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Is Federal Tax-Exemption Policy for Nonprofit Hospitals Moving to a Clearer *Quid pro Quo* Basis?

Beaufort B. Longest Jr.

Abstract

The question of whether federal tax-exemption policy for nonprofit hospitals is moving to a clearer and more robust quid pro quo basis is examined. The question is important because heretofore the basis for federal exemption has been vague and fluid. Utilizing a quid pro quo rationale for federal tax-exemption of nonprofit hospitals as a framework, the chronological record of policy in this area is organized into three major periods: (1) A Simple Quid pro Quo: Early Federal Tax Policies for Nonprofit Hospitals; (2) A Changing Quid pro Quo: The Modern Era of Federal Tax Policy for Nonprofit Hospitals; and (3) An Emergent, Clearer Quid pro Quo: Recent Congressional Activism on Exemption Policy, including relevant provisions of the ACA. The article concludes with discussion of continuing vagueness and ambiguity in federal corporate income tax policy for nonprofit hospitals. The importance of enhanced clarity and specificity in the information upon which policy in this area is based is discussed, as are actions needed by Congress and the Internal Revenue Service to accomplish improved exemption policy.

KEYWORDS: nonprofit hospitals, federal tax policy, tax-exemption

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Introduction

Nonprofit hospitals are among the mainstays of the U.S. healthcare system. Distinct from other organizational forms of hospitals, these organizations are a subset of the nation's approximately 5,000 community hospitals. Of these hospitals, almost 3,000 are classified as nonprofit, about 1,000 are for-profit organizations and about 1,000 are state or local government organizations (American Hospital Association 2012). The three types of community hospitals operate under different legal rules, principally that the for-profits may distribute profits to shareholders while the nonprofits and government-owned hospitals may not, but they benefit from income and property tax exemptions. However, as Horwitz (2005, 790) has observed the three types of community hospitals "all treat patients with a mix of needs, contract with the same insurers and government payers, operate under the same health regulations, and employ staff with the same training and ethical obligations." Citing an extensive literature comparing performance across hospital types, she concludes that, "it is not surprising that much of the empirical literature on corporate ownership finds little difference among hospital types (Horwitz 2005, 790).

By definition, nonprofit hospitals are "nongovernmental, acute care, general hospitals organized and operated for a nonprofit purpose and not designed primarily for profit-making purposes" (Government Accountability Office 2008, 1). It has been widely recognized since Kenneth Arrow's seminal article (1963) that medical care, including hospital services, are different from other components of the U.S. economy. Distinguishing factors in the markets for medical care include the information asymmetries described by Arrow, but also extensive government intervention, very high levels of uncertainty, significant barriers to entry, and the roles played by third-party agents for consumers (Phelps 2009).

In the context of market uniqueness for all types of hospitals and the similarities in performance across the types, it is central to this article that all levels of government have exempted the nonprofit hospitals from a variety of taxes if they meet certain requirements (Arnsberger, Ludlum, Riley, and Stanton 2008). Specifically, this article focuses on these requirements – which can be characterized as shifting over time – at the federal level. First, however, a few words about the value of exemption policy to hospitals.

Although the value of tax-exempt status to nonprofit hospitals is difficult to quantify precisely (Staff of the Joint Committee on Taxation 2009, 41), the most credible estimate was developed by the Joint Committee on Taxation and first published in a report by the Congressional Budget Office (CBO) (Congressional Budget Office 2006, 5). Based on information from IRS Forms 990 filed for 2002 by nonprofit hospitals, the value of the exemption from federal corporate income taxes was about $2.5 billion. Simply inflating the CBO's

estimates by the increases in CPI suggests that the current total value of this exemption is about $3 billion. This estimate also reflects an estimate of government tax revenues foregone under existing policy. To provide context for these numbers, the nation spends more than $873 billion on hospital care annually (Centers for Medicare and Medicaid Services 2012).

The value of tax-exemption for any specific hospital is unique to that hospital's circumstances and there is wide variation across hospitals in the monetary value of their exemptions (O'Donnell and Martire 2009; Waymire and Christensen 2011). It is important to note that the value of tax exemption extends beyond its monetary impact. It goes to the institutional identities of these organizations and makes exemption policy important to those who govern and manage nonprofit hospitals beyond monetary impact. It is also important to policy makers who are responsible for shaping policy in this area and to members of society who bear costs or receive benefits because of the policy.

Currently, nonprofit hospitals qualify for federal tax-exempt status through compliance with section 501(c)(3) of the Internal Revenue Code and newer requirements imposed by the Patient Protection and Affordable Care Act of 2010 (ACA). Generally, states and municipalities impose requirements that reflect more of a *quid-pro-quo* rationale than does the federal exemption (Brody 2007; Waymire and Christensen 2011). However, this may be changing. Emerging changes in federal policy nonprofit hospital tax-exemption are the focus of this article in which the purpose is to offer a framework within which nonprofit hospitals' federal exemption from income taxes can be systematically considered over time. This framework rests upon the fact that there is a *quid pro quo* relationship between various levels of government and nonprofit hospitals regarding their taxation, even if the relationship has been largely implicit at the federal level. As will be seen below, the relationship was clearly evidenced in the earliest federal tax policies for nonprofit hospitals and continues to help explain why nonprofit hospitals are exempt from federal income taxes.

The *quid pro quo* relationship is one of several theories of why the federal government exempts nonprofit hospitals from income taxes. Other theories include trust, sovereignty, and more recently the notion of leveling the playing field between for-profit and nonprofit health care providers through subsidies (Gray 2011). The roles played by these theories are not universally accepted; however, *quid pro quo* provides a basis for dividing and examining the chronology of federal exemption policy for nonprofit hospitals into three relatively distinct phases: (1) A Simple *Quid pro Quo*: Early Federal Tax Policies for Nonprofit Hospitals; (2) A Changing *Quid pro Quo*: The Modern Era of Federal Tax Policy for Nonprofit Hospitals; and (3) An Emergent, Clearer *Quid pro Quo*: Recent Congressional Activism on Exemption Policy, including relevant provisions of the ACA.

A Simple *Quid pro Quo*: Early Federal Tax Policies for Nonprofit Hospitals

The first hospital in the U.S., the Pennsylvania Hospital, was founded in 1751 expressly "to care for the sick-poor and insane who were wandering the streets of Philadelphia" (University of Pennsylvania Health System 2011). This was followed in 1771 by New York Hospital which was established by Royal Charter granted by King George III. Still operating today, these hospitals were established before the Declaration of Independence in 1776 or adoption of the U.S. Constitution in 1789.

Those earliest hospitals, and many that were yet to come, arose in the tradition of "voluntary" organizations and associations necessary in the absence of the emergent government's ability to meet needs for such services as those provided by schools, churches, fire departments, orphanages, and hospitals. Two distinct types of voluntary organizations formed: public-serving and member-serving (Salamon 1992, 14). In general, the public-serving organizations evolved into what are now called nonprofit organizations and are described under section 501(c)(3) of the Internal Revenue Code, including religious, educational, nonprofit, scientific, or literary organizations; organizations that test for public safety; and organizations that prevent cruelty to children or animals, or foster national or international amateur sports competition. Member-serving organizations are covered under other subsections of 501(c). Nonprofit hospitals are an example of the public-serving organizations, along with churches and schools, while such organizations as teacher's retirement fund associations and state-chartered credit unions are examples of member-serving organizations.

The extent of the role of voluntary organizations in the early U. S. is partially reflected in Alexis de Tocqueville's observation, made during his famous visit in 1831, that "Americans of all ages, conditions, and dispositions constantly unite together … to hold fetes, found seminaries, build inns, construct churches, distribute books…." (2003, 596). Although he did not say it specifically, de Tocqueville also could have noted the growing number of voluntary hospitals in the young nation.

The early voluntary hospitals were supported primarily through philanthropy, had physicians work in them without compensation, and served almost exclusively the poor who were sick (Joint Committee on Taxation 2005, 124). Subsequent changes in these and other characteristics of voluntary or nonprofit hospitals is an important aspect in the evolution of tax policy for them, as is the corollary question of did changes in the basis for exemption actually change tax-exemption policy. In this early phase of nonprofit hospital tax policy, the *quid pro quo* relationship was simple and straightforward; nonprofit hospitals were exempt in return for being nonprofit. The concept of nonprofit purposes derives from the 1601 English Statute of Nonprofit Uses and the statute's original

intent of public benefit, primarily expressed as the relief of poverty (Jones 1969). In this early period, the charity practiced by hospitals was seen to be a matter of taking care of the poor. The *quid* was exemption and the *quo* was charitably taking care of the poor.

Organizations that operated for a nonprofit purpose were exempted from federal income tax from the outset of policy in this domain. Recognizing the importance of the nonprofit sector, early federal policy makers considered this in their decisions from the beginning of tax policy development. This simple *quid pro quo* relationship continued into the first half of the twentieth century. The Revenue Act of 1913 created the modern federal income tax system. It contained two extraordinarily important provisions affecting nonprofit hospitals, although the act did not mention nonprofit hospitals by name. First, the act continued from previous policy the principle pertaining to tax exemption for nonprofit organizations. It did so without further clarification of what charity practiced by hospitals actually meant. In addition, the act also paved the way for the use of tax-exempt debt by nonprofit hospitals. Technically, the act excluded from taxable income the interest income earned by holders of the debt obligations of states and their political subdivisions. By extension to nonprofit hospitals, the ability to issue tax exempt bonds has been of great benefit in acquiring capital for purposes such as extending markets, modernizing their physical plants, and incorporating advancing technology.

The Revenue Act of 1917 provided tax deductions for individuals making donations to nonprofit organizations. In 1918, this deduction feature was extended to estate tax returns and in 1936 corporations were also permitted to claim the nonprofit deduction.

The earliest tax policies, in general, reflected the federal government's favorable tax treatment of nonprofit hospitals, exemption being the most positive treatment possible. Each policy fostered more financial support for nonprofit organizations including nonprofit hospitals. By the time these hospitals were receiving subsidies in the multiple forms of exemption from federal income taxes, eligibility to receive tax-deductible contributions, and authority to use tax-exempt bond financing, the value to them was substantial (Lunder and Liu 2009).

As noted above, early hospitals were considered voluntary or nonprofit organizations because of their substantial philanthropic support, the fact that physicians worked in them without compensation by the hospitals, and they served almost exclusively the sick poor (Joint Committee on Taxation 2005, 124). These variables underpinned the *quid pro quo* arrangement whereby government exempted nonprofit hospitals from taxes on the basis of their real or perceived nonprofit behaviors. However, one aspect of this underpinning changed dramatically at the end of the nineteenth and beginning of the twentieth centuries: the mix of patients being served by the hospitals.

These changes are well documented elsewhere (Starr 1984; Stevens 1989) so are only briefly outlined here. The changes were technologically driven. Surgical advances made hospitals attractive for an increasing number of patients who were able to benefit from the new services, and to pay for them. As surgery and other medical technologies emerged and attracted paying patients, the original nature of nonprofit hospitals changed. Moving from western states eastward, the proportion of hospitals drawing substantial amounts of their operating income from paying patients grew dramatically. By 1903, thirteen states reported their nonproprietary hospitals receiving more than 70 percent of their operating income from paying patients (Stevens 1989, 30).

As Stevens (1989, 33) has noted, as this shift in the income of nonprofit hospitals occurred they became "peculiar hybrids economically." Resources for buildings and other capital projects were almost entirely nonprofit gifts and endowments, while their operations ran more like businesses. Stevens summarizes the situation of nonprofit hospitals in the early twentieth century as follows:

> The more attractive the hospital was to paying patients, the greater its income; the greater its income, the greater the level of medical facilities and amenities that it could offer, and in turn, the greater its attraction to paying patients who might otherwise be treated at home (1989, 33).

For its part, government seems to have taken no notice of this substantial change; at least it had no discernible impact on policy in this area. Indeed, nonprofit hospitals received favorable tax treatment from the beginning of federal tax policy throughout this phase. Even though the value of federal exemptions were growing for nonprofit hospitals throughout the first half of the 20th century, limited attention was being given to the size of the federal subsidy, and even less attention to determining the value of the nonprofit care being provided in return, at least in terms of the relationship of these values to tax policy. The extant *quid pro quo* existed without close attention to the value of the *quid* or the *quo*.

To summarize tax policy in this early phase, government sought to encourage and abet the continued development of these organizations through favorable tax policies in return for them operating charitably, and without getting precise about what charity meant. What could have been simpler?

A Changing *Quid pro Quo*: The Modern Era of Federal Tax Policy for Nonprofit Hospitals

The 1954 development of the current structure of the Internal Revenue Code, with its Section 501(c)(3), marked the beginning of what is called here the modern era of federal tax policy. Section 501(c)(3) of the Code described nonprofit organizations and listed requirements for their exemption from federal income

taxes including: (1) the organization must be organized and operated exclusively for certain purposes – religious, nonprofit, scientific, testing for public safety, literary, educational, the fostering of national or international amateur sports competition, or the prevention of cruelty to children or animals; (2) there must not be private inurement to organization insiders; and (3) the organization's political activities were limited, among other provisions.

The Code permitted a wide variety of nonprofit organizations to attain exempt status. Organizations as varied in purpose as hospitals, elder care facilities, low-income housing organizations, college sports organizations, credit counseling organizations, and organizations intended to protect the environment can be recognized as nonprofit organizations under Section 501(c)(3). These and many other organizations were viewed as nonprofit for tax policy purposes so long as they met the standards for charity in their respective domains. The standards have evolved over time, perhaps none more so than those for nonprofit hospitals, under the fluid mix of pressure from interest groups and various decisions made by Congress, the IRS, and the courts (Joint Committee on Taxation 2005, 122). The basis of the *quid pro quo* relationship began to change during this period. The basic question was what did nonprofit mean?

Tax exemption for nonprofit hospitals simply because they were considered nonprofit was not directly provided for by the Code in 1954. Instead, hospitals could qualify for tax exemption by being organized and operated for a nonprofit purpose and meeting the additional requirements of Section 501(c)(3). Essentially, however, nonprofit hospitals remained exempt from federal income taxes because they were nonprofit organizations. The code made the concept of nonprofit as applied to hospitals critical to their federal tax-exempt status and, even more broadly to their very identities as institutions.

IRS's Standards for Nonprofit Hospital Tax Exemption

The IRS is responsible for determining what requirements must be met if nonprofit hospitals are to qualify for tax-exempt status as nonprofit organizations. Continuing to the present, their rulings in this regard have served as the "main guideposts" (Studdert, Mello, Jedrey, and Brennan 2007, 626) in this area of policy. The *quid pro quo* arrangement whereby nonprofit hospitals are tax-exempt so long as they are nonprofit, however vaguely defined, changed in 1956 when the IRS turned its attention specifically to the tax-exemption of nonprofit hospitals (Internal Revenue Service 1956).

Revenue Ruling 56-185: The Financial Ability Standard

Revenue rulings are official interpretations by the Commissioner of the Internal Revenue Service of the Internal Revenue Code, related statutes, and regulations in terms of how they apply to a specific set of facts. In the 1956 Revenue Ruling 56-185, the IRS directly addressed the tax-exempt status of nonprofit hospitals.

A key policy element of the 1956 ruling was its adoption of the "financial ability standard," which required, albeit quite imprecisely, that a nonprofit hospital be "operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay" (Fox and Schaffer 1991, 252). This degree of relative specificity represented an important step in the evolution of what government viewed the *quo* in their *quid pro quo* arrangement with nonprofit hospitals to actually be.

The financial ability standard meant in effect that nonprofit hospitals had to accept patients who needed hospital care even though they could not pay for the services. In other words, "the benefits of tax exemption were used to generate free care for the poor" (Crossley 2008, 2). However, the ruling granted hospitals flexibility in meeting the requirement to provide charity care. For example, hospitals could satisfy their charity requirements by providing services at rates below their costs. Importantly, the financial ability standard represented a policy decision that tax-exempt hospitals should have to provide potentially significant amounts of care to people who could not pay for it.

The central contribution to federal tax-exemption policy of Revenue Ruling 56-185 was its requirement that nonprofit hospitals provide some amount of free care or care at reduced rates in order to qualify for tax-exempt status. This was a significant change in the original simpler *quid pro quo* arrangement. However, imprecision as to how this requirement could or should be met was the ruling's most serious flaw.

Revenue Ruling 69-545: The Community Benefit Standard

Even with its imperfections and limitations, the financial ability standard established in the 1956 ruling prevailed until 1969, when Revenue Ruling 69-545 was issued. During the years between these rulings, some members of Congress were concerned about the imprecise way in which the 1956 ruling guided nonprofit hospitals in their decisions about obligations to accept patients who were unable to pay. In addition, the equation was changed by passage of landmark legislation in 1965 creating the Medicare and Medicaid programs. These programs began insuring portions of the population who had been recipients of significant amounts of free care provided by nonprofit hospitals (Kaiser Family Foundation 2010).

Revenue Ruling 69-545, even more than the earlier 1956 ruling, changed the *quid pro quo* arrangement whereby nonprofit hospitals gained federal tax exemption by complying with the "financial ability standard." The new ruling clarified a number of points regarding tax-exemption policy for nonprofit hospitals including confirming that the promotion of health, in and of itself, serves a nonprofit purpose. From the ruling (Internal Revenue Service 1969, 117), "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 … ."

This ruling, which quickly became known as the "community benefit standard" and with only minor adjustments made since its issuance, has meant that nonprofit hospitals are deemed by the IRS to serve a nonprofit purpose so long as they promote health in their communities. A hospital could meet this standard and qualify for federal tax exemption under Section 501(c)(3) if: (1) it was governed by a board whose members were prominent members of the community; (2) maintained an open medical staff policy which made staff privileges available to all qualified physicians in the area; (3) maintained a generally accessible emergency room available to all persons without regard to ability to pay; (4) provided care to all persons able to pay for the care; including through public and private insurance programs; and (5) utilized surplus funds to expand, improve, or replace existing facilities and equipment, amortize indebtedness, improve quality of care, or advance medical training, education, and research.

The requirements for exempt status under this ruling went further than the IRS had previously gone in specifying what government meant the *quo* in their *quid pro quo* arrangement to be. Government greatly expanded the ability of nonprofit hospitals to include in their *quo* in return for exemption a broader array of services and activities and to provide them to the entire community. Even so, many aspects of these requirements and how they should be documented were left even vaguer than the requirements under the 1956 financial ability standard.

Since the 1969 ruling, the IRS has provided little further guidance on how nonprofit hospitals warrant exempt status. An exception was Revenue Ruling 83-157 in 1983 which generally reinforced the application of the community benefit standard but made a substantive clarification regarding maintenance of a widely accessible emergency room (Internal Revenue Service 1983, 94). The ruling declared that a nonprofit hospital need not operate an emergency room in situations where a state planning agency or authority has found that doing so would unnecessarily duplicate other similar services already available in the community.

Otherwise, except for some additional requirements discussed below which were imposed by the ACA (U.S. Congress 2010), the pathway to

qualifying for federal tax-exempt status under Section 501(c)(3) involves hospitals being able to show facts and circumstances consistent with the requirements set forth in Revenue Ruling 69-545 as listed above.

Responsibility for Revenue Ruling 69-545

It has been suggested, although evidence is elusive and incomplete, that the hospital industry sought the shift in the basis for tax exemption in the 1969 ruling "not because they asserted that the free care requirement [promulgated in Revenue Ruling 56-185] was too onerous or would put them out of business, but because they believed the new federal programs [Medicare and Medicaid with their new coverage of some of the medically indigent for whom care had been previously provided under the financial ability standard] would eliminate the demand for free care" (Crossley 2008, 2). The hospital industry suggests that the "final impetus for the IRS to alter its 1965 ruling requiring a not-for-profit hospital be operated 'to the extent of its financial ability for those not able to pay' came as a response to suggestions from Congress" (Lofton 2006).

Whatever its multiple origins, the fundamental shift in the basis for nonprofit hospitals' federal tax-exempt status in 1969 was supported by the industry and presumably most if not all its individual nonprofit hospital members. This was made exquisitely clear in testimony by the then chair-elect of the American Hospital Association who observed that

> Since 1969, not-for-profit hospitals have been able to fulfill their nonprofit obligations through an appropriate mix of charity care, financial assistance to low-income patients, subsidized health care, research, health professions education and other community-building activities that are tailored to the needs of the communities they serve (Lofton 2006).

Whatever the roles played by Congress, the hospital industry, and the IRS, the resulting policy contained in Revenue Ruling 69-545 was vague as to the requirements for nonprofit hospitals to qualify for tax-exemption by providing community benefits. The fundamental issue this vagueness has wrought is "exactly what kinds of behaviors by nonprofit hospitals this extremely large 'carrot' of tax exemption is promoting? What kinds of behaviors is tax exemption deterring?" (Crossley 2008, 3). This circumstance caused some policy makers to remain concerned about whether nonprofit hospitals provide enough in the way of community benefits to justify the tax revenues foregone by the federal government. This concern was exacerbated by the fact that there was not "consensus on what constitutes a community benefit or how to measure such benefits" (Congressional Budget Office 2006, 1). In terms of the *quid pro quo*

arrangement guiding federal tax policy toward nonprofit hospitals, the *quid* was relatively easy to assess (about $3 billion in tax relief from federal income taxes as noted earlier) but the *quo* was not, giving rise to the third phase of evolving federal tax-exemption policy for nonprofit hospitals.

An Emergent, Clearer *Quid pro Quo*: Recent Congressional Activism on Exemption Policy

Following a long period of relatively constant federal policy regarding nonprofit hospital tax exemption, interrupted by two periods of particularly active Congressional interest in this area, significant changes are contained in ACA. These two periods of relatively active Congressional interest have been instrumental in an emerging clearer (more precise) *quid pro quo* in which the value of the *quo* may be much clearer and more precise, making judgments about balance in the equation easier.

U.S. House of Representatives, 1990-1991

The first round of activity was centered in the House of Representatives in 1990-1991. The interest in tax exemption of nonprofit hospitals at that time arose primarily in response to the growing numbers of uninsured people (Sullivan and Moore 1990). Estimates of 35-40 million people without insurance were prevalent in 1990 (Flynn 1992). Two bills emerged during this period of activism, both seeking to tie the tax-exempt status of nonprofit hospitals to a defined amount of charity care.

The first bill, H.R. 790, the Charity Care and Hospital Tax-Exempt Status Reform Act of 1991, was introduced by Representative Edward Roybal (D-Calif.) who at the time chaired the U.S. House Permanent Select Committee on Aging. He had requested a study by the General Accounting Office (now Government Accountability Office), *Nonprofit Hospitals: Better Standards Needed for Tax Exemption* (Government Accountability Office 1990). The letter transmitting the completed study to Representative Roybal, stated "This report concludes that the Congress should consider revising the criteria for hospitals' tax exemption if it believes that providing charity care should be a fundamental basis for such an exemption" (Government Accountability Office 1990, 1).

Representative Roybal felt strongly that establishing a clear connection between tax-exempt status and charity care was an important step for Congress to take. His bill would have amended the Internal Revenue Code

> to declare that an otherwise tax-exempt organization which operates a hospital shall not be exempt from tax unless the hospital: (1) has an open-door policy toward Medicare and

> Medicaid patients and serves in a nondiscriminatory manner a reasonable number of such patients; and (2) provides in a nondiscriminatory manner sufficient qualified charity care and sufficient qualified community benefits (Congressional Research Service 1991, 1).

The second bill introduced during the 1990-1991 period was H.R.1374, sponsored by Representative Brian J. Donnelly, D-MA. Among other provisions, this bill would have required tax exempt hospitals to provide a specified amount of charity care. The bill would have clarified and codified the community benefit standard and would have added a charity care requirement in order for nonprofit hospitals to maintain tax-exemption (McGovern 1992). Both the Roybal and Donnelly bills were subjects of a hearing before the Ways and Means Committee. Interestingly, neither the IRS nor the nonprofit hospital industry supported a change from the community benefit standard to a more specific charity care standard. The industry's position has been summarized as opposing "any changes, arguing that the existing community benefit standard is sufficient and that the decision of how to benefit the community should be by an individual hospital and its community" (McGovern 1992, 38).

Eliciting little surprise at the time, neither bill received further legislative action. However, it has been suggested that the 1990-1991 period of activity stimulated broader consideration among policy makers of issues related to appropriate requirements that nonprofit hospitals should meet to retain their exemption from federal income taxes (Speizman 2009). Even more recent events, as described below, support this view.

U.S. Senate, 2001-2010

The more recent second round of intensified Congressional interest and activity concerning federal tax exemption for nonprofit hospitals both stimulated and responded to controversies about whether nonprofit hospitals actually deserve the benefits associated with tax-exempt status. Specific controversial issues included (Lunder and Liu 2009, 4):

- Prices charged to low-income uninsured patients for medical care in comparison to those charged patients paying through insurance.
- Methods used by hospitals to collect payment from patients.
- Classification of bad debt as a community benefit by some hospitals.
- Growing number and complexity of partnerships formed between tax-exempt hospitals and for-profit entities.
- Level of compensation paid to top executives and other employees.

- Questions about whether the community benefit standard is correct, or whether tax-exempt hospitals should categorically be required to provide a certain level of charity care.

Congressional interest during the 2001-2010 period triggered hearings on tax-exempt hospitals in the 109th Congress (House Ways and Means Committee 2005; Senate Committee on Finance 2006). Much of the interest was centered in the U.S. Senate under the highly visible initiative of Senator Charles Grassley (R-IA). Senator Grassley's interest in tax-exemption for charities of all types – not just nonprofit hospitals – closely corresponded to his involvement on the Senate Committee on Finance. He served as either the Ranking Member or Chairman of this committee from 2001 through 2010, and continues to serve as a senior member of the committee.

From the vantage point of his involvement on the Committee on Finance, Senator Grassley took significant steps to advance thinking on and attention to the nonprofit hospital exemption issue. For example, the minority staff of the Committee on Finance produced and, under his direction, released a discussion draft outlining possible tax-exempt hospital reforms. A key proposal was that nonprofit hospitals maintain and publicize a charity care program and that they provide minimum amounts of charity care measured as a percentage of each hospital's total operating expenses (Senate Committee on Finance Minority Staff 2007).

In addition, Senator Grassley requested that the GAO analyze the status of community benefit requirements for nonprofit hospitals to maintain federal tax-exempt status. The resulting report, *Nonprofit Hospitals: Variation in Standards and Guidance Limits Comparisons of How Hospitals Meet Community Benefit Requirements* contains two conclusions with continuing relevance.

1. The community benefit standard, as articulated by the IRS in Revenue Ruling 69-545, does not require nonprofit hospitals to provide any specific amount of charity care in order to qualify for federal tax exemption, so long as they engage in activities that benefit their communities. Within this framework, nonprofit hospitals are allowed broad latitude to determine the services and activities that constitute community benefit. Although state requirements lie outside the scope of this article, the report notes that the states vary greatly in terms of whether they have community benefit requirements, whether in statutes or regulations, for a hospital to qualify for state tax-exempt or nonprofit status, and where they do exist the requirements vary substantially in scope and detail.
2. Among the federal agencies and healthcare industry groups studied (Note #1)there is general consensus that, from the viewpoint of the hospitals, charity care means unreimbursed cost of means-tested government health care programs (programs for which eligibility is based on financial need,

such as Medicaid), and many other activities that result in community benefit. However, the consensus among these perspectives does not extend to the inclusion of bad debt and the unreimbursed costs of Medicare as community benefits. The GAO further concludes that there is also variation in how the costs of benefits are measured. Differences in the activities that hospitals might count as community benefits and differences in how the costs of the activities are measured means the reported community benefits are not standardized across hospitals. In GAO's words, "at present, determination and measurement of activities as community benefit for federal purposes is still largely a matter of individual hospital discretion" (Government Accountability Office 2008, 7).

The Patient Protection and Affordable Care Act of 2010 (ACA)

With limited fanfare, perhaps reflective of the law's overall massive size and scope, ACA introduced the newest elements of the *quid pro quo* arrangement through which nonprofit hospitals can maintain their federal tax exempt status. The new requirements are best described as a work in progress, but they do represent a way forward in the evolution of policy in this area. In fact, if fully implemented, ACA will change the organization and financing of health care to such an extent that implementation will likely open many aspects of health policy – including tax exemption – to new Congressional review.

Senator Grassley co-authored the additional requirements and refers to them as "standards for the tax exemption of nonprofit hospitals" (Grassley 2010). Unlike the previous "financial ability standard" and "community benefit standard," these new requirements haven't yet attracted a catchy name. One candidate might be the "needs-based community benefit standard," but that awaits further development. In any case, the central new requirement is for nonprofit hospitals to conduct community needs assessments and to base much of their community benefit activity around responding to the identified needs of their communities.

The needs assessment requirement and other new requirements for nonprofit hospitals to qualify for federal tax-exempt status are contained in section 9007 of ACA, Additional Requirements for Nonprofit Hospitals, which amends the Internal Revenue Code of 1986 (Note #2). The changes require nonprofit hospitals to:

- Conduct a "community health needs assessment" at least once every three years, taking into account "input from persons who represent the broad interests of the community served by the hospital facility, including those

with special knowledge of or expertise in public health" and make the assessment "widely available to the public" (U.S. Congress 2010, 856).

- Adopt an "implementation strategy to meet the community health needs identified through such assessment." Submit on Internal Revenue Service Form 990 "a description of how the organization is addressing the needs identified" and "a description of any such needs that are not being addressed together with the reasons why such needs are not being addressed" (U.S. Congress 2010, 856 and 858).
- Establish and widely publicize a financial assistance policy for making available free or reduced cost care to eligible persons. The written policy must include "eligibility criteria for financial assistance, and whether such assistance includes free or discounted care; the basis for calculating amounts charged to patients; and the method for applying for financial assistance." In addition, the policy must describe the actions that will be taken in the event of nonpayment, "including collections action and reporting to credit agencies" (U.S. Congress 2010, 856).
- Establish a written policy "requiring the organization to provide, without discrimination, care for emergency medical conditions," regardless of the individual's financial eligibility (U.S. Congress 2010, 857).
- Limit the amount charged for emergency or medically necessary care provided to those who are eligible for financial assistance "to not more than the lowest amounts charged to individuals who have insurance covering such care and prohibits the use of gross charges" (U.S. Congress 2010, 857).
- Avoid engaging in "extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy" (U.S. Congress 2010, 857).
- Provide the organization's audited financial statements (U.S. Congress 2010, 858).

Important to operationalizing these changes, the IRS redesigned Form 990 during 2006-2009. This form, since its inception in 1943, remains the main tool though which the IRS verifies that an organization complies with the requirements for tax exemption. As part of this overhaul, a new Schedule H was established and designated for use solely by tax-exempt hospitals. With implementation of Section 9007 of ACA in tax years beginning after March 2010 and in subsequent years, the IRS has positioned itself to more fully understand what nonprofit hospitals do to justify their tax exemption, and to more precisely determine the monetary value of these societal benefits. The monetary value of these benefits is difficult to quantify. As CBO notes, "there is little consensus on what constitutes a community benefit or how to measure community benefits"

(Congressional Budget Office 2006, 1). Progress is being made, but clarification and full specification of both the values of exemptions and of community benefits remains to be accomplished.

The more complete information available through the revised Form 990 and its Schedule H will facilitate future policy making and help clarify for all purposes the basis of the *quid pro quo* relationship between tax exemption and nonprofit behavior by nonprofit hospitals. Going forward, the new information collected will make it easier to determine the monetary value of the benefits provided by hospitals to society, perhaps leading to a more balanced *quid pro quo* arrangement. For now however, policy makers must rely largely upon estimates of these values.

Conclusion

As described in this article, vagueness and ambiguity have characterized much of federal exemption policy for nonprofit hospitals. There has been movement toward more specificity and clarity as to what nonprofit hospitals must do to warrant federal tax exemption. Yet, ambiguities remain. The extent of this problem can be seen in contrast to what many states are doing in this area. A number of states have made their *quid pro quo* arrangements for granting tax exemptions to nonprofit hospitals quite specific and clear and others are doing so (Brody 2007, 288). Changes contained in section 9007 of ACA will at least ameliorate some of the ambiguity at the federal level. These changes will also partially address many of the controversial issues identified by Lunder and Liu (2009, 4) and noted above.

Coupled with the information required from nonprofit hospitals on the current IRS Form 990 and Schedule H, it is possible that a much clearer and more specific *quid pro quo* policy may emerge. At least the groundwork for more clarity has been laid. Yet, more needs to be done to achieve an unambiguous *quid pro quo*-based federal tax-exemption policy for nonprofit hospitals. This will require decisions and actions by Congress and the IRS. As GAO notes, "it would be preferable to have congressional direction for such a policy change" (Government Accountability Office 2008, 45). A step in this direction was taken with enactment of ACA, which contains the strongest congressional guidance to date in this policy area. However, there is still room for more clarity in this guidance. A variety of pressures are pushing for this clarity.

The emergence of for-profit hospitals may be a factor considered in future tax policy for nonprofit hospitals. A voluminous literature has been compiled comparing the two forms, some also including government-sponsored hospitals in the comparisons on a number of variables. Overall, the results of these studies are inconclusive, often showing more similarities than differences in the two forms

(Frank and Salkever 2000; Sloan 2000, 2001; Government Accountability Office1990).

Future consideration of appropriate tax policy is likely to take into account the role of tax policy in achieving social policy goals. The tax system is replete with examples of provisions which include encouraging and facilitating certain types of behaviors including purchase of health insurance, accumulating retirement resources, community banking, and the provision of charity and other community benefits by nonprofit hospitals.

Whichever of these and perhaps other factors affect the future decisions of policy makers contemplating exemption policy, the most important will likely be for them to take into account the value of enhanced clarity, transparency, and specificity in those policies for the body politic. Well-developed policies typically reflect a cause and effect relationship, even if this is only implicit in the policy (Longest 2010, 131). This relationship, at least as intention, is difficult to discern in much of the federal policy related to tax-exemption of nonprofit hospitals, and the relationship has regularly changed with the passage of time as in the shift from the "charity care standard" to the "community benefit standard."

Ambiguities and vagueness in the *quid pro quo* policies guiding federal nonprofit hospital tax exemption, especially the nature of the *quo* aspects of the equation, can obviously continue. This merely requires that no change or limited change be made in existing policy. However, clarity in this area has significant potential benefits. A concrete Congressional decision, reflected in new or amended public law, about the continuing appropriateness of the *quid pro quo* arrangement and its balance that has long guided policy in this area would be better policy and provide clearer direction for nonprofit hospitals.

Trustees or directors of these institutions bear the duty of obedience to nonprofit purpose. Fulfilling this important duty has never been easy, in part because of the shifting and often vague criteria used by the IRS. As has been observed, "To the hospital board falls the unenviable task of demonstrating and articulating obedience to a nonprofit purpose in an increasingly harsh commercial environment" (Studdert, Mello, Jedrey, and Brennan 2007, 630). Although some who manage and govern nonprofit hospitals may prefer existing policy ambiguities, many others seek clarity and guidance in performing their duty in pursuit of their hospital's nonprofit purposes.

More clarity could yield better policy in this area. Elegantly simple tax-exemption policy such as Goldsmith's (2010) idea to make "an explicit numerical relationship between the value of the tax exemption and quantifiable community benefit," could emerge. Another idea posited more than a decade ago by Reinhardt (2000, 185) suggests imposing the corporate income tax on all hospitals, whether nonprofit or for-profit, and then permitting both types of hospitals "to treat as a dollar-for-dollar tax offset the auditable and certifiable

monetary estimate of the value of uncompensated community benefits that they have rendered during a given fiscal period."

The path to more rational and equitable exemption policy envisioned in such ideas as those noted above would be eased by the information the IRS is poised to collect. The outcome, however, also requires a commitment by all relevant policy makers to utilize the information to guide their decisions about the appropriateness and balance of the *quid pro quo* between their tax advantages and the future benefits nonprofit hospitals will provide society. In effect, the nation could achieve an unambiguous *quid pro quo* in which the value of exemption to nonprofit hospitals and the benefits they provide to society are well balanced for each institution.

Notes

1. The government agencies and healthcare industry groups included were the Centers for Medicare & Medicaid Services (CMS), Internal Revenue Service (IRS), the American Hospital Association (AHA), the Catholic Health Association of the United States (CHA), VHA Inc., and the Healthcare Financial Management Association (HFMA). In addition to reviewing standards and guidance provided by these entities, GAO also interviewed representatives from them as well as from other organizations: Association of American Medical Colleges; Federation of American Hospitals; National Association of Children's Hospitals; state hospital associations and state health officials from California, Indiana, Massachusetts, and Texas; and seven nonprofit healthcare systems.
2. The changes are shown in a new Section 501(r) which the law adds to the Internal Revenue Code. Section 501(r) applies to hospital organizations that are currently described in Section 501(c)(3) of the Code.

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