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IN THE LINE OF FIRE

**THE BATTLE OVER
TAX-EXEMPT
STATUS CONTINUES**

“The threats from tax assessors and policymakers are providing a call to deeper, more realistic self-evaluation and renewal. This can be a service to an institution even when it makes the people involved quite uncomfortable. We can all profit from that type of call to integrity and renewed commitment to mission. In this case it is a valuable challenge to ensure that the whole healthcare operation is mission-permeated and mission-driven, that it is primarily a healthcare ministry, not simply a healthcare industry.”

—Rev. James E. Hug, SJ, “Preface,” in *Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint*, Catholic Health Association, St. Louis, 1989.



REVISE OR PRESERVE?

When the 102d Congress convened, leaders from both houses pledged to make healthcare reform a priority in 1991-92. The reform would be aimed at improving citizens' access to healthcare and long-term care services and at paring costs. With that goal on record, and with the introduction early in the year of two bills that would link tax exemption to charity care, it is no surprise that 1991 witnessed what may prove to be the most important congressional hearing in the tax-exempt organization sector since the 1987 unrelated business income tax hearings. I am speaking about the July 10 House Ways and Means Committee hearing on the tax-exempt status of hospitals.

Ways and Means Committee Chairperson Dan Rostenkowski, D-IL, set the stage for the debate in the press release announcing the hearing:

The Committee on Ways and Means has not reviewed the issues pertaining to the general tax-exempt status of not-for-profit hospitals since 1969. At that time, only 11 percent of Americans lacked health insurance, whereas today approximately 16 percent have no insurance. This lack of coverage has caused many Americans to turn to not-for-profit and public hospitals in order

A Flurry Of Views On Revision Of Tax- Exemption Standards

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Health Associations of Canada and the United States, Montreal, June 1991.

to receive basic health services. In addition, changes in the organization, structure, and activities of hospitals, as well as in the fi-

Summary Many groups would be affected if Congress changes the tax laws governing not-for-profit hospitals. The community benefit standard now in place focuses on nondiscriminatory treatment of patients whose care is paid for by public programs such as Medicaid. It also fosters universal access to emergency care regardless of ability to pay.

In 1990, however, a U.S. General Accounting Office (GAO) report suggested that if Congress believes tax-exempt hospitals should provide more charity care, it should consider revising the criteria for exemption. This created a flurry of responses from the groups that would be affected.

In response to the GAO's report, Rep. Edward R. Roybal, D-CA, introduced H.R. 790, and Rep. Brian J. Donnelly, D-MA, introduced H.R. 1374, bills linking tax exemption to charity care. The Roybal bill requires not-for-profit hospitals to have an open-door policy for Medicare and Medicaid patients and to provide services to a reasonable number of these patients. The Donnelly bill would in essence codify the IRS's interpretation of the community benefit standard and add to it a charity care requirement.

The administration reported it was opposed to a change from the current community benefit standard to an express charity care standard. Nevertheless, it would not oppose a more limited change that codifies the current position.

Not-for-profit hospitals have opposed any changes, arguing that the existing community benefit standard is sufficient and that the decision of how to benefit the community should be made by an individual hospital and its community.



nancing system, suggest that a review of these issues is appropriate.

Although charity care took top billing, the hearing focused more broadly on all operational aspects of tax-exempt hospitals. In this article I explore the issues confronting Congress in deciding whether to change the tax laws affecting not-for-profit hospitals. (On p. 52, T. J. Sullivan considers the changing nature of tax-exempt hospitals' financial arrangements with physicians. And J. David Seay discusses the criteria for hospital tax exemption on p. 42.)

CHARITY CARE

The United States is facing a healthcare crisis. An estimated 16 percent of the population has no health insurance. The joint federal-state Medicaid program covers 24 million low-income persons, but these account for only about 40 percent of the nation's poor. People in both these groups may have trouble finding a physician and may not have equal access to many of the nation's hospitals. With the estimated value of federal tax exemption at approximately \$4.5 billion a year,¹ a critical inquiry must involve the following questions regarding the current standards for hospital tax exemption:

- What are they?
- Are they appropriate?
- Are they being met?

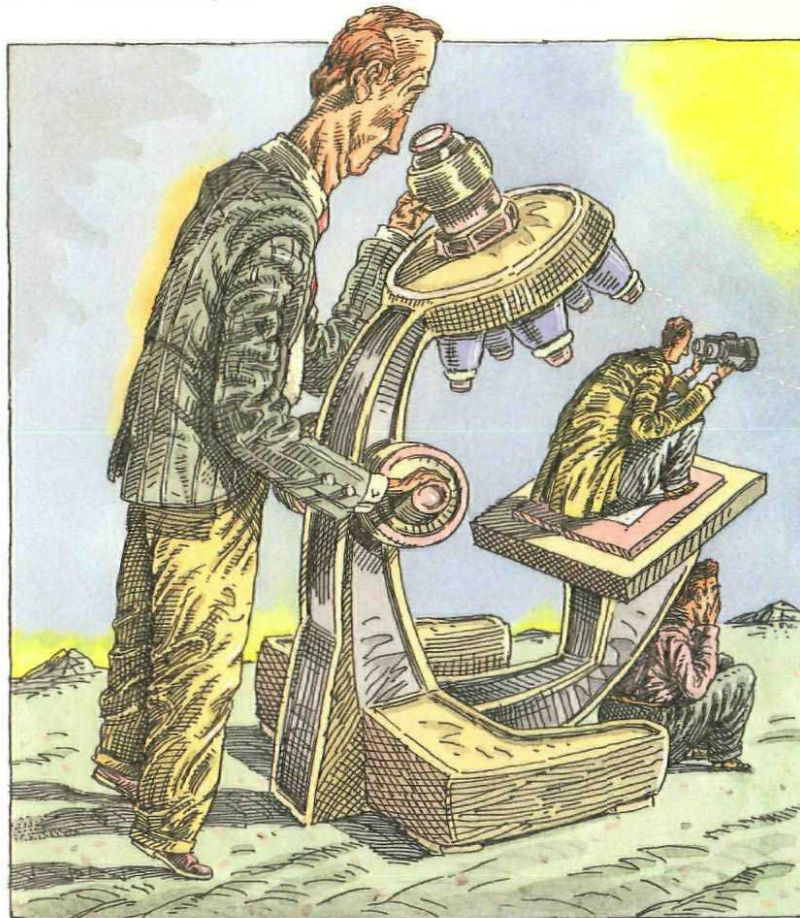
Community Benefit Standard

Under the Internal Revenue Code, a not-for-profit hospital can be exempt from federal taxation if it is organized and operated exclusively for charitable purposes.² The community benefit standard, announced in Revenue Ruling 69-545 (1969-2 C.B. 117), is the Internal Revenue Service's (IRS's) current position on what it takes for a hospital to be considered charitable and thus exempt. The 1969 community benefit standard was a departure from qualification based primarily on the *amount* of charity

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care provided. Its purpose was to ensure that the entire community (rich and poor alike) receives some benefit from the hospital's operation. As such, the community benefit standard focuses on nondiscriminatory treatment of patients whose care is paid for by public programs such as Medicaid. It also fosters universal access to emergency care regardless of ability to pay. The community benefit standard was deemed appropriate under the conditions prevailing in 1969, just a few years after Medicare and Medicaid were implemented, but Congress is reexamining it to determine whether it remains sufficient for today's conditions.

The IRS has always believed that operation of a full-time emergency room open to all without regard to ability to pay and participation in the Medicare and Medicaid programs are virtual requirements to demonstrate community benefit. This was the expectation when Revenue Ruling 69-545 was promulgated and was the basis on which the IRS defended the ruling in the federal courts in the early 1970s. For example, the IRS's brief to the Supreme Court in the *Eastern Kentucky Welfare Rights* case defended the decision to drop its former absolute charity care requirement:



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The institution of Medicare and Medicaid since the promulgation of the first Revenue Ruling [Rev. Rul. 56-185, 1956-1 C.B. 202] has resulted in the admission and treatment by private hospitals of large numbers of insured persons of whom a substantial percentage, in the absence of such governmental reimbursement, would be unable to pay the cost. Thus, a private hospital which meets the criteria of the current Rev. Rul. 69-545, and admits any patient with some form of health insurance, is accepting many of those persons who



would have required free or below-cost care in 1956, prior to the advent of Medicare and Medicaid. As a result, the free care for indigents required by the prior Revenue Ruling is of lesser significance for the health care of the poor today than it was in 1956 [footnote omitted].

Moreover, the emergency room requirements of the current Rev. Rul. 69-545 fulfill a significant part of the hospital care needs of the poor. For it is true, if unfortunate, that the emergency room is to most poor persons what the family doctor is to the economically advantaged.³

Citing the court of appeals decision, which upheld the IRS's position, the brief argues that Revenue Ruling 69-545 did not abolish the general requirement that a hospital furnish some type of free care to the indigent. Rather, it provided an additional means (free emergency room treatment) by which a hospital could qualify for tax-exempt status. The brief states, "In no sense, therefore, can a general hospital under the current ruling policy systematically exclude those who cannot pay from all treatment and retain its tax-exempt status."⁴

By the mid-1980s, however, there were indications that hospitals, squeezed by mounting economic pressures, were beginning to view the factors in Revenue Ruling 69-545 as merely illustrative of the types of activities that can demonstrate community benefit. This engendered a reaction of growing concern from Congress and the IRS. **Antidumping Law** The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires all hospitals that participate in Medicare (almost all do) and have emergency departments to screen and treat any patient in an emergency condition regardless of the patient's ability to pay.⁵ This is known as the anti-patient dumping law, which is a Medicare provision, not a tax-law provision. The antidumping law directly affects nearly every U.S. for-profit and not-for-profit hospital. COBRA's legislative history states the underlying congressional concern clearly:

The Committee is greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance. The Committee is most concerned that medically unstable patients are not being treated appropriately. There have been reports of situations where treatment was simply not provided. In numerous other instances, patients in an unstable

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condition have been transferred improperly, sometimes without the consent of the receiving hospital.

There is some belief that this situation has worsened since the Prospective Payment System for hospitals became effective. The Committee wants to provide a strong assurance that pressures for greater hospital efficiency are not to be construed as license to ignore traditional community responsibilities and loosen historic standards.⁶

In 1989 Congress revisited the antidumping law and strengthened it by requiring hospitals to adopt and enforce a policy to ensure compliance, keep records regarding transfers for five years, and post a notice in emergency rooms specifying rights to emergency treatment and whether the hospital participates in Medicaid.⁷

REVISING EXEMPTION CRITERIA

Congress again focused on charity care in 1990 when the U.S. General Accounting Office (GAO) reported finding a weak link between tax-exempt status and the provision of charitable activities for the poor or underserved and wide variation among individual facilities in the amounts of uncompensated care they provided.⁸ The report suggests that if Congress believes tax-exempt hospitals should provide more charity care, it should consider revising the criteria for exemption.

IRS's Views Shortly after the GAO report was published, Rep. Edward R. Roybal, D-CA, chairperson of the House Select Committee on Aging, introduced H.R. 5686 (reintroduced in the 102d Congress as H.R. 790) and called a hearing. The bill, which would relink charity care to tax exemption, requires not-for-profit hospitals to have an open-door policy for Medicare and Medicaid patients and to provide services to a reasonable number of these patients. However, the bill does not define a "reasonable number" of Medicare and Medicaid patients. The number would be determined on the basis of each hospital's circumstances. At the June 28, 1990, hearing I testified for the IRS, addressing the development of the service's current standards and the general issues involved; however, the service did not take a position on the legislation. No further legislative action was taken.

In 1991 Rep. Brian J. Donnelly, D-MA, introduced H.R. 1374, a bill that would require a hospital to have a full-time emergency room open to all without regard to ability to pay, would recognize the overlap of COBRA violations with this requirement, and would require nondiscriminatory



ry provision of care to Medicaid patients.

The Donnelly bill would also require hospitals to provide a stated amount of charity care or provide other objective, measurable evidence of community benefit. This proposal would in essence codify the IRS's interpretation of the community benefit standard and *add* to it a charity care requirement, or at least a requirement of more objective evidence of community benefits or services.

Administration's Views At the July 10 hearing on H.R. 790 and H.R. 1374, Michael Graetz, the deputy assistant secretary for tax policy of the Department of the Treasury, presented the administration's views. Graetz told members of the House Ways and Means Committee that the administration opposed a change from the current community benefit standard to an express charity care standard. Nevertheless, Graetz said the administration would not be opposed to a more limited change that codifies the current position on emergency rooms and Medicaid. Also of significance, he admitted that enforcement of the existing standard has been hampered by the lack of any sanction short of revocation of exemption. Although not calling for legislation, he stated that reexamination of this situation might be appropriate and that any intermediate sanctions should be modeled on the private foundation excise-tax provisions.⁹

Not-for-Profit Hospitals' Views In the past not-for-profit hospitals have opposed any legislative amendment to or clarification of the community benefit standard. They have argued that the existing community benefit standard is sufficient and that the decision of how to benefit the community should be made solely at the *local* level by an individual hospital and its community. For example, a *National Catholic Register* article states that industry concern arises "when the federal government defines what a hospital must do specifically. . . . When it comes to determine how to serve the community, hospitals are in the best position to do that."¹⁰

When I addressed an American Hospital Association group in early 1990, I heard strong criticism of the GAO report, some of which referred to the Catholic Health Association (CHA) rebuttal to that report.¹¹ Apparently, a lot of energy has been spent quibbling over the GAO's methodology. Whatever the scope of the methodology, the debate itself should remain properly focused.

First, everyone should recognize that the community benefit standard is not a hospital industry standard but a *federal* tax standard articulated in Revenue Ruling 69-545. Some hospitals (and their tax advisers) may not readily agree with the

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IRS's interpretation of that standard (i.e., the requirement of an open emergency room, the overlap with the COBRA provisions, and nondiscriminatory provision of care to Medicaid eligibles). Healthcare representatives sometimes seem to argue that a hospital can meet the community benefit standard just by being there. That is not the service's view.

Second, Congress has indicated that the community benefit standard is fair game for legislative consideration. The Department of the Treasury has defended the existing standard, but hinted that some improvement in enforcement and sanctions might be desirable. Where the debate will take us from here remains to be seen. Whatever the next step, I am confident that CHA will play a significant role. The IRS has read with interest CHA's April 1991 *Agenda for Advocacy*¹² and noted from the association's July 1991 testimony that CHA has created a task force to make formal recommendations on hospital tax-exemption policy. The IRS is also well aware that CHA's *Social Accountability Budget* is beginning to have as wide a readership outside religious-sponsored hospitals as within.¹³

HOSPITAL OPERATIONS

The July 10 Ways and Means hearing also focused on recent changes in not-for-profit hospital organization, structure, and activities. Although the national healthcare crisis has given the charity care issue a high profile, other developments put the operational aspects of hospitals in the spotlight.

One significant development has been state court and legislature inquiries into the operational aspects of hospital systems. These inquiries began in 1985 when the Utah Supreme Court had difficulty distinguishing between for-profit and not-for-profit healthcare systems.¹⁴ This type of scrutiny has continued in Vermont, Texas, Pennsylvania, and other states and has not escaped the attention of the U.S. Congress.¹⁵

CURRENT ENFORCEMENT EFFORTS

Even in the midst of the debate over whether the standards for tax exemption need changing, the IRS is moving forward. In 1990 the service initiated a pilot project for its Coordinated Examination Program for large, complex, tax-exempt organizations, particularly hospital systems. The IRS pilot examination, involving a large Western multi-institutional system, will serve as the prototype and was the subject of a training videotape for IRS field agents.¹⁶ In fiscal year 1992 each IRS Exempt Organizations Key District will initiate two coordinated examinations of hospital systems

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The task force offers a vision of reform distinctly different from other proposals.

dren in this blessed country who, through no fault of their own, are being excluded daily from full participation in the world's most technologically advanced and sophisticated healthcare system.

In proposing a delivery system that responds to the healthcare needs of people, families, and communities, the task force offers a vision of healthcare reform that is not only distinctly different from other reform proposals but also is in perfect harmony with our ministry values and Catholic social teaching. In forthrightly addressing the problem of unsustainable healthcare inflation, the task force has, by suggesting an essential reform of the current system, placed at risk the status quo and thus achieved, in my opinion, a credibility that guarantees CHA a seat at the political table to debate the issue of systemic healthcare reform with all stakeholders.

A JUST AND EQUITABLE SYSTEM

This initiative is drawn from our CHA 2000 Task Force report, which calls CHA to be a leader in the movement toward a redesigned U.S. healthcare system that is just and equitable. This same vision statement challenges us to refrain from seeking easy solutions or making proposals that provide comfort by preserving the status quo. Our vision and our proposal do neither, but they are worthy of the important work to which we have been called. □

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in addition to their ongoing regular examination activities. Also, for the second time in two years, the IRS is revising and expanding the examination guidelines for hospitals.

The Treasury Department and the IRS have told Congress that it can expect compliance in the tax-exempt sector to improve if it authorizes intermediate sanctions, short of revocation, for certain abuses. IRS agents often find it difficult to propose revocation of exemption for an important community resource such as a hospital when the abuse involves only a small part of its activities. This reluctance may have insulated some misconduct or may have encouraged aggressive transactions that could cross the line into prohibited private inurement. Charitable hospitals should watch developments in this area carefully and begin thinking now about whether any recent activities or arrangements in which they have engaged warrant reconsideration.

DEMONSTRATE COMMUNITY BENEFIT

Midway through the 102d Congress, it is impossible to predict whether the standards for hospital tax exemption or the sanctions for failing to meet them will be revised. For now, individual facilities should heed the questions being raised at the federal, state, and local levels and take stock of how well they fulfill their tax-exempt purposes. Although views on what standards should apply may vary, one thing is certain: Hospitals will be best prepared to meet any challenge to exemption—judicial, legislative, or administrative—by being able to demonstrate how they benefit their communities. □

NOTES

1. John Copeland and Gabe Rudney, *Federal Tax Subsidies for Not-for-Profit Hospitals*, 46 Tax Notes 1559 (1990).
2. IRC Sec. 501(c)(3) does not specifically mention hospitals or healthcare, but lists certain types of organizations that are exempt, including those organized and operated exclusively for religious, charitable, scientific, or educational purposes.
3. *Eastern Kentucky Welfare Rights Organization v. Simon*, 426 U.S. 26 (1976), vacating, 506 F.2d 1278 (D.C. Cir. 1974) (Brief for Secretary of Treasury at 94).
4. *Eastern Kentucky Welfare Rights Organization* (Brief for Secretary of Treasury at 89).
5. Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, Sec. 9121(b), 100 Stat. 1874, 1996, codified as amended at 42 U.S.C. Sec. 1395dd.
6. H.R. Rep. No. 241, Pt. 1, 99th Cong., 1st Sess. 27 (1986).
7. Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, Sec. 6018, 103 Stat. 2106, 2165.
8. U.S. General Accounting Office, "Nonprofit Hospitals: Better Standards Needed for Tax Exemption," HRD-90-84, Washington, DC, May 1990.
9. Chapter 42 of the Internal Revenue Code (Secs. 4940-4948) imposes excise taxes on certain tax-exempt organizations that engage in specified activities or transactions.
10. John Paul Arnerich, "For Non-Profit Hospitals, a Hard Time from Feds?" *National Catholic Register*, April 14, 1991.
11. Lewin/ICF, "The General Accounting Office Report on Hospital Tax Exemption: An Analysis," July 11, 1990; reprinted in 3 Exempt Organization Tax Review 751 (September 1990).
12. Catholic Health Association, *Agenda for Advocacy*, St. Louis, 1991.
13. *Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint*, Catholic Health Association, St. Louis, 1989.
14. See *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265, 270 (Utah 1985). ("Traditional assumptions bear little relationship to the economics of the medical-industrial complex of the 1980's.")
15. See, for example, *Medical Center Hospital of Vermont, Inc. v. City of Burlington*, Chittendon County Super. Ct., Docket No. S-658-87 CnC (Vt. Super. 1987), *aff'd*, 566 A.2d 1352 (Vt. 1989); *School District of the City of Erie v. Hamot Medical Center*, No. 138-A-1989 (Ct. Common Pleas, Erie County, slip op. May 18, 1990); *St. Luke's Hospital v. Board of Assessment Appeals*, No. 88-C-2691 (Ct. Common Pleas of Lehigh County, Apr. 19, 1990); *Downtown Hospital Ass'n v. Tennessee State Bd. of Equalization*, No. 87-1612-III (Ch. Ct., 20th Jud. Dist., Davidson County Tenn., Feb. 4, 1988); *Callaway Community Hospital Ass'n v. Craighead*, 759 S.W. 2d 253 (Mo. Ct. App. 1988).
16. Internal Revenue Service, *Auditing Tax Exempt Hospital Systems* (videotape) and User Guide, 1990. Reprints of the tape, obtained under the Freedom of Information Act, are available for \$10 from the Catholic Health Association, St. Louis. Contact Karen Kaltenbach at 314-427-2500, ext. 258.