WHY THE IRS COMMUNITY BENEFIT STANDARD FOR TAX-EXEMPT HOSPITALS HAS ENDURED

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Over the past several years, tax-exempt hospitals have faced increasing scrutiny over the level of community benefit they provide. Watchdog groups, researchers, members of Congress and other critics have called for laws requiring hospitals to provide a minimum threshold of community benefit to qualify for tax-exempt status.[1]

But what these critics seek to overturn — the Internal Revenue Service (IRS) community standard for hospitals' federal tax exemption — has weathered similar criticism for more than 55 years and endured.

HOSPITAL TAX EXEMPTION STANDARDS

In the 18th and 19th centuries, most American hospitals were operated primarily to serve low-income and vulnerable populations. In the 20th century, even as hospitals evolved from almshouses for the poor to community health centers, state courts commonly denied tax exemptions to hospitals whose primary purpose was to care for and treat paying rather than nonpaying patients.[2] In 1956, the IRS followed this "relief of poverty" approach in Revenue Ruling 56-185, its first detailed ruling on tax-exemption qualification criteria for hospitals. Among other requirements, it required exempt hospitals to be operated, to the extent of their financial ability, for those not able to pay for medical services (the "financial ability standard").

Under the financial ability standard, it wasn't clear to what extent a hospital needed to treat people who were unable to pay in order to maintain tax-exempt status. Further, the percentage of such patients decreased significantly with the advent of Medicare and Medicaid in 1965, creating less of a need for hospitals to provide free and discounted care.[3]

To address the uncertainty over how hospitals could qualify for tax exemption and account for the lesser need for charity care, in 1969 the IRS modified Revenue Ruling 56-185 to establish an alternative, more flexible "community benefit standard" for exemption. That ruling set forth two examples, one of "Hospital A," which was operated primarily to promote the health of its community and thus qualified for exemption, and one of "Hospital B," which was owned and operated primarily for the private benefit of physicians and thus did not qualify for exemption.

The positive facts suggesting that Hospital A was operated to promote community benefit included its (1) independent community board; (2) open medical staff; (3) emergency room, open to everyone in the community, regardless of ability to pay; (4) provision of nonemergency care to anyone in the community able to pay, either directly or through public programs like Medicare; (5) use of surplus funds to improve patient care; and (6) medical training, education and research.

In Revenue Ruling 69-545, the IRS acknowledged that tax-exempt charitable purposes under Code Section 501(c)(3) can extend beyond relief of poverty and cover a broad array of community benefit activities:

> The promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community.[4]

EARLY CHALLENGES TO THE COMMUNITY BENEFIT STANDARD

In the early 1970s, several indigent rights groups challenged Revenue Ruling 69-545 in court, on the grounds that the community benefit standard was inconsistent with the concept of "charity" and that the IRS lacked authority to promulgate the standard. None of these challenges were successful.

In one such case, the U.S. Court of Appeals in the District of Columbia held that the IRS's promulgation of Revenue Ruling 69-545 was not an abuse of IRS authority because the standard was founded on a permissible definition of the term "charitable."[5] The court stated, "While it is true that in the past Congress and the federal courts have conditioned a hospital's charitable status on the level of free or below cost care that it provides for indigents, there is no authority for the conclusion that the determination of 'charitable' status was always to be so limited. Such an inflexible construction fails to recognize the changing economic, social and technological precepts and values of contemporary society."

Revenue Ruling 69-545 has been modified slightly over the years to reflect such changing precepts and values; for instance, in Revenue Ruling 83-157, the IRS clarified that the absence of an emergency room is not a negative factor if other emergency rooms operate in the hospital's community.

COMMUNITY BENEFIT REPORTING ON FORM 990, SCHEDULE H

On occasion, Congress has held hearings on hospitals' tax-exempt status and called on the IRS to regulate exempt hospitals more strictly.[6] Partly in response to congressional pressure, in 2008 the IRS added Schedule H to Form 990, requiring hospitals to annually demonstrate compliance with the community benefit standard.

In designing Schedule H, the IRS drew on the CHA community benefit framework and calculation methodology and adopted CHA's eight categories of community benefit. Half of those categories (financial assistance, health professions education, medical research and Medicaid) reflected community benefit types referenced in Revenue Ruling 69-545. The other half (community health improvement services (including community benefit operations), subsidized health services, other means-tested government programs and contributions for community benefit) are either closely analogous to the ruling's categories or reflect charitable purposes. For example, both subsidized health services and community health improvement services are conducted to meet a community health need at a financial loss.

In addition to requiring reporting of community benefit expense, Schedule H also requires narrative reporting on how hospitals meet different elements of the community benefit standard. The former is much more closely scrutinized than the latter by community benefit standard critics.

RECENT CHALLENGES AND PROPOSED ALTERNATIVES

In a 2018 study, a group of researchers from Johns Hopkins University published a report on hospital community benefit in which they stated: "There is an expectation that nonprofits provide sufficient community benefit to justify their tax-exempt status." The researchers didn't define what a "sufficient" level of community benefit would be to justify tax-exempt status, but concluded that "the value of the tax exemption averages 5.9% of total expenses, while total community benefits average 7.6% of expenses."[7]

A number of community benefit standard critics have cited this and similar reports in arguing that exempt hospitals should meet a quantitative standard of community benefit spending to justify their federal tax exemption.[8] Some argue that hospitals must justify their exemption by incurring community benefit expense that exceeds the value of their federal and state tax exemptions; for example, the amount of tax hospitals would pay if they were taxable.[9]

QUANTITATIVE STANDARDS AND TAX EXEMPTION

Proposed alternatives to the community benefit standard that would establish a minimum threshold of community benefit spending are viewed by many as problematic and thus have not been adopted to date, for several reasons. Among the arguments offered by opponents of these alternatives are, first, that they are reductionistic, as they don't take into account nonquantifiable community benefit or value that hospitals provide to their communities. Second, such standards are unworkable, given that quantifying the value of community benefit a hospital provides is inherently challenging (e.g., the value of curing diseases, saving lives and addressing community health needs) and quantifying the amount of tax it would pay if it were taxable is equally challenging, given the complex tax profiles of hospitals and variables such as credits, deductions and

possible restructuring to minimize tax. Third, such standards are inconsistent with Section 501(c)(3), which requires consideration of *qualitative* facts and circumstances — not a minimum *quantity* of expenditures — in determining whether an organization qualifies as a charity.

Other critics argue that the community benefit standard isn't sufficient, so exempt hospitals should be subject to greater regulation by the IRS.[10] Exempt hospitals are already regulated by the IRS in a number of ways, more heavily than most types of exempt organizations. In addition to complying with the community benefit standard, they must (1) comply with general Section 501(c)(3) exemption standards; (2) comply with the financial assistance policy, billing and collections, and community health needs assessment requirements of Code Section 501(r), established by the Affordable Care Act (ACA); (3) annually complete Form 990 Schedule H; and (4) be subject to constant scrutiny and examination by the IRS.

The ACA requires the IRS to review the community benefit provided by every tax-exempt hospital at least once every three years,[11] and the IRS Tax-Exempt and Government Entities (TE/GE) division has examined dozens of these hospitals over the past two years. The division still lists tax-exempt hospitals as a top examination priority.[12]

Lastly, some critics contend that exempt hospitals' operations are substantially identical to those of for-profit hospitals, and therefore they should not be tax-exempt. In response, others point to research indicating that exempt hospitals are more likely than for-profit hospitals to provide needed community services that are not profitable.[13] They provide evidence that exempt hospitals operate at significantly lower margins compared with the margins of for-profit hospitals,[14] as exempt hospitals prioritize community health needs over shareholder profit. The community benefit standard allows these factors to be considered in evaluating hospitals' qualification for tax exemption, unlike proposed alternative standards that would establish a minimum threshold of community benefit spending.

ILLUMINATING COMMUNITY BENEFIT

As outlined above, challenges to the community benefit standard and hospitals' tax exemption highlight the need for exempt hospitals to better explain and promote their community benefit activities, especially their less visible ones. By more fully and accurately reporting their community benefit on Schedule H and supplemental reports, exempt hospitals can more effectively demonstrate both the quantitative and qualitative community benefit that they provide to their communities.

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