

Erika Lunder and Edward C. Liu, American Law Division

July 31, 2008

Abstract. This report examines the standards under which hospitals qualify for tax-exempt charitable status under federal law, recent inquiries made by Congress and the IRS into whether hospitals are conducting sufficient activities to justify their exemption, and the new Schedule H. It ends with a brief discussion of H.R. 973 (110th Congress) and H.R. 6420 (109th Congress).

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CRS Report for Congress

Tax-Exempt Section 501(c)(3) Hospitals: Community Benefit Standard and Schedule H

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Prepared for Members and
Committees of Congress

Tax-Exempt Section 501(c)(3) Hospitals: Community Benefit Standard and Schedule H

Summary

Non-profit hospitals receive billions of dollars in governmental subsidies due to their tax-exempt status as § 501(c)(3) charitable organizations. Among other requirements, these hospitals must be organized and operated for a charitable purpose in order to maintain their tax-exempt status. Under the “community benefit” standard developed by the IRS, charitable hospitals are judged on whether they provide sufficient health benefits to the community. Recently, questions have arisen as to whether § 501(c)(3) hospitals are providing adequate public benefits to justify their status as charitable organizations.

Both Congress and the IRS have examined the issue of hospitals’ tax-exempt status over the past several years. One outcome has been that the IRS developed a new annual reporting requirement (Schedule H of the Form 990) for hospitals to report information regarding their activities. The new Schedule H has been controversial.

In the 110th Congress, the Charity Care for the Uninsured Act of 2007 (H.R. 973) would create a new tax credit for physicians who provide charity care. No legislation has been introduced in the 110th Congress that would address the tax treatment of hospitals. There was such a bill in the 109th Congress — the Tax Exempt Hospitals Responsibility Act of 2006 (H.R. 6420). Among other things, this bill would have imposed a tax on § 501(c)(3) hospitals that failed to treat low-income uninsured patients.

This report examines the standards under which hospitals qualify for tax-exempt charitable status under federal law, recent inquiries made by Congress and the IRS into whether hospitals are conducting sufficient activities to justify their exemption, and the new Schedule H. It ends with a brief discussion of H.R. 973 (110th Congress) and H.R. 6420 (109th Congress).

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Tax-Exempt Section 501(c)(3) Hospitals: Community Benefit Standard and Schedule H

Non-profit hospitals receive billions of dollars in governmental subsidies due to their status as charitable organizations.¹ Benefits that arise from this status under federal law include exemption from federal income taxes, eligibility to receive tax-deductible contributions, and authority to use tax-exempt bond financing.² In recent years, Congress, the Internal Revenue Service (IRS), and members of the public have questioned whether hospitals are conducting sufficient charitable activities to justify these benefits.

Standard for § 501(c)(3) Status as a Charitable Organization

Non-profit hospitals typically qualify for federal tax-exempt status as charitable organizations under § 501(c)(3) of the Internal Revenue Code.³ There is no definition in the tax code for the term “charitable.” A regulation promulgated by the Department of the Treasury provides some guidance, although it does not explicitly

¹ See Congressional Budget Office, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS, Dec. 2006, at 5 (reporting that the estimated value of the federal and state tax exemptions received by charitable hospitals in 2002 was \$12.6 billion). A hospital’s eligibility for a state tax exemption is determined under state law, and states are free to use any criteria they wish. They are not required to use the standard for determining charitable status under federal law. Some states have adopted explicit charity care or community benefit requirements as a condition imposed to receive a state tax exemption or for purposes apart from the tax laws. See, e.g., Community Catalyst, Inc., HEALTH CARE COMMUNITY BENEFITS: A COMPENDIUM OF STATE LAWS, available at [http://www.communitycatalyst.org/doc_store/publications/community_benefits_compendium_2007.pdf] (summarizing state community benefit laws).

² See IRC §§ 501(a), 170(c)(2), 145.

³ IRC § 501(c)(3) describes entities “organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster national or international amateur sports competition ... or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation ... and which does not participate in, or intervene in ... any political campaign on behalf of (or in opposition to) any candidate for public office.” Some hospitals may qualify to be § 501(c)(3) educational or scientific organizations. See Rev. Rul. 56-185; 1956-1 C.B. 202. Non-profit hospitals may also be able to qualify for exemption as § 501(c)(4) social welfare organizations.

address the activities of hospitals. It states that “[t]he term *charitable* is used in section 501(c)(3) in its generally accepted legal sense,” and provides examples of charitable purposes, including the relief of the poor or unprivileged; the promotion of social welfare; and the advancement of education, religion, and science.⁴

In the absence of explicit statutory or regulatory requirements applying the term “charitable” to hospitals, it has been left to the IRS to determine the criteria hospitals must meet to qualify as § 501(c)(3) charitable organizations. Over the years, the IRS has developed two distinct standards: the “charity care standard” and the “community benefit standard.”

Charity Care Standard

In 1956, the IRS issued Revenue Ruling 56-185, which addressed the requirements hospitals needed to meet in order to qualify for § 501(c)(3) status.⁵ One of these requirements is known as the “charity care standard.” Under the standard, a hospital had to provide, to the extent of its financial ability, free or reduced-cost care to patients unable to pay for it. A hospital that expected full payment did not, according to the ruling, provide charity care based on the fact that some patients ultimately failed to pay. The ruling emphasized that a low level of charity care did not necessarily mean that a hospital had failed to meet the requirement since that level could reflect its financial ability to provide such care. The ruling also noted that publicly supported community hospitals would normally qualify as charitable organizations because they serve the entire community, and a low level of charity care would not affect a hospital’s exempt status if it was due to the surrounding community’s lack of charitable demands.

Community Benefit Standard

In 1969, the IRS issued Revenue Ruling 69-545, which “remove[d]” from Revenue Ruling 56-185 “the requirements relating to caring for patients without charge or at rates below cost.”⁶ Under the standard developed in Revenue Ruling 69-545, which is known as the “community benefit standard,” hospitals are judged on whether they promote the health of a broad class of individuals in the community.

The ruling involved a hospital that only admitted individuals who could pay for the services (by themselves, private insurance, or public programs such as Medicare), but operated a full-time emergency room that was open to everyone. The IRS ruled that the hospital qualified as a charitable organization because it promoted the health of people in its community. The IRS reasoned that because the promotion of health was a charitable purpose according to the general law of charity, it fell within the

⁴ Treas. Reg. § 1.501(c)(3)-1(d)(2).

⁵ Rev. Rul. 56-185, 1956-1 C.B. 202.

⁶ Rev. Rul. 69-545, 1969-2 C.B. 117.

“generally accepted legal sense” of the term “charitable,” as required by Treas. Reg. § 1.501(c)(3)-1(d)(2).⁷ Expanding on this point, the ruling stated that

The promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community.⁸

The IRS concluded that the hospital was “promoting the health of a class of persons that is broad enough to benefit the community” because its emergency room was open to all and it provided care to everyone who could pay, whether directly or through third-party reimbursement.⁹ Other characteristics of the hospital that the IRS highlighted included the following: its surplus funds were used to improve patient care, expand hospital facilities, and advance medical training, education, and research; it was controlled by a board of trustees that consisted of independent civic leaders; and hospital privileges were available to all qualified physicians.

It appears that the community benefit standard was adopted partly in response to the enactment in 1965 of Medicare and Medicaid, which some thought would reduce the need for hospitals to provide charity care.¹⁰ Its adoption by the IRS may also have been a response to concerns about the charity care standard. These concerns were evidenced in a legislative proposal, introduced in the same year Revenue Ruling 69-545 was issued, that would have created an explicit category in IRC § 501(c)(3) for hospitals.¹¹ The House Report accompanying the bill expressed concern with how the charity care standard was applied in practice:

In a number of cases internal revenue agents have challenged the exempt status of hospitals on the sole ground that the hospitals are accepting insufficient numbers of patients at no charge or at rates substantially below cost. This has resulted in significant uncertainty as to the extent to which a hospital must accept patients who are unable to pay, in order to retain its exempt status.¹²

Shortly after the House Report was released, the IRS issued Revenue Ruling 69-545. The Senate Finance Committee then removed the hospital provision from the bill, noting the existence of the new ruling and stating it would look at the issue when it

⁷ *Id.* (citing to Restatement (Second), Trusts, sec. 368 and sec. 372; IV Scott on Trusts (3rd ed. 1967), sec. 368 and sec. 372).

⁸ *Id.* (citing to Restatement (Second), Trusts, sec. 368, comment (b) and sec. 372, comments (b) and (c); IV Scott on Trusts (3rd ed. 1967), sec. 368 and sec. 372.2).

⁹ *Id.*

¹⁰ See STAFF OF S. COMM. ON FINANCE, 91ST CONG., MEDICARE AND MEDICAID: PROBLEMS, ISSUES, AND ALTERNATIVES, at 56 (Comm. Print 1970) [hereinafter *Staff Report*].

¹¹ Tax Reform Act of 1969, H.R. 13270, 91st Cong. (1969) (enacted into law, P.L. 91-172, without the hospital provision).

¹² H.Rept. 91-413, pt. 1, at 43 (1969).

addressed pending Medicare and Medicaid legislation.¹³ A subsequent Finance Committee staff document on Medicare and Medicaid issues advocated that the ruling be revoked and the charity care standard be reimposed until Congress could address the situation.¹⁴

Legal Challenge to the Community Benefit Standard. After the IRS released Revenue Ruling 69-545, several indigents and organizations with indigent members filed a class action suit challenging the authority of the IRS to implement the community benefit standard, which they argued was inconsistent with the term “charitable” in IRC § 501(c)(3) because it did not require treatment of the poor. In a 1976 decision, *Simon v. Eastern Kentucky Welfare Rights Organization*,¹⁵ the Supreme Court held that the plaintiffs lacked the constitutionally required standing to bring the suit. To have standing, “[a] plaintiff must allege personal injury fairly traceable to the defendant’s allegedly unlawful conduct and likely to be redressed by the requested relief.”¹⁶ The plaintiffs’ alleged injury was that the adoption by the IRS of the community benefit standard had encouraged hospitals to not provide necessary medical care to the indigents. The Court, in holding that they failed to meet the constitutional requirements for standing, reasoned that it was “purely speculative” as to whether (1) the hospitals had denied the treatment because of the new ruling and not because of other, non-tax reasons and (2) the plaintiff’s success would result in the care being provided since some hospitals could choose to give up their tax-exempt status if the cost of the care was too high.¹⁷

Further Development of the Community Benefit Standard. The IRS continues to use and develop the community benefit standard. For example, in 1983, the IRS issued Revenue Ruling 83-157, which clarifies the standard’s requirement

¹³ S.Rept. 91-552, at 61 (1969).

¹⁴ See Staff Report, *supra* note 10, at 56 (“The staff strongly recommends revocation of Revenue Ruling 69-545 in light of the recent legislative history and continuation of the prior position of the Service until such time as Congress can devise an alternative approach establishing reasonable yardsticks of charitable service related to the financial capacity of a hospital. Such action by the Service would assist in protecting the availability of necessary hospital care to Medicare, Medicaid, and other poor patients”).

¹⁵ 426 U.S. 26 (1976). The plaintiffs had prevailed before the district court, which had voided Revenue Ruling 69-545 as being “improperly promulgated” because there was insufficient justification for the “clear change of previously administered policy.” *E. Ky. Welfare Rights Org. v. Shultz*, 370 F. Supp. 325, 336-38 (D.D.C. 1973). The D.C. Circuit Court of Appeals reversed the district court’s decision, finding that the IRS interpretation of “charitable” was permissible because the term’s definition “has never been static and has been broadened in recent years” and “is thus capable of a definition far broader than merely the relief of the poor.” *E. Ky. Welfare Rights Org. v. Simon*, 506 F.2d 1278, 1286-90 (D.C. Cir. 1974). The court reasoned that limiting the term to relief of the poor “fails to recognize the changing economic, social and technological precepts and values of contemporary society.” *Id.* at 1288.

¹⁶ *Allen v. Wright*, 468 U.S. 737, 751 (1984).

¹⁷ 426 U.S. at 42, 43.

that a hospital operate an emergency room that is open to the public.¹⁸ While an important factor in Revenue Ruling 69-545 was that the hospital operated an emergency room open to everyone, Revenue Ruling 83-157 states that a hospital without an emergency room may still qualify for exempt status if other conditions are met. The ruling recognized that there are circumstances in which hospitals may not need to operate emergency rooms, such as when a state agency has determined that its operation of an emergency room would be duplicative or when a hospital operates in a specialized field in which it is unlikely that emergency care would be required. In these situations, a hospital may still qualify as a charitable organization if it shows other evidence that it provides benefits to the community by promoting the health of a broad class of persons. The ruling listed examples of other factors that may be used as evidence: a board of directors chosen from members of the community; an open medical staff policy; treatment of patients using public programs (e.g., Medicare and Medicaid); and using surplus funds for improving patient care, facilities, equipment, and medical training, education, and research.

Recent Controversy

In the past several years, questions have arisen as to whether non-profit hospitals deserve the benefits they receive as § 501(c)(3) charitable organizations.¹⁹ Areas of controversy include the prices charged to low-income uninsured patients for medical care in comparison to those charged patients paying through insurance; the methods used by hospitals to collect payment from low-income patients (e.g., the use of debt collectors) and the classification of bad debt as a community benefit; an increasing number of partnerships between tax-exempt hospitals and for-profit entities; and the amount of compensation paid to high-level employees. Additionally, some have questioned whether the community benefit standard is correct, or whether tax-exempt hospitals should categorically be required to provide a certain level of charity care.

In 2004 and 2005, more than 45 class action lawsuits were filed in at least 25 states that challenged the treatment and billing practices of § 501(c)(3) hospitals with respect to low-income uninsured individuals.²⁰ One claim in these suits was that IRC § 501(c)(3) created a contract between the federal government and hospitals or a charitable trust for the public's benefit. According to the plaintiffs, the establishment of the contract or trust required tax-exempt hospitals to provide emergency treatment to patients regardless of their ability to pay, charge affordable and fair prices for

¹⁸ Rev. Rul. 83-157, 1983-2 C.B. 94.

¹⁹ See, e.g., John Carreyrou and Barbara Martinez, *Nonprofit Hospitals, Once For the Poor, Strike It Rich; With Tax Breaks, They Outperform For-Profit Rivals*, Wall St. J., Apr 4, 2008, at A.1.

²⁰ See, e.g., *McCoy v. E. Tex. Med. Ctr. Reg'l Healthcare Sys.*, 388 F. Supp. 2d 760 (E.D. Tex. 2005); *Valencia v. Miss. Baptist Med. Ctr., Inc.*, 363 F. Supp. 2d 867 (S.D. Miss. 2005); *Amato v. UPMC*, 371 F. Supp. 2d 752 (W.D. Penn. 2004); *Ferguson v. Centura Health Corp.*, 358 F. Supp. 2d 1014 (D. Colo. 2004); *Quinn v. BJC Health Sys.*, 364 F. Supp. 2d 1046 (E.D. Mo. 2005). The Judicial Panel for Multidistrict Litigation denied a motion to consolidate the cases. See *In re Not-for-Profit Hospitals/Uninsured Patients Litigation*, 341 F. Supp. 2d 1354 (J.P.M.L. Oct. 19, 2004).

medical care, and not engage in abusive collection practices. Courts have rejected these claims, finding that IRC § 501(c)(3) clearly neither creates a contract or a charitable trust, nor provides third-party beneficiaries with a private cause of action. As one court stated, “Plaintiffs here have lost their way; they need to consult a map or a compass or a Constitution because Plaintiffs have come to the judicial branch for relief that may only be granted by the legislative branch.”²¹ While these suits were dismissed, they did bring additional attention to the issue of whether § 501(c)(3) hospitals are providing sufficient social benefits to justify their tax-exempt status.

Recent Congressional Activity

In 2005 and 2006, both the Senate Finance and House Ways and Means Committees held hearings on tax-exempt hospitals.²² Additionally, in 2007, the minority staff on the Senate Finance Committee released a discussion draft of possible tax-exempt hospital reforms and invited public comment on them.²³ Among the proposals put forth in the discussion draft were a requirement that each hospital maintain and publicize a charity care program and provide minimum amounts of charity care measured as a percentage of that hospital’s total operating expenses.²⁴

Recent IRS Activity and Schedule H of Form 990

In 2006, the IRS sent questionnaires to approximately 600 large hospitals throughout the country to collect information on how hospitals operated (e.g., billing practices, emergency room availability, and compensation) and what types of community benefits they provided.²⁵ Amid concerns about “whether there [were] differences between for-profit and tax-exempt hospitals,”²⁶ the IRS announced that hospitals would be required to provide additional information specific to their industry on a new Schedule H of the redesigned Form 990 (the annual information

²¹ *Kolari v. New York-Presbyterian Hosp.*, 382 F. Supp. 2d 562, 565-56 (S.D.N.Y. Mar. 29, 2005), *vacated, in part, and remanded*, 455 F.3d 118 (2d Cir. 2006).

²² *Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals: Hearing before the Senate Committee on Finance*, 109th Cong. (2006), available at [<http://finance.senate.gov/sitepages/hearing091306.htm>]; *Hearing on the Tax-Exempt Hospital Sector before the House Committee on Ways and Means*, 109th Cong. (2005), available at [<http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=415>].

²³ Senate Finance Committee Minority Staff, *Tax-Exempt Hospitals: Discussion Draft (2007)*, available at [<http://finance.senate.gov/press/Gpress/2007/prg071907a.pdf>].

²⁴ *Id.* at 6-10.

²⁵ The questionnaire, Form 13970, is available on the IRS website at [<http://www.irs.gov/charities/charitable/article/0,,id=157660,00.html>]. An initial report discussing the number and types of responses to the survey is available at [http://www.irs.gov/pub/irs-tege/eo_interim_hospital_report_072007.pdf].

²⁶ IRS, *Draft Form 990 Redesign Project - Schedule H: Instructions*, at 1, June 14, 2007, available at [http://www.irs.gov/pub/irs-tege/draftform990redesign_schh_instr.pdf] [hereinafter *June 14 Draft Comments*].

return filed by tax-exempt organizations).²⁷ The IRS released a draft Schedule H in June 2007 and, after seeking public comment on the draft, issued the final version in December 2007. Drawn heavily from, but not identical to, the community benefit reporting model used by the Catholic Health Association of the United States (CHA), Schedule H was drafted to “combat the lack of transparency surrounding the activities of tax-exempt organizations that provide hospital or medical care.”²⁸

Comments on the draft expressed immediate concerns about the technical and procedural implications of the addition. For example, comments on draft versions of Schedule H reflected uncertainty over what constituted a hospital and whether multiple iterations of the Schedule were required for entities that operated more than one hospital facility. The comments by the IRS released simultaneously with the final revision indicated that the IRS intended to defer to definitions of hospitals found in the various states’ laws and that only one Schedule H would be required for an entity with a single employer identification number, regardless of the number of hospitals run by it.²⁹

The IRS specifically solicited comments on the possibility that the proposed rollout of Schedule H could impose a heavy burden if entities would need to retool their internal accounting or reporting mechanisms in order to gather the necessary information.³⁰ In response to received comments, the new Schedule H will be rolled out gradually. Beginning with tax year 2008 (returns filed in 2009), the only portion of Schedule H required will be the disclosure and description of the hospital facilities operated by the filing entity. The portions of the Schedule used to report details of a hospital’s charity care program and community benefit expenditures will be optional. However, the entire Schedule will be mandatory beginning with tax year 2009.³¹

Schedule H contains six parts, each of which will be discussed in detail below. Part I requests details about a hospital’s charity care program and attempts to quantify charity care expenditures. Part II quantifies the hospital’s community building activities. Part III quantifies the costs due to Medicare shortfalls and bad debts owed to the organization. Part IV requires disclosure of any joint ventures in which a hospital participates. Part V requests information about the entity’s health care

²⁷ IRS, *Press release: IRS Releases Final 2008 Form 990 for Tax-Exempt Organizations, Adjusts Filing Threshold to Provide Transition Relief*, Dec. 20, 2007, available at [<http://www.irs.gov/newsroom/article/0,,id=176722,00.html>]. The new Schedule H is part of a significant redesign of the entire Form 990.

²⁸ *June 14 Draft Comments*, *supra* note 26, at 1.

²⁹ IRS, *Form 990 Redesign for Tax Year 2008 Schedule H, Hospitals — Highlights*, at 2, Dec. 20, 2007, available at [http://www.irs.gov/pub/irs-tege/highlights_schedule_h.pdf] [hereinafter *Dec. 20 Draft Highlights*]. *See, also*, IRS, *2008 Schedule H (Form 990) Instructions - Draft*, at 4-5, Apr. 7, 2008, available at [http://www.irs.gov/pub/irs-tege/990_instructions_schh_040708.pdf].

³⁰ IRS, *Background Paper: Redesigned Draft Form 990*, at 5, June 14, 2007, available at [http://www.irs.gov/pub/irs-tege/form_990_cover_sheet.pdf].

³¹ *Dec. 20 Draft Highlights*, *supra* note 29, at 5-6.

facilities. Part VI provides an area in which to discuss, in a narrative fashion, other charitable activities that may be difficult to quantify.

Part I: Quantifying the “Community Benefit” Standard. Part I attempts to quantify the amount of community benefit provided by hospitals on an annual basis. The metric the IRS has chosen to quantify community benefit is dollars spent. Qualifying expenses include free care, unreimbursed Medicaid, community health improvement services, health professions education, subsidized health services, research, and contributions to other community groups.³²

Aside from concerns about the technical aspects of the new Schedule H, several substantive criticisms also emerged from the public comments. For the most part, these criticisms stemmed from the perception that the categories of charity care and community benefit envisioned by the IRS were underinclusive.³³ The agency had explicitly stated in its comments accompanying the initial draft of Schedule H that the Schedule was an attempt to “quantify, in an objective manner, the community benefit standard applicable to tax-exempt hospitals.”³⁴ While the IRS did not suggest a minimum level of expenditures that would be required in order to justify tax-exemption, it is probable that some hospitals were concerned that the exclusion of certain expenditures would make themselves appear, on paper, undeserving of tax-exempt status. By and large, these criticisms focused on three specific omissions: community building expenditures, Medicare shortfalls, and bad debt.

Part II: Community Building. The final draft of Schedule H includes an area, Part II, in which to report community building expenditures. Although the definition of “community building” may not be obvious at first glance, it is generally understood to refer to programs that are intended to have a beneficial impact upon the health of a community but that do not provide medical care.³⁵ Examples of community building taken from the final draft of Schedule H are housing improvements, economic development, community support, environmental improvements, leadership development, coalition building, community health improvement advocacy, and workforce development.³⁶

The initial draft of Schedule H did not include community building activities in its calculation of community benefit. In comments on the initial draft, the CHA

³² IRS, *Schedule H to Form 990, Final Draft*, at Part I, December 20, 2007, available at [<http://www.irs.gov/pub/irs-tege/f990rschh.pdf>] [hereinafter *Schedule H, Final Draft*].

³³ See, e.g., American Hospital Association, *Comments on Draft Schedule H*, at 2-4, Aug. 21, 2007 [hereinafter AHA Comments]; Catholic Health Association of the United States, *Comments Related to Schedule H*, at 4, Sept. 12, 2007, [hereinafter CHA Comments]; Health Law and Taxation Sections of the American Bar Association, *Comments Concerning Discussion Draft of Redesigned Form 990 for Tax-exempt Organizations*, at 66-69, Oct. 4, 2007 [hereinafter ABA Comments].

³⁴ *June 14 Draft Comments*, *supra* note 26, at 1.

³⁵ See, e.g., AHA Comments, *supra* note 33, at 7; CHA Comments, *supra* note 33, at 8; ABA Comments, *supra* note 33, at 69.

³⁶ *Schedule H, Final Draft*, *supra* note 32, at Part II.

strongly opposed their exclusion. The CHA argued that “there is clear consensus in the public health community that social and environmental factors are strong determinants of health for vulnerable populations,” citing publications from the Centers for Disease Control and other scholarly articles.³⁷ Additionally, the CHA noted that “every community building activity would qualify for exemption on a stand-alone basis.”³⁸

Despite the inclusion of community building metrics in the final draft of Schedule H, these numbers are still separate from the reporting of charity care and community benefit expenditures in Part I. The IRS commentary on the final draft reflected the view that the link between community building and health was still tenuous and that the reporting tools in Schedule H are intended to operate, in part, as data collection methods for the IRS to discern what links exist.³⁹

Part III: Medicare Shortfalls. Hospitals incur costs when treating all patients, including patients who are covered by Medicare. Medicare, however, may not reimburse a provider for the total cost of services received by a patient. The difference between the Medicare reimbursement rates and the costs incurred by a hospital are called shortfalls.

Some commentators expressed a belief that a hospital should be allowed to include the aggregate amount of these shortfalls in any calculation of the total community benefit provided by that hospital. For example, comments from the Health Law and Taxation Sections of the American Bar Association (ABA) reasoned that “the entire amount of any ‘Medicare shortfall’ should count as ‘charity care,’ because the elderly constitute a clearly-recognized charitable class.”⁴⁰ Additionally, the American Hospital Association (AHA) commented that “many Medicare beneficiaries, like their Medicaid counterparts, are poor,” and would have qualified for a hospital’s charity care program or Medicaid in addition to Medicare.⁴¹ If these patients had been treated as charity care, the entire cost of medical care would have been considered community benefit under Part I. Additionally, any shortfall in Medicaid reimbursement would similarly have been included in community benefit.

Others, however, argued that Medicare shortfalls are not a useful metric for determining community benefit. The Catholic Health Association, opposing inclusion, noted that “many for-profit hospitals compete aggressively for these [Medicare] patients.”⁴² In its view, measuring Medicare shortfalls would not usefully distinguish for-profit hospitals from those seeking tax exemption, and creating

³⁷ CHA comments, *supra* note 33, at 9.

³⁸ *Id.* at 10.

³⁹ *Dec. 20 Draft Highlights*, *supra* note 29, at 4.

⁴⁰ ABA Comments, *supra* note 33, at 66 (citing Rev. Rul. 1972-124, 1972-1 C.B. 145).

⁴¹ AHA Comments, *supra* note 33, at 5.

⁴² CHA Comments, *supra* note 33, at 14. The discussion of Medicare shortfalls may also raise the question whether shortfalls in reimbursement from *for-profit* insurers should also be counted as uncompensated care.

distinctions between these two groups is necessary to ensure that tax exemption retains its credibility with policy makers. Notwithstanding these arguments, the CHA noted that “if, at some point, access problems emerge for Medicare patients, the rationale for including Medicare services as community benefit increases.”⁴³

In the final draft of Schedule H, the IRS provided a dedicated area in Schedule H in which to report Medicare shortfalls. Despite the addition of Part III, the IRS does not treat Medicare shortfalls as a direct measure of community benefit, in and of themselves. Instead, hospitals are asked to “[d]escribe ... the extent to which any shortfall reported in [this part] *should* be considered as community benefit.”⁴⁴

Part III (continued): Bad Debt. Hospitals regularly engage in billing and collection practices in order to recoup co-pays, deductibles, and other expenses from patients. During the collection process, there may occur a point at which it becomes apparent that a debt owed to the hospital has little or no potential of repayment. In accordance with sound accounting practices, it is customary to “write off” these debts as “bad debt.”

Because bad debts, by definition, represent services hospitals have provided without compensation, some believe that the aggregate amount of bad debt should be included in any calculation of community benefit. Community benefit in the context of the provision of health care services normally refers to means-tested eligibility programs, but the ABA noted that “hospitals continue to have difficulty separating traditional uncompensated care from true bad debt” due to “issues associated with identifying individuals who qualify for uncompensated care.”⁴⁵ Some portion of bad debt, therefore, appears to include the provision of care to individuals who would have been eligible for charity care.⁴⁶ Proponents argue that it is unfair to penalize a hospital with a reduced community benefit calculation simply because the charity care program did not accurately classify these individuals.⁴⁷

Support for inclusion of bad debt was not universal among the comments submitted. The Catholic Health Association noted that bad debt is a “‘cost of doing business’ that affects taxable and tax-exempt organizations.”⁴⁸ In CHA’s opinion, reporting bad debt does not create meaningful distinctions between for-profit and

⁴³ *Id.*

⁴⁴ *Schedule H, Final Draft, supra* note 32, at Part III (emphasis added).

⁴⁵ ABA Comments, *supra* note 33, at 66.

⁴⁶ Uninsured or under-insured patients that cannot afford to pay are nevertheless charged, and that inevitably leads to bad debt precisely because they cannot afford to pay.

⁴⁷ One alternative put forth by the ABA is to include some percentage of bad debt, in proportion to the amount of bad debt universally in a given region, as community benefit. ABA Comments, *supra* note 33, at 67.

⁴⁸ CHA comments, *supra* note 33, at 15.

non-profit entities that would justify tax exemption.⁴⁹ CHA did not necessarily dispute the theory that bad debt includes some patient charges that should be considered charity care. Rather, CHA argued that hospitals should improve their charity care programs to identify these patients at the onset of treatment, rather than using bad debt to approximate the impact of these patients after the fact.⁵⁰ In support of this argument, CHA also noted that “many Catholic hospitals have changed their policies and improved their ability to identify patients eligible for financial assistance.”⁵¹ Some patient advocates have also noted the perceived inequity in allowing hospitals to benefit from bad debt after instituting potentially aggressive and damaging collection practices against patients.⁵²

The final version of Schedule H allows hospitals to report bad debt in Part III alongside Medicare shortfalls.⁵³ As with Medicare shortfalls, filing hospitals will have to explain what portion of bad debt should be considered community benefit.⁵⁴ The IRS comments accompanying the final draft indicated that it does not intend to automatically consider any portion of bad debt a community benefit, citing a lack of consensus regarding bad debt policies among hospitals.⁵⁵

Part IV: Management Companies and Joint Ventures. Part IV of Schedule H asks tax-exempt entities that operate hospitals to list the joint ventures they participate in. Joint ventures can be problematic in the non-profit healthcare context for a variety of reasons. If physicians with staff privileges at the hospital also have a proprietary interest in the joint venture, referrals to that joint venture may violate federal prohibitions against self-referrals or kickbacks.⁵⁶ If directors or trustees of the hospital have a proprietary interest in that joint venture, the non-profit status of the hospital could be jeopardized by any benefit that they receive as a result of their interest in the venture.⁵⁷ Similarly, in *St. David’s Health Care System v. United States*, the Fifth Circuit held that a joint venture’s profit motive could undermine a non-profit partner’s status as a charitable organization.⁵⁸

⁴⁹ *Id.*

⁵⁰ *Id.* at 14-15.

⁵¹ *Id.* at 15.

⁵² See, e.g., Lucette Lagnado, *Twenty Years and Still Paying: Jeanette White is Long Dead But Her Hospital Bill Lives On*, WALL ST. J., Mar. 13, 2003, at B1.

⁵³ *Schedule H, Final Draft, supra* note 32, at Part III.

⁵⁴ *Id.*

⁵⁵ *Dec. 20 Draft Highlights, supra* note 29, at 3.

⁵⁶ For a more detailed discussion of physician self-referral and federal law, see CRS Report RL32494, *Medicare: Physician Self-Referral (“Stark I and II”)*, by Jennifer O’Sullivan; CRS Report RS22743, *Health Care Fraud and Abuse Laws Covering Medicare and Medicaid: An Overview*, by Jennifer Staman.

⁵⁷ Under IRC § 501(c)(3), the net earnings of a charitable organization may not flow to the benefit of any private shareholder or individual.

⁵⁸ *St. David’s Health Care System v. United States*, 349 F.3d 232, 237 (5th Cir. 2003).

For the most part, these issues are common to all tax-exempt organizations. The majority of comments addressing this issue noted that the IRS already receives information on joint ventures in the redesigned Form 990, and that only organizations that operate hospitals are burdened with this extra reporting requirement in Schedule H.⁵⁹ In response, the IRS noted that the “unique relationship between hospitals and physicians resulting from their special status of having medical staff privileges without regard to employment appears to have no clear analogy in other exempt organization contexts.”⁶⁰ The IRS did limit this reporting requirement to those joint ventures where directors, trustees, and physicians with staff privileges together owned at least 10% of the joint venture.

Part V: Facility Information. Organizations are asked, in Part V of Schedule H, to identify all hospital or medical care facilities and to indicate the types of medical services provided by each. The definition of hospital or medical care does *not* include assisted living services, vocational training for the disabled, or medical education and research.⁶¹ In order to alleviate the burden of adapting to the new Schedule H, this is the only part that will be required for tax year 2008.

Part VI: Supplemental Information. Part VI of Schedule H provides an area in which to provide narrative information regarding the amount of community benefit provided. The IRS stated that this area could be used to explain why some portion of Medicare shortfall or bad debt reported in other areas of the Schedule should be considered community benefit.⁶² In addition, hospitals may provide details about other community benefits they provide that are not easily quantifiable.⁶³

Legislation

110th Congress. It does not appear that any bills have been introduced in the 110th Congress that would address the tax-exempt status of hospitals. There is a bill, the Charity Care for the Uninsured Act of 2007 (H.R. 973), that would create a new tax credit for physicians who provide charity care. The credit would range from \$1,000 for physicians who had provided between 25 and 30 hours of medical care on a volunteer or pro bono basis to \$2,000 for those who had provided at least 50 hours of such care. The care would have to be “for diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.”

109th Congress. In the 109th Congress, then-Chairman William Thomas of the House Ways and Means Committee introduced the Tax Exempt Hospitals

⁵⁹ See, e.g., AHA Comments, *supra* note 33, at 8-9; CHA Comments, *supra* note 33, at 12-13; ABA Comments, *supra* note 33, at 73.

⁶⁰ Dec. 20 Draft Highlights, *supra* note 29 at 5.

⁶¹ June 14 Draft Comments, *supra* note 26, at 8.

⁶² Dec. 20 Draft Highlights, *supra* note 29, at 5.

⁶³ *Id.*; See also, Schedule H, Final Draft, *supra* note 32, at Part III.

Responsibility Act of 2006 (H.R. 6420). This bill would have imposed requirements on § 501(c)(3) medical care providers relating to their treatment of low-income uninsured individuals. Medical care providers subject to the bill would be those (1) with the principal purpose of providing medical or hospital care; (2) with the principal purpose of providing medical education or research that are actively engaged in providing medical or hospital care, or (3) required to be licensed as hospitals under state law.

A medical care provider would have only been eligible for § 501(c)(3) status if it (1) adopted policies and procedures, consistent with the requirements imposed by the new excise taxes discussed below, for providing and charging for medically necessary care to low-income uninsured individuals, and (2) normally operated in a manner consistent with those policies and procedures. Not only would a provider that failed to meet these requirements be ineligible for § 501(c)(3) status, but no deduction would be allowed for making what would otherwise be a charitable contribution to it. “Medically necessary care” would be defined as medical care within the scope of care provided by the provider unless (1) the treating physician determined the care to be unnecessary; (2) the patient signed a waiver acknowledging it was unnecessary; or (3) the care involved an organ transplant, cosmetic or experimental care, or treatment to improve the functioning of a malformed member.

The bill would have also created three new excise taxes to penalize medical care providers that failed to meet certain requirements. First, a tax of \$1,000 would be imposed each time a provider failed to provide the necessary care to a low-income uninsured individual who sought care in person. Second, a tax would be imposed if a provider collected an amount for necessary care from a low-income uninsured individual that exceeded the maximum allowed charge. The tax would equal 3 times the excess. The maximum allowed charge would be (1) \$25 per visit if the patient’s household income was not more than 100% of the applicable poverty line or (2) the average amount paid to the provider under contracts with private health insurers if the patient’s household income was between 100% and 200% of the applicable poverty line. Third, providers would be taxed if they failed to disclose their policies on providing and charging for medical necessary care. The penalty would be (1) \$1,000 for each time the provider failed to provide the information in the patient admission process or when attempting to charge the patient or (2) \$1,000 for each day, with a maximum of \$50,000, the provider failed to make publicly available its policies and average prices paid for medical care, grouped by private health insurance, self-pay, and government health programs.

The bill, through its excise tax scheme, would have addressed some of the concerns expressed about § 501(c)(3) hospitals relating to charity care, prices charged to low-income uninsured patients, and transparency about policies and prices. Without explicitly stating it, the bill would have essentially defined the term “charitable” in IRC § 501(c)(3) as it relates to hospitals to require relief of the poor. However, this implicit charity care requirement does not squarely match the historic charity care standard. The bill would only require charity care if it is “medically necessary” and would not make any exceptions for hospitals that did not have the financial means to provide charity care. It would appear that hospitals could fail to comply with the new excise tax requirements without jeopardizing their tax-exempt status under this bill so long as such failures were not normal. This seems to leave

open the possibility that, for example, a hospital could choose to pay the \$1,000 tax rather than provide treatment to a particular patient. However, even where such behavior was not normal, these incidents might undercut a hospital's rationale for enjoying tax-exempt status. It could also be unclear where the bill would leave the community benefit standard since it would not expressly repeal it.