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PROBLEMS AND DEVELOPMENTS IN THE TAX-EXEMPTION OF HEALTH CARE PROVIDERS

Patrick Manders*

The charitable status of tax-exempt providers is being challenged and is increasingly subject to financial pressures, exacerbated by the recent financial crisis. Although the crisis affected all areas of the economy, the traditional difficulty of non-profit entities, including charitable health care institutions, at raising capital, presents unique problems.¹ Since the decision in *Utah County v. Intermountain Health Care, Inc.*, state governments have increasingly limited the extent of or the requirements to obtain tax-exempt status by charitable institutions.² Recently, the federal requirements for a charitable tax-exemption under the “community benefits” standard explicated by Revenue Ruling 69-545 was modified in the Patient Protection and Affordable Care Act to provide more stringent accounting of community benefits.³ A balanced approach to assessing community benefit is necessary to ensure the public receives the actual value of tax-exemption, but must allow for current and structural difficulties facing non-profit charitable institutions, as well as flexibility to account for the inherent differences between health care providers.

This article evaluates prospective requirements for non-profit health care providers to qualify for tax-exemption, in consideration of the risks and difficulties facing these providers. To do so, the article will first address the overall federal basis for tax-exemption under I.R.C. Section 501(c)(3) and the prevailing community benefits standard. The reasons and theories justifying a tax-exemption will be considered to understand the basis for exemption.⁴ Then, recent state and federal initiatives to require minimum charity to qualify for tax-exempt status are considered in order to evaluate their effect on non-profit charitable health care providers. Finally, disparities in charitable activity and financial difficulties among non-profit hospitals will be considered as they underlie the need for effective requirements concerning community benefits.

Historically, tax-exemption derived from early English law allowing exemption to encourage “socially desirable behavior.”⁵ The English Statute of Charitable Uses first comprehensively defined

charity by including the “relief of aged, impotent and poor” and the “maintenance of sick and maimed soldiers” as proper use of charitable trusts.⁶ After the Revolutionary War, the former colonies encouraged charitable entities to act in corporate form, allowing a tax-exemption at the state and eventually the federal level after implementation of the federal income tax.⁷ From the colonial period through the late-19th century, charitable hospitals mainly served the impoverished indigent and were primarily financed through voluntary charitable donations with little government funding or patient fees.⁸ Physicians and aides at these early hospitals worked without remuneration.⁹ Tax-exemption was justified because these hospitals relieved the government of its burden of caring for the indigent.¹⁰ Accordingly, these hospitals not only served medical issues among the poor, but also were social institutions for the indigent.¹¹ The wealthier parts of society depended upon private physicians and largely avoided hospital care.¹²

Starting in the early-20th century, hospitals began to operate along commercial principles financed by patient fees.¹³ Advances in medical science increased the costs of providing care, making the modern hospital system more lucrative and more practical for the provision of modern medical treatment.¹⁴ By the late-20th century, non-profit hospitals were increasingly commercial in nature, often with large revenues, actively competing with other non- and for-profit hospitals.¹⁵ The rise in for-profit hospitals and the similar commercial nature of both for-profit and non-profit hospitals created vulnerabilities in justifying an exemption that gave non-profits a competitive advantage over for-profit hospitals.¹⁶ Accordingly, most modern hospitals no longer depend upon charitable contributions or the primary use of volunteers for the provision of services.¹⁷ In short, as non-profit hospitals took on more aspects of for-profit enterprises, they faced increasing difficulties justifying tax-exemption.

The modern composition of hospitals indicates the decreasing distinction between non-profit and for-profit hospitals. Today, non-profit hospitals make up slightly more than half of all registered hospitals, with for-profits making up roughly seventeen percent of total hospitals, and the rest split among government and non-government institutions.¹⁸ Reports indicate

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“Today, non-profit hospitals make up slightly more than half of all registered hospitals, with for-profits making up roughly seventeen percent of total hospitals, and the rest split among government and non-government institutions.”

relatively little difference in the provision of charity care between non-profit and for-profit hospitals, demonstrated by a 0.5 percent operating expense difference between uncompensated care provided by non-profit and for-profit hospitals.¹⁹ Several studies conclude that non-profit hospitals acquired by for-profit hospitals do not reduce their provision of community benefits, despite becoming non-charitable institutions.²⁰ To define charitable purposes, federal law and many states refer to the “community benefits” standard.

Federal tax-exemption of non-profit health care providers derives from I.R.C. Section 501(c)(3), which exempts organizations operated exclusively for charitable purposes if no earnings inure to the benefit of a private individual.²¹ Revenue Ruling 69-545 explicates the community benefits standard to determine whether a non-profit health care provider qualifies for exemption as a charitable organization.²² The standard’s general factors are whether a tax-exempt provider (1) is governed by a board of trustees or directors drawn from the community; (2) has an open medical staff policy; (3) operates a full time emergency room open to all regardless of pay; and (4) admits as patients those able to pay whether by private payment, third parties, or government programs.²³ Revenue Ruling 83-157 allows hospitals without an emergency room to show the needs for that service are otherwise met in their community.²⁴ The community benefits standard does not require a minimum level of charity care or that charity care be provided to all members of the community, so long as the class of beneficiaries is not so small as to provide no benefit to the community.²⁵ At issue are state and federal initiatives further defining a minimum requirement of charity and the continuing societal value of tax-exemption.

A tax-exempt corporation must operate exclusively for “charitable purposes” under Section 501(c)(3), which is met through the organizational and operational tests.²⁶ The organizational test requires the exempt organization, in its articles of organization, to: (1) limit the purpose of the organization to one or more exempt purposes; and (2) not expressly empower the organization, except as insubstantial part of activities, in activities not in furtherance of exempt purposes.²⁷ The operational test requires the exempt organization to engage primarily in activities accomplishing an exempt purpose of Section 501(c)(3), and will not be exempt if more than an insubstantial part of activities is not in furtherance of the exempt purpose.²⁸ Exempt purposes include charity, which is understood in the “generally accepted legal sense,” including the

provision of public health.²⁹ An organization may satisfy Section 501(c)(3) even though it operates a trade or business as a substantial part of its activities, so long as the business is in furtherance of an exempt purpose and the organization is not organized primarily to carry on the business.³⁰ Section 511 allows the imposition of a tax on unrelated business income of Section 501(c)(3) exempt organizations.³¹

The original rationale justifying tax-exemption for providers is that the exemption subsidizes the provision of public goods represented by charitable care.³² The subsidy rationale posits that tax-exempt hospitals relieve the government of a burden it would otherwise have to bear, shifting the costs by forgoing revenue it would garner from exempt entities to compensate the entity for the costs of providing a public good, providing charitable care to those unable to pay.³³ The Supreme Court recognized this principle in *Bob Jones University* by stating that, “charitable exemptions are justified on the basis that the exempt entity confers a public benefit.”³⁴ But this rationale only explains a subsidy so far as it relieves the public of the costs of indigent care.³⁵

Another theory justifying tax-exemption is income measurement, which argues that the income for non-profit and charitable organizations is difficult to define and tax under current tax law.³⁶ The significant number of for-profit hospitals and the commercial nature of many non-profit hospitals argue against the income measurement theory as applied to modern hospitals.³⁷ The Capital Formation Theory states that tax-exemption compensates non-profit entities for lack of access to traditional investment through equity.³⁸ Other theories postulate that the exemption is based on altruism or philanthropy.³⁹ The Risk Compensation Theory justifies a continuing tax-exemption for charitable organizations based on the inherent risk of providing public goods without any expectation of financial return.⁴⁰ Risk Compensation posits that tax-exemption allows the non-profit sector to provide goods that neither the private for-profit or government sector is able to provide in sufficient quantity. Basic to any of these theories is the assumption that the benefits to society of charitable activity are worth the financial costs of exempting part of the tax base.⁴¹

A continuing tax-exemption for non-profit hospitals should comport with actual social benefits to balance the costs implicit in exempting a significant sector of the economy from taxation. Tax-exemption results in at least three identifiable costs on society: (1) the risk of undeserving organizations benefiting from an exemption; (2) subsidizing some organizations but not others; and (3) the diminishment of the tax base,

with a corresponding increase in the burden on others.⁴² Because non-profit hospitals share many characteristics with their for-profit competitors, the conferral of a tax-exemption should balance a measurable benefit to society.⁴³ Many states have limited the risk of undeserving organizations from obtaining an exemption by imposing stricter requirements regarding charitable status, including stripping health care providers from long-standing exemptions.⁴⁴

I. Recent Treatment of Tax-Exempt Providers by State Governments

The majority of states follow the federal treatment of public health as a charitable purpose deserving of tax-exemption.⁴⁵ The actual state tax-exemption qualifications vary widely. Roughly fifteen states have a community benefits requirement similar to the federal standard, while many others make reference to community benefits in hospital reporting or licensure, but do not explicitly require it for exemption.⁴⁶ Five states, including Texas, require specific minimum amounts of community benefits.⁴⁷ Community benefits states typically require that the hospital identify community needs and then develop and implement a plan to meet those needs, with reporting and disclosure of community benefits provided.⁴⁸ The recently enacted Patient Protection and Affordable Care Act of 2010 (PPACA) includes similar requirements.⁴⁹ States often exempt charitable organizations from local property or sales taxes as well as income taxes. Since 1985, states have increasingly challenged local tax-exemption, often through local tax-collecting authorities claiming lack of sufficient charity.⁵⁰

State governments primarily limit non-profit hospital tax-exemption through the exclusivity requirement or by requiring a minimum level of care to qualify for tax-exempt treatment.⁵¹ Recently some states have considered, but not implemented, certain taxation or even complete revocation of the tax-exemption for non-profit hospitals.⁵² The Supreme Court of Illinois recently upheld the denial of a charitable tax-exemption on the grounds the hospital devoted only 0.7 percent of its revenue to charitable care.⁵³ Texas has instituted specific requirements for minimum charity care in order to obtain tax-exemption.⁵⁴

Although a number of states have since reviewed the qualifications for charitable tax-exemption, the decision in *Utah County v. Intermountain Health Care, Inc.* is the first major decision by a state high court revoking the long-held tax-exempt status of a health care provider.⁵⁵ In 1985, the Supreme Court of Utah ruled on the validity of a statute based upon the state constitutional provision allowing property tax-exemption of land used for charitable purposes.⁵⁶ The Court held that the health care provider did

not demonstrate the property was used exclusively for charitable purposes and prospectively stripped the provider from future property tax-exemption, reaffirming that a statute cannot expand, limit, or defeat the exemption provided by the Utah Constitution.⁵⁷ Utah County contended that the statute unconstitutionally expanded the charitable exemption granted in the Utah Constitution, but did not dispute that the hospital complied with the statute.⁵⁸

In order to interpret the Utah constitutional exemption provision, the Court defined the meaning of “charitable” purposes as the contribution or dedication of something valuable to the common good.⁵⁹ Distinguishing from historical bases of charitable tax-exemption, the Court concluded that the modern medical-industrial complex transformed a traditional charitable basis to a business model.⁶⁰ A particular example of the change is that Intermountain owned at least one for-profit subsidiary and competed with for-profits.⁶¹ Although some of Intermountain’s stated purposes satisfied the



requirement of charitable use, the Court identified similar rates of charge for services and free services constituting less than one percent of revenue as demonstrating a lack of charitable purpose.⁶² Drawing on the operating similarity between Intermountain and its for-profit competitors, the Court rejected the dissent’s claim that revoking tax-exemption would increase costs to consumers or lower quality of care.⁶³ Distinguishing state tax-exemption requirements from federal, the Court concluded

that Intermountain confused state constitutional requirements of charity as a gift to the community, with the separate concept of community benefit or usefulness to the community.⁶⁴

In response to a challenge by the Texas Attorney General against the tax-exempt status of a large non-profit hospital, the Texas legislature passed a statute requiring non-profit hospitals to provide a specific percent of revenue to charitable care or community benefits to qualify for tax-exemption.⁶⁵ The statute requires tax-exempt charitable hospitals to develop a community benefits plan to serve the community’s health care needs determined through a community needs assessment.⁶⁶ The level of benefit must meet one of the following standards: (1) a level reasonable in relation to community needs as determined through the assessment; (2) charity care provided at least equal to 100 percent of the hospital’s state tax-exemption; or (3) charity care and community benefits in an amount equal to at least five percent of the hospital’s net patient revenue.⁶⁷

Reports are unclear regarding the effect of the Texas statute on charity care, but do not support a substantive increase in charitable care.⁶⁸ Furthermore, hospital organizations disapprove of similar statutes that enforce a “hard” minimum of charity without regards to the wide disparities in hospital and community types.⁶⁹ A recent Internal Revenue Service (IRS) Exempt

Organizations study noted significant variations in the level of charity care and community benefits provided among different types and hospital sizes.⁷⁰ Although the precise effects of the Texas statute on charitable care is unclear, provisions requiring hospitals to report charity and community benefits should provide a clearer picture of the value of the tax-exemption through community benefits provided.⁷¹

In 2002 the Director of the Illinois Department of Revenue denied Provena Covenant Medical Center (PCMC) tax-exempt status solely on the grounds that PCMC devoted only 0.7 percent of revenue to charity care.⁷² After Provena appealed revocation in circuit court, the court held Provena was entitled to both a charitable and a religious exemption.⁷³ On appeal the Supreme Court of Illinois upheld the revocation of Provena's tax-exempt status and assessed a \$1.1 million property tax.⁷⁴ Because Illinois state law allows a property tax-exemption for property used exclusively for charitable purposes, the main issue was exclusive charitable use relative to the amount of charity care and the commercial nature of the business.⁷⁵

The taxpayer was Provena Hospitals, a corporation created by a consolidation of Roman Catholic health care operations running six hospitals, including PCMC.⁷⁶ Although the taxpayer qualified under other tax-exemptions, the case concerned the revocation of the property tax-exemption for PCMC.⁷⁷ The Supreme Court of Illinois noted that charitable donations to PCMC were virtually non-existent, only \$6,938 in 2002, that PCMC was profitable, and that it spent substantial amounts of money on advertisement, but did not advertise any discounted or free care despite a stated policy to do so.⁷⁸ Only 0.27 percent of PCMC's total patients in 2002 received any charity care.⁷⁹ The Supreme Court of Illinois first emphasized that exemption was by far the exception to taxation, as shown through a strictly construed statutory exception where any doubt must be resolved in favor of taxation.⁸⁰

The Supreme Court of Illinois identified the characteristics of charitable institutions as: (1) has no capital, capital stock or shareholders; (2) earns no profits or dividends, but derives funds mainly from charity holding them in trust; (3) dispenses charity to all who need it and apply; (4) does not provide private gain or profit; and (5) does not place obstacles to those who would avail themselves of charity.⁸¹ Although health care providers are charitable institutions, the provision of health care alone is not sufficient to justify a property tax-exemption as a charitable use.⁸² The first and fourth factors clearly weighed in favor of exemption for PCMC, but the Court found the remaining factors weighed against exemption as a charitable institution.⁸³ The second factor of charitable donation was completely negligible and the Court found the level of charity care was insufficient to qualify under the third and fifth factors.⁸⁴ Although the Court mainly relied upon exclusive charitable use of the property and lack of charity care as grounds for revoking PCMC's tax-exemption, the inclusion of charitable donations as a factor is problematic for modern hospitals that depend almost entirely upon patient fees.⁸⁵

The subsidization rationale for tax-exemption, where certain activities are exempted on the basis they relieve the government of burdens it would otherwise bear, is explicitly recognized as a *sine qua non* of charitable status for Illinois state property tax-exemption.⁸⁶ A specific dollar-for-dollar amount comparing lost taxes and charity provided by the hospital is not necessary, but it must show that it relieves some government financial burden.⁸⁷ Distinguishing from *People ex rel. Cannon v. Southern Illinois*

Hospital Corp., where the hospital in question demonstrated it provided discounted care to the county government that paid for indigent care, the Court found that Provena's offset of government costs through charity care was *de minimus*.⁸⁸

The minimal amount of charity care is significant to the issue of whether the property was used solely for charitable purposes. Because Provena did not advertise its financial assistance policy and typically forwarded all unpaid bills to collection agencies, there was practically no difference between Provena's behavior and the behavior of a for-profit institution.⁸⁹ Provena argued that PCMC served an area that did not require additional charitable services, but the Court rejected the claim on grounds that 13.4 percent of the county's population was below the federal poverty level.⁹⁰ Provena's discounted care was rejected because PCMC still ran a surplus and expected to make up revenue by charging higher amounts to other users.⁹¹ Such "cross-subsidizing" is an established practice among business enterprises and makes Provena even more similar to its for-profit competitors.⁹² The Court rejected counting Medicare and Medicaid underpayments as charity, noting that the programs were voluntary and consistent with the hospital's financial interests.⁹³

The *Provena Covenant* case illustrates the difference between federal and state exemptions, which can vary widely. In Illinois, the property tax-exemption at issue required the use of the property to be charitable and alleviate a government burden, so the state does not take into account activities the local government is not responsible for.⁹⁴ For example, the Court rejected the use of medical training as a charitable expense by Provena because the training was not within the local government's jurisdiction, nor was it a cost the local government would bear.⁹⁵

II. Recent Treatment of Tax-Exempt Providers by the Federal Government

Federal initiatives have focused on collecting information on the value of tax-exemption to non-profit hospitals. The PPACA borrows from some state requirements by mandating a community needs assessment. The IRS began the Hospital Compliance Project in May 2006 to gather information regarding community benefit by non-profit hospitals and issued the final report in February 2009.⁹⁶

The second major federal effort to evaluate community benefit by tax-exempt non-profit hospitals started in 2008 when hospitals were required to report community benefit and other information on Form 990, Schedule H.⁹⁷ Schedule H is intended to promote uniform reporting through clear standards and filing, but does not completely address issues related to some questionable community benefits, such as bad debt and Medicare shortfalls.⁹⁸ The required reporting includes six parts: (1) charity care and other community benefits at cost; (2) community building activities; (3) bad debt, Medicare, and collection practices; (4) management companies and joint ventures; (5) facility information; and (6) supplemental information (e.g. community needs assessments).⁹⁹ Schedule H also allows for hospitals to account for non-quantifiable community benefit by explaining the activity, even if it does not fit into the other quantifiable activities.¹⁰⁰

Hospital organizations must file a single Schedule H that aggregates the relevant information for the tax year.¹⁰¹ Hospital organizations must separately list and account for each individual health care facility.¹⁰² The

American Hospital Association (AHA) is seeking modification on Schedule H reporting because of studies indicating many hospital organizations will file “multiple and seemingly unconnected Schedule H’s.”¹⁰³ Prospective duplicative filing may interfere with the uniformity Schedule H is intended to promote.

PPACA stipulates specific requirements non-profit hospitals must satisfy to qualify for tax-exempt status.¹⁰⁴ PPACA does not establish a “hard” minimum of charity care, but instead requires a community needs assessment and the implementation of a policy to meet these needs.¹⁰⁵ For a hospital to qualify as a Section 501(c)(3) tax-exempt entity PPACA requires that the hospital implement: (1) a community health needs assessment; (2) financial assistance policy requirements; (3) requirements on charges; and (4) billing and collection requirements.¹⁰⁶

The community health needs assessment is similar to those required by many states.¹⁰⁷ PPACA states that the assessment “takes into account input from persons who represent the broad interests of the community served by the hospital facility” and that it be widely available to the public.¹⁰⁸ The assessment must be completed in the taxable year or in either of the two prior years.¹⁰⁹ The hospital must then adopt and implement a plan to meet the health needs identified in the assessment.¹¹⁰ Since many states already require community needs assessments, this provision would not further burden those hospitals and allows for a flexible approach to meeting the needs of widely differing communities.¹¹¹ By requiring a community needs assessment the hospital must investigate and account for the specific needs of different communities, which may mitigate the wide variations in the provision of community benefits within community and hospital types.

The financial assistance policy requirement mandates a written policy setting forth the eligibility for financial assistance.¹¹² The basis for calculating charge amounts and applying financial assistance must be widely publicized within the community.¹¹³ *Provena Covenant* illustrates the necessity of wide publication because PCMC had a written financial assistance policy that was not widely publicized, resulting in only 0.27 percent of patients availing themselves of the policy.¹¹⁴ PPACA further requires a written statement regarding provision of emergency medical care.¹¹⁵ PPACA also limits charges for emergency or medically necessary care to individuals eligible under the financial assistance policy to no more than the lowest charges to individuals with insurance coverage.¹¹⁶ Simply put, PPACA requires charges under the financial assistance policy to be

no higher than the lowest charge for insured care. PPACA’s billing requirement mandates a hospital make reasonable efforts to determine if the individual is eligible for assistance under the policy before beginning “extraordinary” collection actions.¹¹⁷

PPACA requires hospital organizations consisting of multiple hospitals to account for each specific hospital individually with penalties to each individual hospital if they do not satisfy the new requirements.¹¹⁸ The AHA recently urged the IRS against individual reporting on Schedule H by alleging it adds complexity and skews the reporting of community benefits.¹¹⁹ Although the AHA’s complaint is concerned with Schedule H reporting and not the PPACA’s Section 501 requirements, both treat hospitals on an individual basis without taking into account the entire organization. The AHA reports that because nearly sixty percent of non-profit hospitals are part of multi-hospital organizations, requiring individual reporting may not accurately assess their community benefit.¹²⁰ By making each individual hospital meet the requirements, PPACA may more efficiently address the problems of disparities in community benefit because measuring benefits through the entire hospital organization would not address some hospitals providing substantially more or less of the overall benefit of the hospital organization.

Unlike the Texas statute, which depends solely on revocation of tax-exempt status to punish offenders, the Act allows a fifty thousand dollar excise tax on charitable hospitals that fail to comply.¹²¹ The excise tax allows greater flexibility in enforcing the new Section 501 requirements and avoids the extremity of full revocation. An excise tax would be a more efficient and effective enforcement mechanism than full revocation of tax-exemption because the non-profits would be less willing to bear the litigation costs and would simply pay the tax.

In 2003, the Tenth Circuit affirmed the Tax Court’s denial of tax-exempt status to IHC Health Plans, which was a health maintenance organization (HMO) set up by non-profit IHC to integrate its health care services.¹²² To determine whether IHC Health Plans qualified for tax-exemption the Court asked two questions: (1) whether the services provided by IHC were charitable in nature and (2) whether IHC operated primarily for charitable purposes.¹²³ Charitable services are understood in the “generally accepted legal sense” and must therefore serve a public, not a private, interest.¹²⁴ Although the promotion of public health is clearly charity in the form of community benefit, the Court stressed that not every activity promoting health qualified for tax-exemption.¹²⁵

“Disparities in charity, as measured through community benefit, can reflect both legitimate differences in the hospitals and their communities, as well as a disproportionate provision of community benefits within the non-profit sector.”

“ Although the average 2.5 percent of additional revenue spent by high revenue hospitals shows significant variation depending on the size of the hospital, the difference may be explained by high revenue hospitals’ greater ability to provide for charity and other factors.”

Applying a totality of the circumstances standard, the qualifications for charitable tax-exemption generally require the provider to make services available to the entire community and to provide an additional community benefit by furthering the function of a publicly funded institution or providing a service otherwise not provided in the community.¹²⁶ The benefit provided must show that providing a public benefit is the primary purpose of the institution.¹²⁷

Although noting that charity in the form of reduced fees, as opposed to entirely free services, can qualify alone as a community benefit, the Tenth Circuit affirmed the revocation of tax-exempt status on the grounds that IHC Health Plans did not operate primarily for charitable purposes.¹²⁸ In so holding, the Court distinguished IHC Health Plans, which operated as an HMO, from IHC, a tax-exempt charitable corporation that controlled IHC Health Plans.¹²⁹ Even though IHC Health Plans operated to integrate the delivery of health care by IHC, and charged reduced premiums in some cases, it was not held to operate exclusively for charitable purposes.¹³⁰

III. Disparities in the Provision of Charity

The pressures faced by non-profit, tax-exempt hospitals to account for minimum charity reflect the underlying problem of disparities in their provision of charity. Disparities in charity, as measured through community benefit, can reflect both legitimate differences in the hospitals and their communities, as well as a disproportionate provision of community benefits within the non-profit sector.¹³¹ The challenge is to ensure each tax-exempt hospital bears a share of community benefits sufficient to justify the costs of exemption while accounting for both legitimate differences in community needs and the different activities that may count as community benefits. In the process, a uniform concept of what qualifies as community benefits must be defined to provide predictable standards for non-profit hospitals to apply.

The significant disparities in the amount of charitable activity vary depending on: (1) the size of the hospital and (2) the community being served. The IRS initiated the Hospital Compliance Project in 2006 to study non-profit hospitals and community benefits and released the final report in February 2009.¹³² The report found overall average community benefits expenditures of nine percent of total revenue and a median expenditure of six percent of total revenue.¹³³ The report divided between two extremes of hospital size, as measured by revenue, because the largest and smallest sized hospitals displayed the most acute differences in community benefits: (1) hospitals with revenue less

than \$25 million and (2) hospitals with revenue more than \$500 million.¹³⁴ The former reported an average community benefits expenditure of 9.9 percent of total revenue and a median expenditure of 3.3 percent of total revenue.¹³⁵ The latter high revenue hospitals reported average community benefits expenditures of 12.4 percent of total revenue and a median expenditure of 10.5 percent of total revenue.¹³⁶ Not only is there significant variation in the overall community benefits expenditures between the size of hospitals, as shown by the twenty five percent more spent on community benefits by high revenue hospitals as a percentage of total revenue, but the wide difference in medians indicates significant variation within the group of low revenue hospitals.¹³⁷

Given that the average expenditures for both large and small revenue hospitals is above the average for all hospitals, the intermediate size hospitals must provide lower amounts of benefits than the two extremes. Because the median represents the middle point in the sample, the 6.6 percent difference between the median and average spending in low revenue hospitals means that the portion of the sample above the median must spend significantly more on community benefits than the portion below the median to raise the overall average to three times the median.¹³⁸

Although the average 2.5 percent of additional revenue spent by high revenue hospitals shows significant variation depending on the size of the hospital, the difference may be explained by high revenue hospitals’ greater ability to provide for charity and other factors.¹³⁹ There is a much smaller difference (1.9 percent) between the median and average percent of community benefits as a percentage of total revenue for high revenue hospitals.¹⁴⁰ This smaller difference indicates a more uniform spread of community benefits across the sample of large hospitals. Measured by the size of the hospital (indicated by total revenue) the greatest variations therefore are shown within the category of the low revenue hospitals.¹⁴¹ These disparities may indicate other factors that determine overall community benefits, most particularly the character of the community being served.

The report accounted for community differences in four community types: (1) high population; (2) other urban and suburban hospitals; (3) critical access hospitals, which the report defined as hospitals treating rural areas with no other hospital within thirty-five miles; and (4) rural, non-critical access hospitals.¹⁴² High population hospitals reported an average community benefits expenditure of 12.7 percent of total revenue with a median of 9.8 percent; other urban and suburban hospitals reported an average 8.9 percent

with a median 5.8 percent.¹⁴³ The 3.8 percent difference between averages indicates hospitals serving the highest populations produce the most reported community benefits, a trend that continues with the rural hospitals.¹⁴⁴ The relatively small difference (2.9 percent) between the median and average for high population hospitals indicates a relatively small disparity within the category, as compared to other community categories.¹⁴⁵ The difference between the average and median of other urban and suburban community hospitals was 3.1 percent, indicating slightly more variation within that category.¹⁴⁶

The most significant differences are in rural hospitals. Critical access hospitals have an average community benefits expenditure of 6.3 percent with a median expenditure of 2.8 percent; meanwhile, non-critical access rural hospitals have an average community benefits expenditure of 8.4 percent and a median of 3.2 percent of total revenue.¹⁴⁷ Critical access hospitals are below the average (nine percent of revenue) expenditures for hospitals generally by a wide margin, with significant variation within the category shown by a 3.5 percent difference between the average and median, where the average is almost twice the median.¹⁴⁸ The variation within rural hospitals is the most significant, with the average expenditure more than two and one half times higher than the median.¹⁴⁹ This variation indicates significant disparity in community benefits expenditures between urban/suburban and rural hospitals. However, the significant disparities within the rural community hospitals that cannot be explained by differences in communities that result in different needs and therefore produce different benefits are more troubling.

Moreover, both within and among the hospital categories across the board, significant variations in the provision of community benefits exist. The IRS found that community benefits “were not evenly distributed by the hospitals in the study, but were concentrated in a relatively small number of hospitals.”¹⁵⁰ The spending concentration is most clearly displayed by the fact that twenty-one percent of hospitals reported spending less than two percent of revenue on community benefits expenditures and forty-seven percent reported spending less than five percent of revenue on community benefits, despite an average expenditure of nine percent of revenue.¹⁵¹ Such disparity in the provision of community benefits is problematic, both because it indicates a large share of the societal burden is unevenly distributed and because the variation is so significant within types of hospitals. The uneven societal distribution argues for stronger measures to ensure each individual hospital is providing sufficient community benefits to justify tax-exemption. Likewise, given the competitive nature of many non-profit hospitals, a more even distribution of community benefits is necessary to prevent the providers that are acting most charitably from being disadvantaged. Nonetheless, evaluations of community benefits are limited by the ambiguous definition of what community benefits actually constitute.

IV. Uncertain Definition of Community Benefits

There is significant uncertainty regarding what qualifies as community benefits and how to measure the activities that do qualify. A Government Accountability Office (GAO) report on non-profit hospitals found significant uncertainty on the qualifications and measurement of community benefits, partially due to the great variety of state standards.¹⁵² The differences in hospital definitions of community benefits led to significant variations in

the measurement of reported community benefits.¹⁵³ The GAO identified four main categories of community benefit: (1) charity care; (2) bad debt; (3) Medicare shortfalls; and (4) other activities.¹⁵⁴ Although charity care is clearly a community benefit, it is unclear whether the other three categories are included.¹⁵⁵

A Congressional Budget Office (CBO) report came to substantially the same conclusion, finding little consensus on what qualifies as a community benefit.¹⁵⁶ Recognizing the difficulties in categorizing community benefits the report measured benefits as: (1) uncompensated care (charity care and bad debt); (2) provision of Medicaid-covered services; and (3) provision of specialized facilities (burn intensive care, emergency room care, high-level trauma care, and labor and delivery services).¹⁵⁷ The CBO includes Medicaid payment shortfalls because they are unprofitable for hospitals and serve a needy community so are analogous to a community benefit. The GAO, CBO, and IRS reports all include various shortfalls resulting from underpayment of services by government sponsored insurance as community benefits.¹⁵⁸ The IRS report found that forty-four percent of responding hospitals included bad debt as a community benefit and fifty-one percent included private and public insurance shortfalls.¹⁵⁹ The inconsistency in reporting bad debt and shortfalls as community benefits argues for a more definite inclusion of these categories. Because it is unlikely that hospitals not reporting bad debt or shortfalls did not experience them, an accurate assessment of whether the hospitals provide adequate community benefits requires a more uniform definition.¹⁶⁰

Payment shortfalls from means-tested government programs, like Medicaid, are generally included as community benefits, but there is no consensus regarding shortfalls from non-means-tested programs, like Medicare.¹⁶¹ Of the major industry groups the GAO examined, only two believed Medicare shortfalls should not count as community benefits, while the remaining groups believed Medicare shortfalls could count.¹⁶² The Centers for Medicare and Medicaid Services (CMS) and the IRS have not taken a position on the issue, but do gather data concerning the amount of Medicare payment shortfalls and the IRS allows hospitals to explain why these costs should be included as community benefits.¹⁶³ PPACA specifically requires the Treasury Department to submit reports including the costs of both means-tested and non-means-tested programs as part of its reporting requirements on “levels of charity care.”¹⁶⁴ The title implies that non-means-tested payment shortfalls could count as charity care, and therefore community benefits, but PPACA does not conclusively state one way or the other.¹⁶⁵ The GAO report found that Medicare payment shortfalls made up a substantial part of operating costs, ranging from 5.4 percent to 13.3 percent across the four states the report examined.¹⁶⁶

Similarly, the inclusion of bad debt into community benefits lacks consensus. The Catholic Health Association (CHA) and the Veterans Health Administration (VHA) state that bad debt should not count as community benefits because the hospitals should instead identify patients eligible for charity care.¹⁶⁷ The Healthcare Financial Management Association (HFMA) does not precisely define bad debt as community benefits, but states hospitals should use more outside information to determine eligibility for charity care policies, as opposed to simply including bad debt as charity.¹⁶⁸ The AHA and several state hospital associations affirmatively include bad debt as community benefit because bad debt generally applies to patients that would otherwise qualify for charity care if the hospital had

the necessary information to make that determination.¹⁶⁹ As with non-means-tested payment shortfalls, the IRS includes bad debt in reporting, but does not include it as community benefits unless the hospital explains why parts of the costs should count as community benefits.¹⁷⁰

The release of Schedule H ameliorated some of these problems by accounting for bad debt and Medicare shortfalls.¹⁷¹ The IRS Exempt Organizations report split community benefits into four categories: (1) uncompensated care; (2) medical training; (3) medical research; and (4) community programs.¹⁷² The report included bad debt and other shortfalls into uncompensated care. The significant variations between hospitals resulted in fourteen percent of hospitals providing sixty-three percent of uncompensated care.¹⁷³ Medical training and research expenditures increased vastly with the size of the hospital and generally corresponded to higher population areas.¹⁷⁴ Most medical research was concentrated in a group of fifteen hospitals.¹⁷⁵ Community health programs are the most open-ended category of community benefits.

Virtually all types and sizes of hospitals provide some form of community program as a community benefit, usually including immunization and health promotion.¹⁷⁶ These programs vary widely, but focus on education, prevention, and the encouragement of health.¹⁷⁷ While these benefits were consistent across each type of hospital, overall community programs were the smallest expenditure of community benefits, though they most closely tie into prevention and health education in the community.¹⁷⁸ With the expected increase in insurance coverage due to PPACA, hospitals should be encouraged to set up community programs to offset less need for charity care.¹⁷⁹ Community programs are by nature more apt to focus on preventative care and promote overall health.

The lesson is that, even with Schedule H, there remain disparities in the provision of community benefits and difficulties in defining what activities should count as a community benefit. Although the vast differences in types of hospitals and their serving communities argues against a one-size-fits all approach to requiring certain community benefits, it is necessary to come up with a concrete inclusion of community benefits to properly assess hospital compliance.¹⁸⁰ Bad debt and shortfalls should be included as community benefits because they represent expenses incurred by the hospital for the community's well-being and offset corresponding government expenses. Since Medicare is a government program, any shortfalls suffered by the hospitals necessarily offset some burden on the government, while bad debt typically represents a less formal method of charity care by forgoing payment.¹⁸¹

By allowing non-profit hospitals tax-exemption they presumably must differentiate themselves from for-profit hospitals through the provision of community benefits to show charitable purpose. Beneficial costs that are substantially shared with for-profit hospitals as operating costs necessary to do business do not differentiate non-profits from for-profits. Even operating costs can provide community benefits that should be encouraged and the non-profit structure forgoes certain financing that is available for their for-profit competitors.¹⁸² The decline in charitable contributions exacerbates the problem with non-profit financing, as compared with for-profit.¹⁸³ When assessing bad debt and Medicare shortfalls one must take into account the degree they represent operating costs that are shared with

for-profit hospitals and so by themselves do not justify tax-exemption as provision of community benefits.¹⁸⁴

Costs shared with for-profit hospitals should not be dispositive in determining whether the expenditure amounts to a community benefit. As the CBO report indicates, expenditures on uncompensated care are only slightly less in for-profit hospitals than in non-profit, demonstrating that for-profit hospitals can and do provide community benefits that overlap with those provided by non-profit hospitals.¹⁸⁵ Some states require all hospitals to provide community benefits through licensure, resulting in similar behavioral incentives shared by for- and non-profit hospitals.¹⁸⁶ Costs shared between both sectors are hardly a reason to exclude such costs from a realistic recognition as community benefits. Doing so discredits admirable behavior by for-profit entities and does not accurately assess the real community benefits provided by any hospital.¹⁸⁷ Taken to extreme, this argument could include benefits such as employment, increased property value, and the like. But the standard of community benefits is in reference to the charitable purpose of providing public health and so relevant benefits should be limited to those directly providing, or otherwise bearing the costs of, public health.

Although a non-profit should be distinguished from a for-profit to justify its exemption, denying a genuine area of community benefit only distorts the measurement of benefit provided. Tax-exempt hospitals should provide greater or more effective community benefits, but benefit cannot be accurately measured by denying certain types.¹⁸⁸ The lack of a "hard" monetary minimum requirement of community benefits means that benefits provided can be assessed on a case-by-case basis, allowing the flexibility to adjust requirements upwards where the hospital appears to rely too much on questionable types of benefits, like bad debt and Medicare shortfalls.

The review of studies on the level of community benefits by tax-exempt hospitals demonstrates that, despite legitimate differences between types of hospitals and their communities, some hospitals bear a disproportionate amount of community benefit costs. Although there are legitimate causes for different levels of community benefits, including differences in the provider's financial situation and the opportunity for certain kinds of benefit, each hospital must justify its charitable tax-exemption through its individual activities. Since the exemption is from taxes the non-profit would otherwise have to pay, a financial inability to provide community benefits is insufficient to explain low amounts of community benefits.¹⁸⁹ Differences in community needs are not sufficient to explain low levels of community benefits because reports demonstrate a wide variety of qualifying activities.¹⁹⁰ Even if there is little need for charity care, other benefits like community outreach to increase preventative care would be beneficial to the community.¹⁹¹ Particularly considering the PPACA, reducing the number of uninsured, and thus reducing the need for charity care, any definition of community benefit should be widely construed to include a variety of activities that can improve and maintain the community's health and well-being.¹⁹²

The concern behind excluding these costs from community benefits is that it provides competitive advantage to non-profit entities and does not sufficiently distinguish non-profit behavior from for-profit behavior.¹⁹³ The simple fact of shared behavior between non-profit and for-profit hospitals ignores activity by for-profit hospitals that is clearly charitable, like charity

care.¹⁹⁴ Instead, bad debt and Medicare shortfalls can be approached as included, but not alone sufficient for determining community benefits. This approach recognizes the true significance of promoting community health and offsetting government costs, while acknowledging the concern of including operating costs shared with for-profit hospitals as community benefits. A non-profit hospital would still need to provide significant other benefits that a for-profit entity would not. The IRS approach, where these costs are reported but not included as community benefits without a specific explanation, effectively enacts this approach while placing the burden on the hospital to justify the costs as community benefits.¹⁹⁵ Having hospitals justify the inclusion as community benefits seems more effective since they are in the best position to report on their own operations.

It is unjustified for some hospitals to allow others to carry the financial burden and moral justification for a continuing tax-exemption. The remaining problem is to account for legitimate differences between hospitals and their communities, while preventing too large a disparity within types that is indicative of a few hospitals bearing the largest share of the burden.

V. A Flexible Approach to the Provision of Community Benefits

The wide variety in types of hospitals and communities served argues against the use of a one-size-fits-all approach to requiring a minimum level of community benefit. The most obvious example of this approach is in Texas, where the statute requires specific expenditures on charity in order to qualify for tax-exemption.¹⁹⁶ By doing so, the State effectively requires a certain level of community benefit, regardless of the actual necessity within the community, potentially resulting in an inefficient use of resources to meet a non-existent need.¹⁹⁷ By requiring minimum levels of charity it may create incentives towards benefits that are more easily measurable, even if those benefits are not optimal to meet the community's needs.¹⁹⁸ By requiring a set amount, the statute potentially encourages over-reporting of community benefit, which is exacerbated in Texas by the lack of sufficient oversight and audit of hospital reporting.¹⁹⁹ This approach is criticized by the hospital industry because it does not sufficiently differentiate between types and organizations of hospitals and their communities.²⁰⁰ The AHA states that, by approaching each individual hospital instead of the overall hospital organization, the IRS creates needless complexity and lessens the overall impact of the hospital organization's community benefits.²⁰¹ Simply requiring a set amount of community benefit risks distorts the most efficient and beneficial spread

of resources by requiring a set amount that may not be most beneficial to the community.

A flexible description and requirement of community benefit is necessary to account for the disparities in hospitals and their communities; it also allows the providers, who are in the best position, the freedom to determine optimal types of community benefits. The disparities in community benefits indicates a strong need for minimum requirements of care, but a flexible approach to account for legitimate differences resulting in varying amounts of community benefit, while ensuring the hospital is not riding off the benefits provided by others.²⁰² This approach includes three main points: (1) a flexible description of community benefits, (2) reporting requirements, and (3) more versatile punishments for providers that fail to qualify.²⁰³ This approach is reflected in a number of jurisdictions and to some degree is present in PPACA.

A flexible description of community benefits is most exemplified through the requirements in many states and the PPACA, instituting a "community needs assessment" that identifies the specific needs of the community.²⁰⁴ A broad qualification for community benefits takes into account the great disparity in communities and hospitals and does not risk putting too much focus on a particular benefit that is disproportionate to its effect. Given the predicted increase in health insurance coverage, the traditional community need for free or discount care should decrease.²⁰⁵ As the formerly uninsured are covered, the community need would change, arguing for a broader application of community benefits. A flexible description would allow for changing conditions. By weighing a broad description of community benefits on a case-by-case basis, the disparities in situations can be accounted for, while preventing insufficient benefit. For example, the largest research hospitals generally provide very little community benefit besides significant research, but clearly fall within tax-exempt standards.²⁰⁶ Other hospitals may depend upon benefits like bad debt or payment shortfalls that are insufficient by themselves to qualify because they are part of the cost of doing business.²⁰⁷ Although bad debt and shortfalls should count as community benefits because they aid the community and offset government costs, too great a dependence on "operating costs" and a corresponding minimal amount of other benefits should detract from charitable status.²⁰⁸

Reporting requirements are essential to ensuring sufficient community benefits to justify tax-exemption, but must be scrutinized to prevent discrepancies. The reporting requirements in Texas resulted in inconsistencies that lack sufficient oversight

Community programs are by nature more apt to focus on preventative care and promote overall health.

infrastructure to regulate, instead depending upon self-reporting.²⁰⁹ Schedule H and the IRS can provide some oversight, while the lack of a specific minimum required community benefit should lessen the incentive to over-report.²¹⁰

Enforcement of minimum community benefits requires a wider range of punishment beyond the extreme of invalidating tax-exemption. PPACA allows for an excise tax of up to fifty thousand dollars, providing greater flexibility to the enforcement of minimum community benefits standards.²¹¹ Providing sanctions that are less extreme than revoking tax-exemption, allows an enforcement mechanism that can flexibly address possible insufficiencies, such as cases where the amount of benefits is not clearly insufficient. For example, a hospital may provide only a very small amount of expenditures on community benefits, but either faces significant financial difficulty or a community that does not need significant benefits beyond what the hospital already provides.²¹² By allowing fines less extreme than total revocation of tax-exemption, it is possible to sanction insufficient community benefits in a manner more commensurate to the offense.²¹³ An excise tax coincides with the subsidization rationale of exemption because fines can be tailored to subsidize the hospital relative to the benefit it did provide. Even if the benefit is not enough to justify an exemption, the excise tax effectively takes back that part of the exemption that was not justified.

VI. Conclusion

The evolution of the hospital system towards a commercial model has resulted in a changing justification of continuing tax-exemption. The prevailing community benefits standard raises issues both state and federal governments have addressed by requiring more stringent reporting requirements and ensuring a minimum level of community benefit. Recent reports show significant disparities in the provision of community benefits among hospitals and their communities that may indicate an unfair and inefficient distribution of benefits.²¹⁴ Any approach should account for the reality that each hospital must justify its exemption individually and should not ride on the efforts of others.²¹⁵ Any effort to require more stringent enforcement of the community benefits standard should account for the legitimate differences in communities and their hospitals through a flexible approach. A flexible approach to measuring and requiring certain levels of community benefit is necessary because it can account for the costs of providing a tax-exemption, while allowing for legitimate differences in the community needs these benefits address.

¹ Alice A. Noble, Andrew L. Hyams, Nancy M. Kane, *Charitable Hospitable Accountability: A Review and Analysis of Legal and Policy Initiatives*, 26 J.L. MED. & ETHICS 116, 117 (1998).

² See 725 P.2d 1357 (Utah 1986) (rejecting automatic exemptions or minimal efforts at charity, ruling only that the specific taxpayer did not prove gift to the community sufficient for exemption).

³ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9007, 124 Stat. 119, 737-41 (2010).

⁴ See TEX. HEALTH & SAFETY CODE ANN. § 311.045 (2009); see also *Provena Covenant Med. Ctr. v. Dep't of Revenue*, 894 N.E.2d 452 (Ill. App. Ct. 2008), *aff'd* No. 107328, 2010 Ill. LEXIS 289 (Ill. 2010).

⁵ See Kevin M. Wood, Note, *Legislatively-Mandated Charity Care for Nonprofit Hospitals: Does Government Intervention Make any Difference?*, 20 REV. LITIG. 709, 713 (2001); see also Margaret A. Potter & Beaufort B. Longest, Jr., *The Divergence of Federal and State Policies on the Charitable Tax Exemption of Nonprofit Hospitals*, 19 J. HEALTH POL'Y & L. 393, 396 (1994).

⁶ The Statute of Charitable Uses, 43 Eliz. Ch. 4 (1601) (Eng.); see also Nina J. Crimm, *An Explanation of the Federal Income Tax Exemption for Charitable Organizations: A Theory of Risk Compensation*, 50 FLA. L. REV. 419, 425 (1998).

⁷ Crimm, *supra* note 6, at 425.

⁸ William P. Gunnar, *The Fundamental Law that Shapes the United States Health Care System: Is Universal Health Care Realistic Within the Established Paradigm?*, 15 ANNALS. HEALTH L. 151, 174-76 (2006).

⁹ Gabriel O. Aitsebaomo, *The Nonprofit Hospital: A Call for New National Guidance Requiring Minimum Annual Charity Care to Qualify for Federal Tax Exemption*, 26 CAMPBELL L. REV. 75, 76 (2004).

¹⁰ *Id.*

¹¹ See *id.*; see also Wood, *supra* note 5, at 713.

¹² See Gunnar, *supra* note 8, at 174-76.

¹³ *Id.*

¹⁴ *Id.*

¹⁵ David A. Hyman, *The Conundrum of Charitability: Reassessing Tax Exemption for Hospitals*, 16 AM. J. L. AND MED. 327, 336 (1990).

¹⁶ See *id.*; but see Lawrence E. Singer, *The Conversion Conundrum: The State and Federal Response to Hospitals' Changes in Charitable Status*, 23 AM. J. L. AND MED. 221, 221-222 (1997) (concerning a trend in hospitals to convert from non-profit to for-profit status to take advantages of increased capital).

¹⁷ See Eugene Steuerle, *A Method for Measuring and Partially Testing 'Charitability'*, TAX NOTES, July 30, 2007, at 393-94, available at <http://www.urban.org/publications/1001097.html>.

¹⁸ American Hospital Association, *Fast Facts on US Hospitals* (2009), <http://www.aha.org/aha/resource-center/Statistics-and-Studies/fast-facts.html>; see also CONG. BUDGET OFFICE, *NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS*, 12 (Dec. 2006).

¹⁹ CBO, *supra* note 18, at i, 8 (finding an average expenditure on uncompensated care by nonprofit hospitals of 4.7% of operating costs and an average of 4.2% of operating costs by for-profit hospitals).

²⁰ See *id.*

²¹ I.R.C. § 501(c)(3) (2010).

²² Rev. Rul. 69-545, 1969-2 C.B. 117.

²³ See Aitsebaomo, *supra* note 9, at 82-83 (discussing that the factors depend upon the circumstances and are not necessarily determinative).

²⁴ Rev. Rul. 83-157, 1983-2 C.B. 94.

²⁵ Rev. Rul. 69-545, 1969-2 C.B. 94.

²⁶ Treas. Reg. § 1.501(c)(3)-1(a) (2010); see also Noble, *supra* note 1, at 118.

²⁷ Treas. Reg. § 1.501(c)(3)-1(a); see also *St. David's Health Care Sys. v. United States*, 349 F.3d 232, 234 (5th Cir. 2003).

²⁸ See 349 F.3d at 234; see also Treas. Reg. § 1.501(c)(3)-1(a).

²⁹ Treas. Reg. § 1.501(c)(3)-(d)(2) (2010).

³⁰ *Id.* at (e)(1).

³¹ *Id.* at (e)(2).

³² See *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265, 267 (Utah 1985); see also Aitsebaomo, *supra* note 9, at 84-85.

³³ See Aitsebaomo, *supra* note 9, at 84-85.

³⁴ *Bob Jones University v. United States*, 461 U.S. 574, 591 (1983); see also *IHC Health Plans, Inc. v. Comm'r*, 325 F.3d 1188, 1195 (10th Cir. 2003).

³⁵ 709 P.2d at 276-77.

³⁶ See Crimm, *supra* note 6, at 425.

³⁷ Declines in charitable donation and the rise of third-party payment makes modern non-profit hospitals operate much like a commercial enterprise and like their for-profit competitors. See *Utah County*, 709 P.2d at 270-72.

³⁸ See Crimm, *supra* note 6, at 429-30.

³⁹ See *id.*

⁴⁰ See *id.* at 462.

⁴¹ See *Bob Jones University*, 461 U.S. at 591; see also *IHC Health Plans*, 325 F.3d 1194.

⁴² See Hyman, *supra* note 15, at 330-336.

⁴³ See *id.* at 336.

⁴⁴ See *Utah County*, 709 P.2d 265; see also *Provena Covenant Med. Ctr. v. Dep't of Revenue*, 925 N.E.2d 1131 (Ill. 2010); Stephanie Strom, *States Move to Revoke Charities' Tax Exemptions*, N.Y. TIMES, February 28, 2010, at A21.

- 45 See Noble, *supra* note 1, at 119.
- 46 U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-08-880, NONPROFIT HOSPITALS VARIATION IN STANDARDS AND GUIDANCE LIMITS COMPARISON OF HOW HOSPITALS MEET COMMUNITY BENEFIT REQUIREMENTS 16 (2008).
- 47 See *id.*
- 48 See *id.*
- 49 Pub. L. No. 111-148, 124 Stat. 119-1025.
- 50 See *Provena Covenant Med. Ctr.*, 925 N.E.2d 1131; see also Noble, *supra* note 1.
- 51 See TEX. HEALTH & SAFETY CODE ANN. § 311.045 (West 2009); 210 ILL. COMP. STAT. 89/1 (2010); see also *Utah County*, 709 P.2d 265.
- 52 See Strom, *supra* note 44; see also James Drew, *Call for Hospital Reform Widens*, BALTIMORE SUN, February 23, 2009, at 1A.
- 53 See *Provena Covenant Med. Ctr.*, 925 N.E.2d 1131.
- 54 TEX. HEALTH & SAFETY CODE ANN. § 311.045.
- 55 709 P.2d 265.
- 56 Utah Const. Art. XIII, § 2; see also *Utah County*, 709 P.2d at 267.
- 57 See *Utah County*, 709 P.2d at 277.
- 58 See *id.*
- 59 See *id.* at 267.
- 60 See *id.* at 268.
- 61 See *id.* at 270-71.
- 62 See *id.* at 271-73 (rejecting the argument that third-party payment makes philanthropic hospitals an anachronism because the development of third-party payment is a major cause of the erosion of the difference between non-profit and for-profit hospitals).
- 63 See *Utah County*, 709 P.2d at 275.
- 64 See *id.*
- 65 TEX. HEALTH & SAFETY CODE ANN. § 311.045; see also Wood, *supra* note 5, at 722-24.
- 66 TEX. HEALTH & SAFETY CODE ANN. § 311.045.
- 67 *Id.*
- 68 See Wood, *supra* note 5, at 733-735 (noting the reported increase in care after the statute was enacted is in contrast to the actual substantive effect).
- 69 *Id.*
- 70 INTERNAL REVENUE SERVICE, IRS EXEMPT ORGANIZATIONS (TE/GE) HOSPITAL COMPLIANCE PROJECT FINAL REPORT (2009).
- 71 See Wood, *supra* note 5, at 730-34.
- 72 *Provena Covenant Med. Ctr. v. Dep't of Revenue*, 925 N.E.2d 1131, 1131, 1140 (Ill. 2010).
- 73 *Id.* at 1135-36.
- 74 *Provena Covenant Med. Ctr. v. Dep't of Revenue*, 894 N.E.2d 452, 456 (Ill. App. Ct. 2008), *aff'd* 925 N.E.2d 1131 (Ill. 2010).
- 75 35 ILL. COMP. STAT. 200/15-65 (2010); see also 925 N.E.2d at 1145.
- 76 925 N.E.2d at 1135.
- 77 *Id.*
- 78 *Id.* at 1138.
- 79 *Id.* at 1140.
- 80 *Id.* at 1143-45.
- 81 *Methodist Old Peoples Home v. Korzen*, 233 N.E.2d 537, 541-42 (Ill. 1968); 925 N.E.2d at 1145.
- 82 See 925 N.E.2d at 1145.
- 83 *Id.*
- 84 *Id.*
- 85 894 N.E.2d at 469, *aff'd* 925 N.E.2d at 1131.
- 86 925 N.E.2d at 1147-48.
- 87 *Id.* n.10.
- 88 *Id.* at 1148-49; *People ex rel. Cannon v. Southern Illinois Hospital Corp.*, 88 N.E.2d 20 (Ill. 1949).
- 89 925 N.E.2d at 1148-49.
- 90 *Id.*
- 91 *Id.*
- 92 *Id.*
- 93 See *id.* (explaining that the state requirements for a charitable purpose must be distinguished from the federal community benefits standard that is used to show a charitable purpose and that in consideration of Illinois' recognition of the subsidization rationale, the local government does not entirely, or at all, bears the costs of Medicaid and Medicare).
- 94 *Id.* at 1153-54.
- 95 *Id.*
- 96 IRS, *supra* note 70, at 1-2.
- 97 *Id.* at 147.
- 98 *Id.* at 149.
- 99 *Id.*
- 100 See *id.* (clarifying that Schedule H allows for hospitals to explain why bad debt and Medicare shortfalls should be treated as community benefits).
- 101 *Id.* at 147.
- 102 *Id.* at 147-48.
- 103 See American Hospital Association, AHA Seeks Modification from IRS on Community Benefit Reporting (Mar. 5, 2010), available at <http://www.aha.org/aha/press-release/2010/100305-pr-schedH.html>. (urging the IRS to improve the Schedule H to reflect the benefits that nonprofit hospitals provide to their communities).
- 104 Pub. L. No. 111-148, § 9007, 2010 Stat. 1, 737-38.
- 105 *Id.*
- 106 *Id.*
- 107 GAO, *supra* note 46, at 52-56 (Appendix III).
- 108 Pub. L. No. 111-148, § 9007, 2010 Stat. 1, 737-38.
- 109 *Id.*
- 110 *Id.*
- 111 See IRS, *supra* note 70, at 6-8 (explaining the different ways non-profit hospitals could meet the community benefits requirements).
- 112 Pub. L. No. 111-148, § 9007, 2010 Stat. 1, , 856.
- 113 *Id.* at 857.
- 114 See 925 N.E.2d at 1140.
- 115 Pub. L. No. 111-148, § 9007, 2010 Stat. 1, 857.
- 116 *Id.*
- 117 See *id.*
- 118 See *id.* at 856-57.
- 119 See AHA, *supra* note 103.
- 120 See *id.*
- 121 Pub. L. No. 111-148, § 9007, 2010 Stat. 1, 857.
- 122 See *IHC Health Plans, Inc. v. Commissioner*, 325 F.3d 1188, 1194-95 (10th Cir. 2003).
- 123 *Id.* at 1194.
- 124 Treas. Reg. § 1.501(c)(3)-1(d)(2).
- 125 See *IHC Health Plans*, 325 F.3d at 1195-97; see also Rev. Rul. 98-15, 1998-1 C.B. 718 (stating that "not every activity that promotes health supports tax exemption under § 501(c)(3)").
- 126 *IHC Health Plans*, 325 F.3d at 1197-98.
- 127 See *id.* at 1197-98.
- 128 See *id.* at 1201-02.
- 129 See *id.* (recognizing the 'integral-part doctrine' but declining to rule on its application, because the Health Service and the petitioner lack a nexus of activities).
- 130 See *id.* at 1203.
- 131 See IRS, *supra* note 70, at 4 (finding that aggregate community benefits expenditures were unevenly distributed and "concentrated in a relatively small group)."
- 132 *Id.* at 1.
- 133 *Id.* at 3.
- 134 *Id.*
- 135 *Id.* at 6.
- 136 *Id.*
- 137 See *id.*
- 138 See *id.*
- 139 See *id.*
- 140 See *id.*
- 141 See *id.*
- 142 *Id.* at 12-14 (explaining that critical access was defined through certification with the Centers for Medicine and Medicaid Services (CMS), and which typically referred to rural hospitals without other hospitals nearby, or otherwise designated as critical access by the relevant state).
- 143 *Id.* at 6.
- 144 See *id.*
- 145 See *id.*
- 146 See *id.*
- 147 *Id.*

¹⁴⁸ *See id.*
¹⁴⁹ *See id.*
¹⁵⁰ *Id.*
¹⁵¹ *Id.* at 4, 3
¹⁵² GAO, *supra* note 46, at 7.
¹⁵³ *See id.* at 19.
¹⁵⁴ *Id.* Bad debt refers to amounts owed to the hospital that has no probability of collection. Medicare shortfalls refer to unreimbursed costs associated with payment in the Medicare program. Other activities include a variety of donations and operations within the community to encourage health.
¹⁵⁵ *Id.*
¹⁵⁶ CBO, *supra* note 18, at 1.
¹⁵⁷ *Id.* at 9-10.
¹⁵⁸ *See id.*; *see also* GAO, *supra* note 46; IRS, *supra* note 70. Government sponsored insurance mostly consists of Medicaid, Medicare, and other smaller programs.
¹⁵⁹ IRS, *supra* note 70, at 153.
¹⁶⁰ *See* ERNST & YOUNG LLP, AMERICAN HOSPITAL ASSOCIATION, COMMUNITY BENEFIT INFORMATION FROM NON-PROFIT HOSPITALS, ii-iii (2006) (supporting uniformity in reporting, but acknowledging hospitals should be allowed to “tell their community benefit story”).
¹⁶¹ *See* GAO, *supra* note 46, at 24-25.
¹⁶² *Id.*
¹⁶³ *Id.*
¹⁶⁴ Pub. L. No. 111-148, § 9007, 2010 Stat. 1, 739-41.
¹⁶⁵ *See id.*
¹⁶⁶ GAO, *supra* note 46, at 28.
¹⁶⁷ *Id.* at 20-22.
¹⁶⁸ *Id.*
¹⁶⁹ *Id.*
¹⁷⁰ *See id.*; *see also* IRS, *supra* note 70, at 149.
¹⁷¹ *See* IRS, *supra* note 70, at 149.
¹⁷² *Id.* at 6-8.
¹⁷³ *Id.*
¹⁷⁴ *Id.*
¹⁷⁵ *Id.* The fifteen research hospitals are relative to the 544 non-profit hospitals the IRS selected for the Hospital Compliance Project and not to all non-profit hospitals.
¹⁷⁶ *Id.* at 45. The IRS included the following as discrete types of community programs: lectures, seminars and education; medical screening; publications; improved access to care; immunization programs; other health promotion; and community needs studies. *See also* AHA, *supra* note 155, at 5-6. The AHA includes substantially the same initiatives as community programs.
¹⁷⁷ IRS, *supra* note 70, at 45; *see also* GAO Report, *supra* note 46, at 49-51 (Appendix II).
¹⁷⁸ IRS, *supra* note 70, at 7.
¹⁷⁹ *See* CBO, letter to the Honorable Nancy Pelosi, providing estimated budgetary and coverage effects of the reconciliation and PPACA, 9 (March 20, 2010), available at <http://www.cbo.gov/doc.cfm?index=11379>. The CBO estimates the number of uninsured will be reduced by 32 million by 2019, leaving 23 million still uninsured.
¹⁸⁰ *See* AHA, *supra* note 160, at ii-iii.
¹⁸¹ *See* GAO, *supra* note 46, at 21; *see also* American Hospital Association, Uncompensated Care Cost Fact Sheet 2 (2009), available at <http://www.aha.org/aha/content/2009/pdf/09uncompensatedcare.pdf> (including bad debt as uncompensated care).
¹⁸² *See* Singer, *supra* note 16, at 221-222.
¹⁸³ *See id.*
¹⁸⁴ *See id.*
¹⁸⁵ *See* CBO, *supra* note 18, at i.
¹⁸⁶ *See* GAO, *supra* note 46, at 66. Specifically, Rhode Island requires all licensed hospitals to comply with community benefits, charity care, and

uncompensated care standards. Non-compliance can result in suspension or revocation of the license. Knowing violation or willingly giving the state false information regarding compliance carries potential fines of up to \$1 million and a prison term of no more than five years.
¹⁸⁷ *See* CBO, *supra* note 18, at i. (finding an average expenditure on uncompensated care by nonprofit hospitals of 4.7% of operating costs and an average of 4.2% of operating costs by for-profit hospitals).
¹⁸⁸ Treas. Reg. § 1.501(c)(3)-1(c)(2). Regardless of their provision of community benefits for-profit hospitals are disqualified from tax-exemption on the grounds that their profits inure to private individuals, so the level of benefits for-profits provide is relevant here only for comparative purposes.
¹⁸⁹ But even if the entity was taxed, if it was financially unable to provide community benefits it would not likely have substantial corporate income tax liability. State taxes levied on non-income would still be liable even if the entity was financially unable, so the money saved would presumably go towards the charitable basis of the exemption.
¹⁹⁰ IRS, *supra* note 70, at 7.
¹⁹¹ *See id.* at 45; *see also* GAO, *supra* note 46, at 49-51.
¹⁹² *See* CBO, *supra* note 179. The CBO estimates the number of uninsured will be reduced by 32 million by 2019, leaving 23 million still uninsured.
¹⁹³ *See* Noble, *supra* note 1, at 130.
¹⁹⁴ *See* CBO, *supra* note 18, at i.
¹⁹⁵ *See* IRS, *supra* note 70, at 149; *see also* GAO, *supra* note 46, at 20-23.
¹⁹⁶ TEX. HEALTH & SAFETY CODE ANN. § 311.045 (West 2010).
¹⁹⁷ *See* Wood, *supra* note 5, at 734.
¹⁹⁸ *See id.* (noting that the Texas statute provides economic incentives towards certain types of reporting resulting in distortions in how hospitals report benefits).
¹⁹⁹ *See id.* at 735.
²⁰⁰ *See id.* at 736-737.
²⁰¹ *See* AHA, *supra* note 103.
²⁰² *See* IRS, *supra* note 70, at 6-7.
²⁰³ *See* Wood, *supra* note 5, at 734. (noting the enforcement problems with the Texas statute, which only allows full revocation of tax-exemption as punishment for failure to comply).
²⁰⁴ *See* Pub. L. No. 111-148, § 9007, 2010 Stat. 1, 119, 855-859.
²⁰⁵ *See* CBO, *supra* note 179 at 9. The CBO estimates the number of non-elderly uninsured will be reduced by 32 million by 2019, leaving 23 million still uninsured.
²⁰⁶ *See* IRS, *supra* note 70, at 6-7.
²⁰⁷ *See id.* at 7-8, 93-94; *see also* Wood, *supra* note 5, at 739.
²⁰⁸ *See* GAO, *supra* note 46, at 5, 11-13. Noting the lack of consensus among government and industry groups whether Medicare and bad debt costs should count as community benefit, but acknowledging they reflect in some part benefits to the community. Nonetheless, such costs may also be part of underlying structural costs necessary to the operation of a modern hospital.
²⁰⁹ *See* Wood, *supra* note 5, at 735.
²¹⁰ IRS, *supra* note 70, at 147.
²¹¹ *See* Pub. L. No. 111-148, § 9007, 2010 Stat. 1, 119, 855-859.
²¹² As stated earlier, financial inability does not excuse a non-profit hospital from providing sufficient community benefits to justify an exemption from taxes it would otherwise have to pay, but should be viewed in the context of the hospital’s historical behavior. Furthermore, it does not behoove the community benefit to add additional stressors to what may simply be temporary financial difficulties.
²¹³ *See* Wood, *supra* note 5, at 734; *see also* Noble, *supra* note 1, at 131. (suggesting the implementation of sanctions against non-compliance).
²¹⁴ *See* IRS, *supra* note 70, at 6.
²¹⁵ IRS, *supra* note 70, at 8. The significant variations within community and hospital types indicate at least some hospitals are providing less community benefits than others without justification.