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Community Benefit and Nonprofit Hospitals

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Thank you for inviting me to be here with you. I always look forward to coming to Austin. I'm glad to be here today not only because this is a great town, but because the topic the Attorney General has served up for us is intellectually fascinating, timely, and vital. It is clearly worthwhile talking about tax-exempt hospitals, and hearing what others have to say.

I'm going to speak this morning about nonprofit hospitals that are exempt under section 501(c)(3) of the Code, and about the community benefit standard that applies to them. I'll also talk about our hospital study, which we expect to release in the near future.

Broadly stated, the question for this morning is what is the service or package of services that tax-exempt hospitals should provide to the community, which supports their privilege of tax-exemption? Put another way, how should community benefit be defined and measured, and what role should it play, under federal tax law?

Today I will outline my view of certain critical considerations regarding the tax-exemption standard that applies to non-profit hospitals seeking exemption from federal income tax. For nearly forty years now, the discussion of this topic has mostly been about what is commonly known as the community benefit standard.

The community benefit standard has become a lightning rod for much of what concerns people about non-profit hospitals, including the cost and delivery of care and the treatment of patients when it comes to billing and collection. To some, community benefit should be narrowly interpreted to equate with charity care; to others, it should be broadly construed to encompass virtually everything a non-profit hospital does. And there are still others that believe it fits somewhere in the midst of these competing interpretations. You and I know it cannot be all these things at the same time.

The issue before us is whether the community benefit standard continues to serve a useful purpose, or whether the time is approaching when a revised or new standard must be adopted to keep pace with the times. Among the questions we need to ask about the current standard is whether it adequately distinguishes non-profit and for-profit hospitals? And equally important, whether it adequately assesses different types of tax-exempt hospitals, such as critical access hospitals or the urban research hospitals?

Demographics of the Hospital Sector

Let's start with something pretty basic. The tax-exempt hospital sector is large and important, and changing too rapidly to ignore. The American Hospital Association reports that there are more than 5,700 hospitals throughout the country. Of these, more than 2,900 are non-governmental not-for profit hospitals. Around 870 are for-profit community hospitals. The remainder are state and local government hospitals.

And the mix of tax-exempt versus for-profit hospitals varies in different parts of the country. According to a 2006 CBO report, for-profits constitute just 6% of the hospitals in the Midwest and the Northeast, but 29% in the South. Here in Texas the split is pretty even. The number of government hospitals also varies across the country.

It is evident that this is a big sector; it is a big part of our economy, and it has changed enormously over the past 40 years. Since the Internal Revenue Service is charged with ensuring that the fisc is protected from unwarranted exemption from income tax, you can understand why we have been focusing some attention here.

The Community Benefit Test at the Federal Level

Introduction

Let me turn to the requirements a hospital must meet to be tax-exempt under federal law. Hospitals are a bit different from other charities. We ordinarily expect a charity to provide for a charitable class of people – a prime example is providing food, clothing and shelter to the poor or distressed. This is not necessarily the standard for a nonprofit hospital. Instead we require the non-profit hospital to show it benefits the community it serves through the promotion of health in its community. Thus, in determining community benefit, the hospital may include services provided to persons commonly thought of as being outside the traditional definition of a charitable class – the poor or distressed.

So what does "benefit the community" mean? We have to understand it in context. Non-profit hospitals operate alongside for-profit counterparts in many parts of the country. To the man on the street, a tax-exempt hospital may look remarkably similar to one that pays tax. And that same man on the street might reasonably ask why the standard I described above – that the hospital benefits the community it serves through the promotion of health – would not also be met by a for-profit hospital. So the tax policy and tax administration question that needs to be addressed is: How does one meaningfully differentiate a tax-paying, for-profit hospital from a non-profit hospital that enjoys exemption from federal and state tax, exemption from property tax, and eligibility for favorable bond financing? That is where

the community benefit standard comes in – to help one make that distinction. And the question then becomes, how good a job does it do?

What is required for tax exemption under federal law?

What is required for a hospital to be tax-exempt under federal law? We last addressed this subject 40 years ago when the Service modified its earlier answer to this question. And the world has been questioning us about it ever since.

It may be somewhat surprising to learn that neither the Internal Revenue Code nor the underlying regulations explicitly provides for the exemption of non-profit hospitals from federal income taxation. Nonetheless, we have long recognized that hospitals may qualify for exemption under section 501(c)(3).

We set out the current community benefit standard four decades ago – in 1969 – in a revenue ruling. Despite enormous changes in the health care sector since then, and the seemingly diminishing distinctions between non-profit and for–profit hospitals, that definition of the community benefit standard continues to guide the federal determination of tax-exempt status for non-profit hospitals.

Let me articulate our 1969 standard. We said that to qualify as an organization described in section 501(c)(3), a hospital must demonstrate that it provides benefits to a class of persons broad enough to benefit the community, and it must show that it is operated to serve a public rather than a private interest. In a nutshell, that is the standard – a hospital must show that it benefits the community and the public by promoting the health of that community.

The 1969 revenue ruling looked at five factors:

(a) A community board;

(b) An open medical staff;

(c) A full-time emergency room open to all regardless of ability to pay;

(d) The admission of all types of patients including those able to pay for care either themselves or through third-party payers; and

(e) How excess funds are used, such as for expansion and replacement of existing facilities and equipment, medical training, education, and research.

These are not the only factors, and the ruling went on to say that it is a facts and circumstances determination, with no one factor controlling. The 1969 ruling also modified (but left in place) an earlier revenue ruling that based exemption on providing charity care. This meant that while a hospital that wanted to be tax-exempt was no longer required to accept indigent patients to the extent of its financial ability, its willingness to do so continues to be an important indicator that the hospital is operated for the benefit of the community.

The community benefit standard is not the only requirement hospitals must satisfy. They also must meet the general requirements for exemption under section 501(c)(3), including the prohibitions against inurement and the payment of excess compensation, and impermissible private benefit.

You know much better than I that the health care industry has changed since 1969. Medicare and Medicaid now reimburse hospitals for medical care for the elderly and the indigent. Hospitals that participate in Medicare and have an emergency room generally are required – for reasons unrelated to the community benefit standard – to treat any patient in an emergency condition, regardless of ability to pay. Further, to achieve cost containment, Medicare and other third-party payers have changed their reimbursement methodologies, which may

impact different hospitals differently depending upon their patient profile and community demographics.

What this means is that certain factors specifically identified in the 1969 revenue ruling appear to be less helpful, 40 years later, in distinguishing tax-exempt hospitals from for-profit hospitals. An open medical staff, participation in Medicare and Medicaid, and treating all emergency patients without regard to ability to pay are characteristics now shared by tax-exempt and for-profit hospitals. So, although they remain factors in assessing whether a non-profit hospital is entitled to tax-exemption, they no longer meaningfully distinguish one type of hospital from another.

Some distinguishing features do remain, however. One is obvious: where do the profits go? That, along with a community board designed to assure that the hospital is accountable to the broader community it serves, are two of the most significant distinguishing characteristics that have survived 40 years of change in the sector. And, of course, charity care and other uncompensated or undercompensated care remain relevant.

The existing community benefit standard has been criticized by some as being no standard at all. Others have argued that it is appropriately flexible and accommodates the diversity of the non-profit health care sector, ranging from large to small, general to specialty, and rural to urban. Others take a middle course, and argue that the existing standard generally works, but that it needs a tune-up to incorporate new factors that reflect the changing times – such as billing and collection practices, accountability to the community, and community needs assessments. Others suggest, and I think there is some sense to this, that, in certain instances, just being there is enough to satisfy exemption requirements where there are no other hospitals present in the community.

Much of the criticism of the community benefit standard relates to its lack of precision. But what some regard as the lack of bright lines has not meant that the IRS has not had an

enforcement presence in this area. We have and will continue to have one. For example, in 2001, the IRS Chief Counsel issued a non-precedential field service advice listing more than a dozen questions our agents should consider regarding the provision of charity care by a nonprofit hospital. But most of our recent enforcement efforts have been in areas like joint ventures, health maintenance organizations, and other primary care health facilities. When all is said and done, we have not used the community benefit standard to challenge the tax exempt status of many non-profit hospitals.

And let's not forget that this debate is not only about federal tax exemption. I also note the increasing role of state rules. Whether it is the recent Provena case in Illinois, or the existing community benefit statute here in Texas – state law matters. It increasingly appears that federal tax exemption is no longer always dispositive of how a state or local government will regard a hospital.

More than a dozen states have adopted written standards involving community benefit. The Texas requirements are similar to the federal standard in some respects, and broader than it in others. Your statute represents an effort to quantify the amount of community benefit that a hospital is to provide. Other state statutes focus on other factors. The community benefit standard varies considerably across that minority of states that have attempted to define community benefit.

In short, we have a longstanding, some would say time-worn, community benefit standard at the federal level. We have formally identified the community benefit factors that are to be used, though some of them have only a fading relevance to the realities of today's health care system. And there is, some say, no clear line establishing the quantitative or qualitative aspects of community benefit that should be provided, or prescribing how to measure it. Given this state of affairs, and the size and importance of the health care sector, it's easy to see why the federal standard is under review.

A fresh look

Both Congress and the IRS are looking at the community benefit standard.

In the Congress, the Senate Finance Committee, and particularly Senator Grassley, the Ranking Member, have been looking closely at tax-exempt hospitals and how they satisfy their obligations under the community benefit standard.
In July, 2007, Senator Grassley's staff on the Finance Committee put forth a proposal to quantify the community benefit that tax-exempt hospitals ought to provide. Their draft proposal was that "no hospital can maintain section 501(c)(3) status without dedicating a minimum of 5% of its annual patient operating expenses or revenues to charity care, whichever is greater." The draft noted that the 5% test reflected what the staff called "the common practice of the IRS in auditing nonprofit hospitals prior to the 1969 regulatory changes." Senator Grassley continues to discuss the possibility of introducing legislation in this area.

The House Ways and Means Committee has also expressed interest in this issue. In July, 2005, then-Chairman Thomas convened a hearing on tax-exempt hospitals and health care organizations, and the IRS's administration of the area. He followed this in December, 2006 with proposed legislation requiring non-profit hospitals to provide a minimum level of charity care to individuals with incomes below the federal poverty limit, and limiting payments to the "average insured rate" for individuals with incomes less than two times the federal poverty limit. Sanctions would have included an excise tax on hospitals and the disallowance of charitable deductions to contributors.

The IRS's fresh look: the New Form 990 and the Schedule H

Let me turn now to what the IRS has been up to, starting with the new IRS Form 990.

As you know, we have been working to redesign the Form 990 for the past few years. One of our goals in doing so was to use the new 990 to contribute to the review of the community benefit standard. Our reasoning was straightforward: better data would allow the public, the Congress, the IRS, the States, and other stakeholders to make better-informed decisions about this area. As part of the 990 redesign, we therefore added a new hospital schedule – the Schedule H – that requires non-profit hospitals to report community benefit and other information about themselves. We did not design the Schedule H to alter the existing community benefit standard, and it does not do so. Rather, it was built with the current standard in mind.

We believe the new Schedule H and its instructions will result in a more consistent measurement and reporting of hospital community benefit expenditures. The 990 will also improve reporting on how the hospital is governed, how it compensates executives, and how it complies with the Code in other areas, such as monitoring tax-exempt debt. But key to today's discussion is that the new Form 990 will provide important insight into the nature and quantity of services that non-profit hospitals provide to satisfy the community benefit standard.

Others have said – and I generally agree – that prior to the new Schedule H, the determination and measurement of community benefit was, as a practical matter, largely a matter of individual discretion. Every hospital had its own way of measuring community benefit – its own view of what counted and how to report it.

The new Schedule H addresses that problem. For the first time, we will be able to make apples to apples comparisons of hospitals. Although it is not perfect, the new Schedule H provides clear standards on a number of points:

- The types of activities reportable or not reportable as community benefit;

- The requirement that community benefit be reported at cost rather than charges, or otherwise; and
- The requirement that community benefit be reported by employer identification number, rather than by hospital or by system.

The Schedule H thus addresses the "what," the "how," and the "by whom" aspects of community benefit, but it does not answer all questions pertinent to this debate. There remain some key areas where consensus does not yet exist as to whether an expenditure, either in whole or in part, should be included in community benefit. These areas include bad debt, the unreimbursed cost of Medicare, and certain community-building activities. These items are reported on the Schedule H, and hospitals may explain what they think should count as community benefit. But, for now, they are still under discussion, and remain outside the quantifiable community benefit identified on the Schedule H.

Nor does the Schedule H provide a bright line standard against which the reported data can be assessed to determine whether the reporting hospital should be tax-exempt or should be taxed. Neither does it resolve the for-profit versus non-profit comparison question I have raised. The Schedule H simply was not built to do all these things. It was built to enhance transparency and compliance in this area.

The IRS's Hospital Study

In addition to revising the Form 990, we decided in May, 2006, to initiate a study of non-profit hospitals.

We sent detailed questionnaires to a sample of over 500 non-profit hospitals. The questionnaires focused on community benefit reporting and executive compensation. The response to our questionnaire was very good, both in terms of the percentage of responders and the high quality of the responses.

In July, 2007 we issued an interim report that outlined the community benefit data that the hospitals had reported to us. We hope to release the final report in the near future, so I want to spend a few moments on it today.

First, I should outline what the report does not do. It does not take a position on what constitutes community benefit. Nor does it take a position on whether or how the existing standard should be modified. Second, the data in the report is subject to a number of limitations that must be kept in mind as people review our findings. What do I mean by this? Well, while the IRS designated the general categories of activities to be reported on in the study, we did not limit what could be included within a category or how things should be measured. This was left to the hospitals. For example, respondents differed as to which shortfalls were included in their calculations of uncompensated care -- some included Medicare and other shortfalls. Moreover, some hospitals were using shortfalls based on charges rather than on costs to calculate what community benefit was provided. This leads me to believe that the results we will outline in the report probably will overstate what would be reported by these hospitals as community benefit on the new schedule H.

Notwithstanding these issues and limitations – I think the report will be very interesting. In our analysis, we divided the hospitals into four groups, based on the types of communities they serve, and into five other groups based on their annual revenues. We also conducted a limited number of audits on executive compensation.

Let me present some key facts and findings from the study:

The report will provide information on four types of community benefit: uncompensated care, medical education, medical research, and other community programs.

Overall, the hospitals reported average combined community benefit expenditures, in all categories, of 9% of total revenues. The median was 6%. Uncompensated care was by far the largest of the expense categories – 56% of expenditures. If you take out the research expenses attributable to the 15 leading research hospitals in the study, which account for 93% of all research reported, uncompensated care constituted 71% of all expenditures. Remember, though, that what hospitals included in uncompensated care in the study differs from what would be presented on the community benefit table on the new schedule H. But this does tell us that uncompensated care, or at least undercompensated care, is the leading community benefit effort in the sampled hospitals.

Next, the report shows which types of hospitals reported spending the most or the least on community benefit? Of those we looked at, the large and the urban hospitals spent the most, both in terms of raw dollars and as a percentage of their revenues. Community benefit expenditures as a percentage of revenues were lowest for rural hospitals. The hospitals with the lowest percentage of all types of community benefits were the critical access hospitals – typically very small rural hospitals. Critical access hospitals also reported the lowest percentage of uncompensated care.

The report also addresses the revenues and profits of hospitals in the study. Not surprisingly, profit margins varied, with just over 20% of respondents in a deficit position, though on an aggregate basis the profit margin was 5%. The data also shows that profit margins increased as revenue size increased. Critical access hospitals, and the other smallest hospitals, had the slimmest profit margins, and research hospitals had the largest.

So what does all this tell us? Looking only at the sample, a few things do come through. First, the hospitals in the study represented a remarkably diverse group as far as size, community served, financial capacity and activities were concerned. Second, and this finding is consistent with those of

recent reports issued by GAO and CBO, there are some hospitals that provide a great deal of charity care and other uncompensated care, but many that do not. Finally, the study suggests that attempts to materially modify the existing standard will have a significant impact on certain hospitals because of the diversity I've been describing.

Let me turn to the part of the report that addresses executive compensation. This, also, is very interesting. Almost every hospital in the study indicated that it used comparability data to set compensation and otherwise used the rebuttable presumption that is available under the excess benefit rules. I think that is a good thing. Still, the compensation amount paid to the top management officials will be considered high by some.

Of the hospitals we selected for compensation examinations, the amounts were even higher. These examinations confirmed widespread use of comparability data and the rebuttable presumption. We determined that nearly all of the compensation arrangements we reviewed were reasonable under the current standard. But compensation was pretty high, and while permissible under current law, I wonder how it will be received in the court of public opinion.

Overall, I'm pleased with this study. I expect it to make a meaningful contribution to the discussion of the community benefit standard that is now going on, and to advance our work in the executive compensation area.

Next Steps

So where are we headed? Let's recap. We have a community benefit standard that is old, and perhaps outdated, at least in part. To the extent we have had any community benefit reporting in the area in the past, it has been inadequate, at best, and more fairly could be characterized as uneven and haphazard.

From our hospital study and our work developing the Schedule H, we have gained a much better understanding of how modern non-profit hospitals are organized and operated.

I believe the data from the new Schedule H will allow us, and other observers, to analyze how – and how much – hospitals around the country are benefitting their communities.

This is real progress, but our work is not done. A key effort, beginning right now, will be to promote complete and accurate Schedule H reporting. As that data comes in, we will assess whether we have identified the right set of expenditures for hospitals to report, and we will take a more informed look at whether any part of bad debt, Medicare shortfalls, or community building should count in the calculation of community benefit.

We also need to consider whether refinements to the standard are warranted. Should someone – Congress or the IRS - attempt to comprehensively redefine the community benefit standard? I know you will be surprised to hear I have no answer to that question this morning.

But however all this unfolds – whether we refine the community benefit standard or not – I believe that the fact that we have created a system for improved reporting will serve a valuable purpose going forward.

Conclusion

I have spoken a long time, and you may have begun to think that I, like the community benefit standard itself, should come to a graceful conclusion.

Let me leave you with four key points I tried to make.

First, the existing community benefit standard, after a long and serviceable career, may be outdated. It may need a tune up; it may need a new engine; we may need a new vehicle.

Second, our goal in redesigning the Form 990 and creating the Schedule H was to improve reporting and transparency. We will have more accurate information, presented uniformly. We, the states, and others will have a rich vein of data that will help us see non-profit hospitals more clearly and allow us to make better informed decisions about them.

Third, at the end of the day, our work on the study indicates that any significant changes to the community benefit standard would almost certainly benefit some hospitals and adversely affect others – there will be winners and losers.

Finally, it appears that we, as a society, may be on the verge of even greater changes in the way we deliver and pay for health care. These changes may dramatically alter the assumptions and ground rules affecting all aspects of health policy, not just tax exemption. In light of this, and given the impact our actions could have on the non-profit sector, is the IRS in the best position to decide whether and how to change the current exemption standard? Do we have the requisite expertise? Do we have sufficient perspective to foresee how our changes might promote – or inadvertently frustrate – much broader health policy goals and changes that will soon be the subject of vigorous debate?

Thank you for your time and your patience.