

Belmont Health Law Journal

Volume 2 *Symposium 2018: All Health Care is Local:
Exploring the Roles of Cities and States in Health Care
Delivery and Reform*

Article 6

2019

Implementing 501(r): Has 501(r) Lived up to Its Intended Purpose?

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Recommended Citation

Huber, Brandon (2019) "Implementing 501(r): Has 501(r) Lived up to Its Intended Purpose?," *Belmont Health Law Journal*: Vol. 2 , Article 6.
Available at: <https://repository.belmont.edu/healthlaw/vol2/iss1/6>

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IMPLEMENTING 501(R): HAS 501(R) LIVED UP TO ITS INTENDED PURPOSE? AND WHAT THE IRS' 2017 REVOCATION ACTION MEANS FOR THE TAX-EXEMPT HOSPITAL COMMUNITY

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A hospital refuses to provide chemotherapy treatment to a woman suffering from leukemia until she pays over \$100,000 upfront.¹ A university medical center redirects poor and uninsured patients from its emergency room to other local clinics.² Another hospital refers its low-income patients to its for-profit debt collection agency before offering any assistance or charity care options.³ At first glance, the scenarios above seem like they would

¹ Barbara Martinez, *Cash Before Chemo: Hospitals Get Tough*, United States Senate Committee on Finance (Apr. 28, 2008), <https://www.finance.senate.gov/imo/media/doc/061008lkttest.pdf>.

² Bruce Japsen, *ER Doctors Condemn University of Chicago Plan to Divert Patients*, CHICAGO TRIBUNE (Feb. 20, 2009), http://articles.chicagotribune.com/2009-02-20/news/0902190858_1_emergency-patients-emergency-room-community-hospitals.

³ Paul Kiel, *From the E.R. to the Courtroom: How Nonprofit Hospitals Are Seizing Patients' Wages*, PROPUBLICA (Dec. 19, 2014), <https://www.propublica.org/article/how-nonprofit-hospitals-are-seizing-patients-wages/>.

be relegated to a thing of the past; or worse, the type of behavior that only for-profit healthcare organizations engage in to maximize their profits.

Unfortunately, each one of these stories share a troublesome commonality: All involve actions taken by nonprofit hospitals. Beyond that, all three hospitals maintain federal tax-exempt status; meaning, that in addition to all of the benefits they receive from their respective status as nonprofit entities, all three hospitals are exempt from paying federal income tax.⁴ Historically, tax-exempt status was granted by the federal government on a *quid pro quo* basis to hospitals that demonstrated an ability to meet a societal need through the use of “charity care⁵,” thereby reducing the burden on the government of providing these health services directly.⁶ As illustrated by the examples above, however, the reality of the situation is that this arrangement has not lived up to its intended purpose.

How much charity care should a tax-exempt hospital provide to its community in exchange for its tax-exempt status?⁷ Does the amount of charity care provided by tax-exempt hospitals, as a whole, justify the loss in tax revenue the government would have otherwise generated? Over the years, questions similar to those posed above have been the subject of fierce debate amongst experts and health consumers alike.⁸ Although this Note does not attempt to address

⁴ 26 U.S.C. § 501(c)(3) (2012).

⁵ The concept of charity care has varied over the years, and there has been some confusion as to how it should be defined. As a result, it is not uncommon for charity care to be confused with “bad debt,” which involves unreimbursed care provided by a hospital for which payment was expected but never received. For purposes of this Note, charity care, in contrast to bad debt, consists of services for which a hospital did not receive, nor expected to receive, payment because the patient’s inability to pay had previously been determined prior to treatment. *American Hospital Association Uncompensated Hospital Care Cost Fact Sheet*, A.H.A. (Dec. 2010), <https://www.aha.org/system/files/content/00-10/10uncompensatedcare.pdf>.

⁶ *IHC Health Plans, Inc. v. Comm’r*, 325 F.3d 1188, 1195 (10th Cir. 2003) (“The public-benefit requirement highlights the *quid pro quo* nature of tax exemptions: the public is willing to relieve an organization from the burden of taxation in exchange for the public benefit it provides.”).

⁷ “Nonprofit status is a state law concept. Nonprofit status may make an organization eligible for certain benefits, such as state sales, property and income tax exemptions. Although most federal tax-exempt organizations are nonprofit organizations, organizing as a nonprofit organization at the state level does not automatically grant the organization exemption from federal income tax.” IRS, *Frequently Asked Questions About Applying for Tax Exemption*, Internal Revenue Service (Jun. 14, 2018), <https://www.irs.gov/charities-nonprofits/frequently-asked-questions-about-applying-for-tax-exemption>.

⁸ According to Paula Song, professor of health services organization at Ohio State University, the goal of affording tax-exemption status is to get close to the value of tax exemption in community benefit. Song further states, however, that “most [tax-exempt] hospitals aren’t providing that.” Elisabeth Rosenthal,

every issue of concern surrounding this expansive topic, it will examine Congress' relatively recent attempt—through the incorporation of Section 501(r) into the Internal Revenue Code—to resolve some of the flaws inherent in the current hospital-specific regulations. This Note also analyzes whether the IRS' 2017 revocation action changes anything for tax-exempt hospitals, and whether the implementation—and IRS enforcement—of Section 501(r) has achieved its goal.

This Note proceeds in four parts. Part I steps back and takes a brief look at the history and background of federal tax law; specifically, as it relates to the hospital-specific requirements the IRS has placed on hospitals seeking to qualify or maintain tax-exempt status over the years. Additionally, Part I discusses the incorporation and implementation of Section 501(r) into the Internal Revenue Code (“IRC”). Part II then explores the IRS' enforcement of Section 501(r), including the IRS' 2017 decision to revoke a “dual status” hospital's tax-exempt status for non-compliance. Then, Part II will conclude by explaining how tax-exempt hospitals can ensure they are in compliance with Section 501(r) and do not experience this same fate. Part III discusses the ripple effects of the IRS' revocation action; the potential effects of such an action on similarly situated hospitals; and whether the IRS' revocation action signals a change in the way Congress views—and the IRS enforces—hospital tax-exemption. Finally, Part IV of this Note considers whether Section 501(r) goes far enough to address the problems with the current system. Part IV will then conclude by presenting a brief argument for why Section 501(r) is a step in the right direction, and, with the implementation of a few small changes, can do even better.

I. BACKGROUND AND HISTORY OF FEDERAL TAX-EXEMPTION

Since the inception of federal tax laws, organizations “organized and operated” for certain specified purposes have been deemed to qualify for tax-exemption status.⁹ Tax-exempt hospitals,

Benefits Questioned in Tax Breaks for Nonprofit Hospitals, N.Y. TIMES (Dec. 16, 2013), <http://www.nytimes.com/2013/12/17/us/benefits-questioned-in-tax-breaks-for-nonprofit-hospitals.html>.

⁹ See 26 U.S.C. § 501(c)(3) (2012) (“Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster national or international amateur sports competition (but only if no part of its activities involve the provision of athletic facilities or equipment), or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in subsection (h)), and which does not participate in, or intervene in (including the publishing or distributing

as well as other nonprofit healthcare entities, have historically qualified for tax-exempt status under the “charitable organization” provision of the code, or what is more familiarly known as “501(c)(3) organizations.”¹⁰

Historically, in order to qualify as a charitable organization and in turn qualify for tax-exempt status, an organization must meet two main requirements.¹¹ First, the organization must be “organized and operated” *exclusively* for a charitable purpose.¹² Second, the organization must satisfy both the requirements of, what has been termed, the “organizational” and “operational” tests.¹³ To meet the requirements of the organizational test, an organization must establish, on the basis of its corporate charter, “that [the organization] was organized exclusively for one or more exempt purposes without reference to its operations.”¹⁴ To satisfy the organizational test, the IRS need look no further than an organization’s charter and by-laws to ascertain its stated purpose(s).

Correspondingly, an organization satisfies the operational test only if the organization primarily engages in activities that accomplish or further its exempt purpose(s).¹⁵ The operational test, unlike its counterpart, is less straightforward and has proven to be a more exacting standard—the full scope of which falls outside the purview of this Note.¹⁶ To determine whether an organization is primarily engaged in activities that further its tax-exempt purpose, the IRS will analyze the conduct of the organization to ensure the organization does not engage in, *inter alia*, any private inurement or

of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.”).

¹⁰ See *Community Benefit 501(r)edx: An Analysis of the Patient Protection and Affordable Care Act’s Limitations under Community Benefit Reform*, 7 ST.

LOUIS U. J. HEALTH L. & POL’Y 449, 454. (“Charitable hospitals are considered tax-exempt under § 501(c)(3) of the Code, although the section of the United States Code [] does not specifically mention hospitals as tax-exempt.”).

¹¹ See *Id.* (citing Barry A. Furrow et al., *HEALTH LAW: CASES, MATERIALS, AND PROBLEMS* 977 (Thomson West, 6th ed. 2008).

¹² *Id.*

¹³ *Id.*

¹⁴ 26 U.S.C. § 501(c)(3) (2012); see also Thomas K. Hyatt & Bruce R. Hopkins, *The Law of Tax-Exempt Healthcare Organizations* 6 (John Wiley & Sons eds., 3d ed. 2008).

¹⁵ See *Operational Test Internal Revenue Code Section 501(c)(3)*, Internal Revenue Service (Last updated Jul. 3, 2018) <https://www.irs.gov/charities-nonprofits/charitable-organizations/operational-test-internal-revenue-code-section-501c3> (“An organization will be regarded as *operated exclusively* for one or more exempt purposes only if it engages primarily in activities that accomplish exempt purposes specified in section 501(c)(3). An organization will not be so regarded if more than an insubstantial part of its activities does not further an exempt purpose.”).

¹⁶ For a more detailed discussion on the operational test see Jessica Pena & Alexander L.T. Reid, *A Call For Reform of the Operational Test For Unrelated Commercial Activity*, N.Y.U. L. REV. 76, 6 (2001).

private benefit; significant business activity unrelated to its exempt purpose; and politics or substantial lobbying efforts.¹⁷

A. Hospital Tax-Exemption and the Charity Care Standard

In addition to the general requirements imposed on 501(c)(3) organizations, over the years, the IRS began implementing healthcare-specific requirements.¹⁸ Technically, nonprofit hospitals have never expressly been classified as tax-exempt organizations. In fact, the promotion of health is not listed, at least by the terms of IRC Section 501(c)(3), as a charitable purpose. In reality, it was not until 1956 that the IRS started to recognize nonprofit hospital work as a charitable, tax-exempt purpose. Over the second half of the twentieth century, the IRS issued several key revenue rulings that offered further clarification and guidance to hospitals seeking tax-exempt status.¹⁹

The first such guidance came in 1956 when the IRS issued Revenue Ruling 56-185, which is more commonly known as the “financial ability” standard.²⁰ Most notably, Revenue Ruling 56-185 required that tax-exempt hospitals, “to the extent of [their] financial ability,” provide health services to individuals unable to pay.²¹ The implementation of the “financial ability” standard was a huge step forward in addressing indigent healthcare needs. With that said, however, the “financial ability” standard failed to specify a minimum level of free care a tax-exempt hospital would be required to provide in order to maintain tax-exempt status. Simply put, although tax-exempt hospitals could continue to charge for services they provided, no longer would they be allowed to selectively treat only those patients with the ability to pay for healthcare services.

Due to the passage of Medicare and Medicaid programs in 1965,²² there seemed to be some confusion as to whether hospitals

¹⁷ See Treas. Reg. § 1.501(c)(3)-1(c).

¹⁸ See Rev. Rul. 56-185, 1956-1 C.B. 202.

¹⁹ See *id.*; see also Rev. Rul. 69-545, 1969-2 C.B. 117.

²⁰ See *id.*

²¹ *Id.*

²² See 42 U.S.C. § 1395 (2012) (Medicare amendment); see *id.* § 1396 (2012) (Medicaid amendment). Signed into law by President Lyndon B. Johnson as amendments to the Social Security Act in 1965, both Medicare and Medicaid provide supplemental insurance coverage to large subsets of the American population. Run primarily by the federal government, the Medicare insurance program provides financial assistance to certain elderly and disabled individuals seeking medical care. Medicaid, on the other hand, although still technically a federal program, is run primarily by the states. Unlike Medicare, Medicaid is a social welfare program implemented for the purpose of providing financial assistance to certain families and individuals with low incomes. Because each state contributes a certain level of funding to the Medicaid program, qualifying for Medicaid assistance varies on a state-by-state basis. See generally Digital

would still be required to provide free or below-cost care to individuals who were not covered by Medicare or Medicaid. In fact, some people even believed that within a few years after the passage of the Medicare and Medicaid programs there would no longer be a need to provide free medical care.²³ As a result, the IRS again modified the standard in 1969 when it released Revenue Ruling 69-545, which is now more commonly known as the “community benefit” standard.²⁴ Under the revised “community benefit” standard, hospitals that “promoted health” to the benefit of the community would now be deemed eligible for tax-exempt status.²⁵ Under this standard, regardless of the level of free care offered by a hospital, as long as a hospital operated an emergency room and benefited a broad enough class of persons to classify as serving the community as a whole, the hospital was deemed to have met the requirements of the “community benefit” standard.

Consequently, the ruling effectively did away with Revenue Ruling 56-185’s requirement that hospitals provide free or below cost service to those unable to pay in order to maintain tax-exempt status.²⁶ As such, according to Revenue Ruling 69-545, so long as a hospital was operating a full-time emergency room and did not deny treatment to those in need of emergency care, a hospital was considered to have met the community benefit standard and was thus eligible for tax-exempt status.²⁷

The IRS again modified this standard in 1989 when it released Revenue Ruling 83-157.²⁸ In doing so, the IRS relaxed the standard even further, determining that hospitals were no longer required to operate an emergency room that was open to the general public in order to meet the community benefit test.²⁹ The IRS clarified, however, that a hospital wanting to qualify for tax-exempt status without providing open and accessible emergency room

Communications Division (DCD), *What is the difference between Medicare and Medicaid?* HHS.gov (Last visited Jan. 6, 2018), <https://www.hhs.gov/answers/medicare-and-medicaid/what-is-the-difference-between-medicare-medicaid/index.html>; see also *Johnson Signs Medicare into Law*, History.com (Last updated Jul. 30, 2018), <http://www.history.com/this-day-in-history/johnson-signs-medicare-into-law>.

²³ See Anne Somers, *Hospital Regulation: The Dilemma of Public Policy* (Princeton, N.J.: Princeton University Press, 1969), p. 41 (“Thanks to Medicare, Medicaid, and numerous other public and private mechanisms for financing care for the indigent and medically indigent, in a few years free medical care will approach the vanishing point.”).

²⁴ Rev. Rul. 69-545, 1969-2 C.B. 117.

²⁵ *Id.*

²⁶ Ceilia M. McGregor, *The Community Benefit Standard for Nonprofit Hospitals: Which Community, and for Whose Benefit?* 23 J. CONTEMP. HEALTH L. & POL’Y 302, 330 (2007).

²⁷ Rev. Rul. 69-545, 1969-2 C.B. 117.

²⁸ Rev. Rul. 83-157, 1983-2 C.B. 94.

²⁹ *Id.*

services to all would still be required to meet certain additional factors indicating the hospital still operated for the benefit of the public at large.³⁰

These factors included, but were not limited to: (1) whether the hospital's board was made up of members of the community; (2) the hospital had implemented an open medical staff policy; (3) the hospital treated patients on public aid programs such as Medicare and Medicaid; as well as (4) whether the hospital had invested any of its surplus in revenue to "improve[e] [the hospital's] facilities, equipment, patient care, medical training, education, and research."³¹ Thus, it seems clear that the IRS purposely defined the community benefit standard as broadly as possible to recognize the diverse needs of every community, and to afford tax-exempt hospitals the opportunity to meet those needs however they best saw fit.

Since the implementation of the community benefit standard, however, critics have argued that the standard does not do enough to differentiate between tax-exempt hospitals and their for-profit counterparts.³² For example, health law professor, Mary Crossley, points out:

[T]he vagueness of the existing federal community benefit standard and its historically lax enforcement mean that we do not really know what or how much beneficial conduct flows from tax exemption and its forgone revenue, or whether that conduct is closely related to improving access and health outcomes for the uninsured or other groups.³³

Related to this failure of the community benefit standard to distinguish tax-exempt hospitals from their for-profit counterparts, other critics have pointed out the difficulty in determining which tax-exempt hospitals are actually providing substantial assistance and which ones are not.³⁴ In a study conducted in 2013, and subsequently published in *The New England Journal of Medicine*, hospital expenditures on charity care and other community benefits varied anywhere from twenty percent of some hospital operating

³⁰ *Id.*

³¹ *Id.*

³² *Id.*

³² Susannah C. Tahk, *Tax-Exempt Hospitals And Their Communities*, 6 COLUM. J. TAX L. 33, 41 (2014).

³³ *Id.* (citing Mary A. Crossley, *Nonprofit Hospitals, Tax Exemption and Access for the Uninsured*, 2 PITT J. ENVTL. PUB. HEALTH. L. 32-36 (2008).

³⁴ *Id.* at 42.

costs all the way down to less than one percent of others.³⁵

Additionally, in its own study conducted in 2009, the IRS found that only a “small subgroup of tax-exempt hospitals [] seemed to be supplying most of the free or discounted care and other types of community benefits....”³⁶ The IRS’ findings went on to state that “[u]ncompensated care and aggregate community benefit expenditures were unevenly distributed among hospitals and concentrated in a relatively small group.”³⁷ As a result of all this, a series of lawsuits were filed against several tax-exempt hospitals in which the plaintiffs argued, albeit unsuccessfully, that tax-exempt hospitals, “while complying with the language of Revenue Ruling 69-545, actually violated the more general requirement that tax-exempt organizations serve the public interest.”³⁸

In one such case, a class action suit was brought challenging the authority of the IRS to enact and implement the community benefit standard on the grounds that the standard was “inconsistent with the term ‘charitable’ in IRC Section 501(c)(3) because it did not require treatment of the poor.”³⁹ The issue before the Court hinged on whether the plaintiffs had suffered an injury due to the IRS’ alleged misconduct. The case was ultimately dismissed on the grounds that the plaintiffs lacked standing to bring the suit.⁴⁰ The Supreme Court held that the plaintiffs failed to demonstrate that they had suffered an injury in fact, and therefore lacked standing.⁴¹ The Court reasoned that “it was ‘purely speculative’ as to whether the hospitals had denied treatment because of the new ruling and not for other reasons and whether the plaintiffs’ success would result in care being provided since hospitals could choose to give up their tax-exempt status if the cost was too high.”⁴²

The inadequacies of the community benefit standard became even more apparent when considered in light of the current climate of the healthcare industry as a whole. There is little disagreement over the profitability of the healthcare industry in America, but just

³⁵ Gary J. Young et al., *Provision of Community Benefits by Tax-Exempt U.S. Hospitals*, 368 NEW ENG. J. MED. 1519 (2013).

³⁶ Tahk, *supra* note 32, at 42.

³⁷ *Id.* (citing IRS, *IRS Exempt Organizations (TE/GE) Hospital Compliance Projects Final Report* (2009), available at <http://www.irs.gov/pub/irs-tege/frepthosproj.pdf>).

³⁸ *Id.* (citing Leah S. Batchis, *Can Lawsuits Help the Uninsured Access Affordable Hospital Care? Potential Theories for Uninsured Patient Plaintiffs*, 78 TEMP. L. REV. 493, n.104 (2005)).

³⁹ Erika Lunder & Edward Liu, Cong. Research Serv., RL34605, *501(c)(3) Hospitals and the Community Benefit Standard* (2009) (referring to United States Supreme Court case *Simon v. E. Ky. Welfare Rights Org.*, 426 U.S. 26 (1976)).

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² *Id.*

how profitable is it? According to the Centers for Medicare & Medicaid Services (“CMS”), the national health expenditures in 2016 reached a staggering \$3.3 trillion, or \$10,348 per person.⁴³

Although much of the revenue generated within the industry can be attributed to, *inter alia*, the growth and expansion of biotech and pharmacy companies, spending on hospital care alone continues to increase, rising 4.7 percent in 2016 from the previous year, or \$1.1 trillion.⁴⁴ Also, with a recent Forbes report projecting the healthcare industry to be one of the most profitable industries in the coming years, the strong growth rate the industry has enjoyed over the last few years does not appear to be on the decline anytime within the foreseeable future.⁴⁵

Despite the healthcare industry’s current growth, however, not every hospital has been able to share in these record-setting profits.⁴⁶ In fact, since the Affordable Care Act’s (“ACA”) coverage expansions have kicked in, much of the revenue has gone to the top hospital systems in the country.⁴⁷ To illustrate, the top seven hospitals in the country, as ranked by *U.S. News & World Report*, saw their revenues increase over fifteen percent within the span of two years.⁴⁸ Moreover, according to a 2016 study co-authored by health care economist, Gerard Anderson, seven of the ten most profitable hospitals in the country are nonprofit, tax-exempt entities.⁴⁹ Meanwhile, during the same two-year period, the charity care provided by these hospitals dropped by over thirty-five percent, despite the fact that the combined total of charity care provided by

⁴³ *National Health Expenditures 2016 Highlights*, Ctrs. for Medicare and Medicaid, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-andReports/NationalHealthExpendData/downloads/highlight.pdf> (last visited Jan. 4, 2018).

⁴⁴ *Id.*

⁴⁵ See Liyan Chen, *The Most Profitable Industries In 2016*, FORBES (Dec. 21, 2015), <https://www.forbes.com/sites/liyanchen/2015/12/21/the-most-profitable-industries-in-2016/#14ebdb9d5716> (projecting health technology to be the most profitable sector in 2016 with a 21.6% net profit margin).

⁴⁶ See Becker’s Healthcare, *60 things to know about the hospital industry*, BECKER’S HOSP. REV. (Jan. 14, 2016), <https://www.beckershospitalreview.com/lists/50-things-to-know-about-the-hospital-industry-2016.html> (57 rural hospitals have closed since 2010, and another 283 hospitals are at risk of closure).

⁴⁷ Dan Diamond, *How Hospitals Got Richer off Obamacare*, POLITICO (Jul. 17, 2017), <https://www.politico.com/interactives/2017/obamacare-nonprofit-hospital-taxes/>.

⁴⁸ *Id.*

⁴⁹ Ge Bai & Gerard F. Anderson, *A More Detailed Understanding of Factors Associated With Hospital Profitability*, HEALTH AFF. (May 1, 2016), <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2015.1193>.

these hospitals was already less than two percent of their total revenue.⁵⁰

Nevertheless, in spite of these record-setting profits, millions of Americans remain uninsured,⁵¹ and millions more, as a result of their medical bills, struggle to pay for even the most basic necessities, such as rent, food, and heat.⁵² For example, notwithstanding the ACA's attempts to make affordable health coverage available to more individuals, medically related expenditures accounted for nearly sixty percent of all U.S. bankruptcies filed in 2013.⁵³ And, although medically related bankruptcies are largely a problem of the uninsured, a study conducted by both the *New York Times* and *Kaiser Family Foundation* found that "... roughly 20 percent of people under 65 with health insurance nonetheless reported having problems paying their medical bills over the last year."⁵⁴

Consequently, for many of the reasons mentioned above, tax-exempt hospitals have been the subject of a fair amount of criticism over the past few years for not doing enough to help alleviate these issues.⁵⁵ As indicated by a recent *Politico* analysis, there is a significant amount of controversy surrounding the current requirements in place for tax-exempt hospitals and the role they should be playing in their communities.⁵⁶

While experts continue to debate what the root cause of these issues might be, critics of the current system tend to agree on at least one thing: Tax-exempt hospitals, on the whole, are not providing enough value to their communities to justify the tax breaks they receive. Nevertheless, despite this criticism, as well as the community benefit standard's complete lack of efficacy, until the relatively recent developments of the ACA, the standard continued

⁵⁰ *Id.*

⁵¹ *Key Facts about the Uninsured Population*, HENRY J. KAISER FAM. FOUND. (Sept. 19, 2017), <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

⁵² See Christina LaMontagne, *NerdWallet Health Finds Medical Bankruptcy Accounts for Majority of Personal Bankruptcies*, NERDWALLET (Mar. 26, 2014), <https://www.nerdwallet.com/blog/health/medical-bankruptcy/>. ("Nearly 10M American adults (ages 19-64) will be unable to pay for basic necessities like rent, food, and heat due to their medical bills.")

⁵³ *Id.*

⁵⁴ Margot Sanger-Katz, *Even Insured Can Face Crushing Medical Debt, Study Finds*, N.Y. TIMES (Jan. 5, 2016), <https://www.nytimes.com/2016/01/06/upshot/lost-jobs-houses-savings-even-insured-often-face-crushing-medical-debt.html>.

⁵⁵ See generally Michael Fricke, *The Case Against Income Tax Exemption for Nonprofits*, 89 ST. JOHN'S L. REV. 1129, 1129-83 (2016).

⁵⁶ See *Politico*, *supra* note 47.

to operate as the key determining factor for whether a hospital qualified for federal tax-exempt status.⁵⁷

B. Incorporation of Section 501(r)

Due to the underwhelming results produced by tax-exempt hospitals under the community benefit standard, Congress looked to pass legislation that would help ensure that tax-exempt hospitals provided value to their communities that more closely corresponded to the value they received as tax-exempt organizations. Over the years, various ideas to reform the community benefit standard were proposed, including a legislative proposal that would have required tax-exempt hospitals spend a minimum of five percent of their annual net revenue on providing free care to indigent members of their communities.⁵⁸ Critics of proposed legislative changes to the community benefit standard argued that implementing such quotas and ridged benchmark standards would prevent hospitals from being able to be responsive to their own individual communities.⁵⁹

Although most of these proposed reforms would never make it out of the draft stage of the legislative process, many of the ideas would later serve as the foundation for the new hospital-specific regulations that would be rolled out under the ACA.⁶⁰ Accordingly, due in large part to the efforts of Senator Charles Grassley⁶¹, Congress promulgated the latest requirements for charitable 501(c)(3) hospitals in 2010 by enacting Section 501(r) of the ACA.⁶² In addition to the community benefit standard, the new law required that hospitals adhere to a more exacting standard in return for tax-exempt 501(c)(3) status, including implementation of new rules concerning hospitals' financial policies, and the methods for assessing as well as acting on their community needs.⁶³ According to the latest regulations, hospital organizations seeking to maintain tax-exempt status must now comply with four additional requirements contained in Section 501(r) of the IRC.⁶⁴

First, Section 501(r) requires that tax-exempt hospitals establish written financial assistance and emergency medical care

⁵⁷ Tahk, *supra* note 32, at 40.

⁵⁸ See Senate Committee on Finance—Minority, *Tax Exempt Hospitals: Discussion Draft* at 7 (Jul. 18, 2007), <https://www.finance.senate.gov/imo/media/doc/prg071907a.pdf>.

⁵⁹ Joe Carlson, *Unlocking the community chest*, MOD. HEALTHCARE (Oct. 20, 2008), <http://www.modernhealthcare.com/article/20081020/NEWS/810179939>.

⁶⁰ Tahk, *supra* note 32, at 44.

⁶¹ Chuck Grassley is the senior Senator from Iowa, serving since 1981. Senator Grassley is currently the ranking Republican on the Judiciary Committee.

⁶² 26 U.S.C. § 501(r) (2012).

⁶³ *Id.*

⁶⁴ § 501(r)

policies (“FAPs”).⁶⁵ Although Section 501(r) does not specifically lay out the eligibility criteria that a hospital’s FAP must meet in order to comply with the statute, as long as a hospital’s FAP includes the type of financial assistance the hospital has made available, and clearly states the eligibility criteria that an individual must meet to receive financial assistance, the hospital’s FAP will be deemed to comply with Section 501(r)’s FAP requirements.⁶⁶

Second, Section 501(r) requires that tax-exempt hospitals limit the amounts charged for emergency or other medically necessary care to individuals eligible for assistance under the hospital’s FAP.⁶⁷ Now, tax-exempt hospitals are no longer allowed to charge uninsured patients—seeking emergency or other medically necessary care—any more than hospitals would otherwise charge individuals covered by insurance. The statute does, however, offer hospitals some flexibility as to the method used for calculating the amount “generally billed” for a particular medical service.⁶⁸ For example, the IRS has provided hospitals with two different methods of calculating the amount that is generally billed for a particular service—*i.e.*, the “look-back” and “prospective” methods.⁶⁹ Under the “look-back” method, the appropriate amount is determined by using a hospital’s actual past claims paid out by both Medicare and private health insurers.⁷⁰ Alternatively, the “prospective” method provides hospitals with the ability to “estimate the amount that Medicare would reimburse the hospital for the care in question if the eligible patient were actually a Medicare fee-for-service beneficiary.”⁷¹

Third, Section 501(r) also requires that tax-exempt hospitals make reasonable efforts to determine whether an individual is eligible for assistance under the hospital’s FAP before engaging in “extraordinary collection actions” against the individual.⁷² A hospital engages in extraordinary collection actions when the hospital either: (1) utilizes legal or judicial processes to procure payment of a charge that is otherwise covered under the hospital’s

⁶⁵ § 501(r)(4)(A)-(B).

⁶⁶ *Id.*

⁶⁶ Rachel Weisblatt, *Uncharitable Hospitals: Why the IRS Needs Intermediate Sanctions to Regulate Tax-Exempt Hospitals*, 55 B.C. L. REV. 687, 695 (2014).

⁶⁷ § 501(r)(5)(A)-(B).

⁶⁸ See generally *Additional Requirements for Charitable Hospitals*, 77 Fed. Reg. 38148-01, 38165 (proposed Jun. 26, 2012)(to be codified at 26 C.F.R. pt. 1).

⁶⁹ Weisblatt, *supra* note 66, at 696.

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² See § 501(r)(6) (“Billing and collection requirements. An organization meets the requirement of this paragraph only if the organization does not engage 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”).

FAP; (2) sells off any debt incurred by an individual to a debt collection agency; or (3) reports an individual's lack of payment to a consumer credit reporting agency.⁷³ Actions that require a legal or judicial process include, but are not limited to, obtaining a lien on an individual's property; forcing foreclosing on real property or seizing an individual's personal property; initiating a civil suit; or garnishing an individual's wages.⁷⁴

Fourth, Section 501(r) mandates that tax-exempt hospitals conduct a community health needs assessment ("CHNA") at least once every three years.⁷⁵ In conducting the CHNA, the hospital should seek the input and advice of various representatives and health experts within the community in which the hospital resides.⁷⁶ Moreover, once a hospital has finalized its CHNA, the hospital must adopt an implementation strategy that allows the hospital to address the health needs of the community identified within its CHNA.⁷⁷

Lastly, in order to fully comply with Section 501(r)'s CHNA requirements, the hospital organization must make its CHNA widely available to the public.⁷⁸ This is accomplished by uploading the CHNA to the hospital's website or some other easily accessible public forum.⁷⁹ Most importantly, any tax-exempt hospital that fails to conduct and implement a valid CHNA may be subject to a \$50,000 excise tax fine for each year the hospital is not in compliance.⁸⁰ Except for the CHNA requirement, which went into effect for tax years beginning in 2012, each of the other Section 501(r) requirements went into immediate effect.⁸¹

⁷³ See Weisblatt, *supra* note 66, at 696-97 (citing Prop. Treas. Reg. § 1.501(r)-6, 77 Fed. Reg. 38148, 38166 (Jun. 26, 2012)) ("Actions that require a legal or judicial process include: (1) obtaining a lien on an individual's property; (2) foreclosing on an individual's real property; (3) attaching or seizing an individual's personal property; (4) commencing a civil suit against an individual; (5) causing an individual's arrest; (6) subjecting an individual to a writ of body attachment; and (7) garnishing an individual's wages.").

⁷⁴ *Id.* at 696.

⁷⁵ § 501(r)(3)(A)-(B).

⁷⁶ § 501(r)(3)(B)(i) ("[CHNA must] take[] 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.").

⁷⁷ *Id.*

⁷⁸ § 501(r)(3)(B)(ii).

⁷⁹ 26 C.F.R. § 1.501(r)-3(b)(7)(i)(A)

⁸⁰ See Treas. Reg. § 53.4959-1 (2015) (allowing the imposition of a \$ 50,000 excise tax on hospitals that fail to meet CHNA requirements).

⁸¹ 1 Taxation of Hospitals & Health Care Organizations § 4.03 (2018) ("The effective dates for Section 501(r) were set forth in the statute itself. The financial assistance policy requirement, the restrictions-on-charges requirement, and the billing and collection requirement apply to taxable years beginning after the date of enactment of the Affordable Care Act, March 23, 2010. The CHNA and implementation plan requirement applies to taxable years beginning after March 23, 2012.").

II. THE IRS' ENFORCEMENT OF SECTION 501(R)

In early August of this past year, the IRS released a letter dated February 14, 2017, which stated that the IRS had revoked a “dual status” hospital’s tax-exempt status for failing to comply with Section 501(r)’s requirements.⁸² While the IRS did not identify the name of the hospital, the letter points out that the reason for the revocation action specifically related to the hospital’s failure to follow through and implement Section 501(r)’s CHNA requirements.⁸³ More specifically, the hospital failed to conduct a community health needs assessment, adopt an implementation strategy, and promulgate the strategy to the public.⁸⁴

The revocation of the hospital’s tax-exempt status comes on the heels of heightened IRS enforcement measures to ensure hospital compliance. In the Tax Exempt and Government Entities FY 2017 Work Plan, released in September of 2016, the IRS stated that it conducted a review of 968 hospitals’ websites and Schedule H filings, and had made a determination to refer 363, or nearly forty percent, of those hospitals for field examinations.⁸⁵ The Work Plan further indicated that the IRS intended to continue to conduct these reviews to ensure that hospitals were complying with Section 501(r)’s requirements.⁸⁶

Despite the hospital industry having been placed on notice of these examinations, however, the IRS’ revocation announcement came as a surprise to many within the industry.⁸⁷ Due to the unique circumstances surrounding the situation as the first revocation action taken by the IRS for noncompliance with Section 501(r), the announcement not only shocked many within the healthcare industry, but, more specifically, caused a significant amount of angst within the tax-exempt community regarding the extent to which the IRS was willing to go in order to enforce these new regulations.⁸⁸

⁸² See Final Adverse Determination Letter (F.A.D.L), 3618 (Rev. 6-2012) (Feb. 14, 2017), <https://www.irs.gov/pub/irs-wd/201731014.pdf>.

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ *Tax Exempt and Government Entities FY 2017 Work Plan*, IRS (amended Mar. 8, 2017), https://www.irs.gov/pub/irs-tege/tege_fy2017_work_plan.pdf.

⁸⁶ *Id.*

⁸⁷ Meg Bryant, *Reading The Tea Leaves in a Hospital's Loss of Tax-Exempt Status*, Healthcare Dive (Sept. 12, 2017), <https://www.healthcarediver.com/news/reading-the-tea-leaves-in-a-hospital-loss-of-tax-exempt-status/504363/>.

⁸⁸ Rich Daly, *IRS Makes First Revocation of Hospital Not-for-Profit Status Under 501(r)*, Healthcare Fin. Mgmt. Ass’n (Aug. 15, 2017), <https://www.hfma.org/Content.aspx?id=55271>.

III. THE EFFECT OF THE IRS' REVOCATION ACTION, AND WHETHER IT SIGNALS A CHANGE IN THE IRS' HESITANCY TO USE REVOCATION AS AN ENFORCEMENT MECHANISM

Over the years, the tax-exempt community had become accustomed to the IRS' lax enforcement of the community benefit standard; which, explains the community's response to the IRS' revocation action.⁸⁹ Historically, complete revocation of tax-exempt status was the only mechanism available to the IRS to enforce hospital compliance with the community benefit standard.⁹⁰ Due in large part to the far-reaching effects of revocation, however, the IRS has exhibited a hesitancy to use revocation to enforce the standard in years past.⁹¹

For most hospitals, revocation of tax-exempt status means more than not having to pay federal income taxes.⁹² In fact, loss of tax-exempt status could force hospitals to cut back on offering valuable health services to the community, or worse, close down altogether. To illustrate, a hospital that has its tax-exempt status revoked, in addition to now having to pay income taxes, is also likely to lose its federal unemployment tax exemption, as well as its communications services excise tax exemption.⁹³

Additionally, because many states confer nonprofit status on organizations that already qualify for federal tax-exemption, when a hospital's tax-exempt status is revoked, many states will often follow suit and revoke the hospital's nonprofit status, too.⁹⁴ Meaning, that once a hospital loses its federal tax-exempt status, there is a good chance the hospital will likely also lose any state tax benefits that come along with being classified as a nonprofit organization within the state.⁹⁵ Although nonprofit tax benefits vary state-to-state, the benefits usually include, but are not limited to, exemption from state property taxes, as well as exemption from state income tax, if applicable.⁹⁶

Furthermore, the potential fall-out resulting from revocation does not stop there. In addition to the new tax liabilities mentioned above, revocation of tax-exempt status has the potential to affect a

⁸⁹ Weisblatt, *supra* note 63, at 700.

⁹⁰ *Id.* at 697.

⁹¹ *Id.*

⁹² *Id.* (citing Jessica Berg, *Putting the Community Benefit Back into the "Community Benefit" Standard*, 44 GA. L. REV. 375, 380 (2010)).

⁹³ *See Id.* at 698 (citing I.R.C. § 3301 (2012); § 4251 (2012)).

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *Frequently Asked Questions About Applying for Tax Exemption Internal Revenue Service*, IRS, <https://www.irs.gov/charities-nonprofits/frequently-asked-questions-about-applying-for-tax-exemption> (last updated June 14, 2018).

hospital's ability to raise capital.⁹⁷ For example, no longer would charitable donations to the hospital be eligible for personal tax benefits.⁹⁸ As a result, the revenue a hospital could expect to receive through personal charitable donations would undoubtedly decrease. Additionally, revocation of tax-exempt status prohibits a hospital from being able to issue tax-exempt "qualified bonds," thus cutting off one of the more effective means nonprofit hospitals have of raising capital.⁹⁹ In sum, there can be little question as to why the IRS was so hesitant to use revocation as a means of enforcing the community benefit standard in years past, and also explains the industry's shock at the news that the IRS had actually used revocation as a means of enforcing Section 501(r).

Further details surrounding the IRS' revocation action, however, strongly suggest that the situation was more akin to that of an outlier rather than the new norm. Instead, what is more likely, the IRS used the uniqueness of the situation as an opportunity to send a strong message to the rest of the tax-exempt community that the new regulations should not be taken lightly. The uniqueness of this particular revocation action is demonstrated by the fact that the hospital seemed to have freely relinquished its tax-exempt status; making it clear the hospital thought it had more to gain through noncompliance than to adhere to the new CHNA requirements.¹⁰⁰

First, in its revocation letter, the IRS specifically stated that a Revenue Agent had met with the executive team of the hospital—including the CEO, CFO, and COO—and on several occasions during the interview, the hospital's administration team made clear that the hospital "really did not need, actually have any use for, or want their tax-exempt status..."¹⁰¹ Additionally, although the hospital's administrators indicated that the "[hospital] had neither the will, financial resources, nor the staff to follow through with the CHNA process,"¹⁰² the letter included some additional statements made by the hospital's administration team indicating that a lack of resources was not the only—nor was it the main—reason for choosing not to comply with Section 501(r)'s CHNA requirements. For example, the letter states that the hospital's administrators freely admitted to only maintaining tax-exempt status "in case any liabilities arose relating to the prior management company who had originally obtained this status from the [IRS]."¹⁰³

Moreover, the letter went on to state that the hospital's administrators also claimed that the hospital's tax-exempt status

⁹⁷ Weisblatt, *supra* note 63, at 699.

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ See F.A.D.L., *supra* note 82, at 2.

¹⁰¹ *Id.*

¹⁰² *Id.* at 6.

¹⁰³ *Id.* at 2.

“actually prevented the [hospital] from becoming involved in some of the various Medicaid reimbursement or payment arrangements.”¹⁰⁴ Thus, as demonstrated by the words and actions of the hospital’s administration team, not only did the hospital not value its 501(c)(3) status, but it was clear the hospital thought it was better off without it.

Second, the requirements of Section 501(r) are set up in such a way that if the hospital was serious about complying with the regulations, it would likely have been able to do so. As previously indicated, unlike the enforcement measures available to the IRS under the community benefit standard, which limited the IRS’ enforcement options to either complete revocation or turning a blind eye to noncompliance altogether, under the new Section 501(r) regulations, the IRS has at least some flexibility to work with noncompliant hospitals before pursuing revocation.¹⁰⁵

For example, the regulations specifically allow for the IRS to excuse or dismiss minor or inadvertent violations.¹⁰⁶ However, according to the tax director of BDO Consulting’s healthcare and nonprofit and education practices, Laura Kalick, it is important to remember that minor really does mean minor.¹⁰⁷ According to the regulations, an example of a minor violation would include a situation where documents may have been temporarily unavailable due to a hospital’s website being down.¹⁰⁸

With that said, the IRS is free to dismiss other types of infractions or violations, provided they do not rise to the level willful or egregious noncompliance with the regulations, and are promptly disclosed and corrected by the offending hospital.¹⁰⁹ And, while it is true that the IRS still retains the ultimate authority to revoke a hospital’s tax-exempt status in instances of willful or egregious violations of Section 501(r),¹¹⁰ the regulations specifically require

¹⁰⁴ *Id.*

¹⁰⁵ Crossley, *Health and Taxes: Hospitals, Community Health and the IRS*, 16 YALE J. HEALTH POL’Y L. & ETHICS 51, 97 n. 201 (2016) (“The possible consequences range from the revocation of §501(c)(3) status for an organization, to the imposition of a \$50,000 excise tax, to the IRS’s ignoring minor omissions and errors that are either inadvertent or due to reasonable cause. If a hospital organization operates multiple hospitals and one of them fails to comply, the income from the noncompliant hospital facility will be subject to taxation.”).

¹⁰⁶ 26 C.F.R. § 1.501(r)-2(b)(1)(ii) (2015); Erica A. Clausen and Abbey L. Hendricks, *Cultivating the Benefit of § 501(r)(3) Requirements for Nonprofit Hospitals*, 20 LEWIS & CLARK L. REV. 1025, 1038 (2016) (“An omission or error related to the CHNA that is minor or inadvertent is not considered to be a “failure” to meet § 501(r) obligations, therefore penalties under § 4959 are not appropriate.”); See T.D. 9708, 2015-5 I.R.B. 344-45.

¹⁰⁷ See Bryant, *supra* note 87.

¹⁰⁸ Rev. Proc. 2015-21, 2015-13 I.R.B. 817, § 5.03 (Mar. 10, 2015).

¹⁰⁹ *Id.* § 5.04.

¹¹⁰ 26 C.F.R. § 1.501(r)-(2)(c).

that in the event such a case arises, the IRS should apply a facts and circumstances test in order to determine whether revocation is warranted.¹¹¹

Moreover, although the new regulations provide the IRS with the authority to levy excise fines of \$50,000 per year against hospitals that fail to conduct a valid CHNA, typical of most types of healthcare legislation, the IRS has not specifically defined how a valid CHNA must be conducted and implemented to be in compliance with Section 501(r).¹¹² Meaning, so long as the basic requirements of the CHNA are met, the framework of Section 501(r) provides flexibility by which hospitals can creatively address the healthcare needs and disparities within their own communities without fear of being penalized for non-adherence to a ridged and formalized standard. It would seem, then, due to the flexibility available to the IRS in situations not arising to the level of willful noncompliance, the IRS may be willing to forgive instances of noncompliance, so long as a good faith effort to comply with the regulations can readily be determined.

Furthermore, although more details would need to be known in order to assess the exact feasibility of this particular hospital's ability to conduct and implement a valid CHNA, in order to demonstrate compliance with Stark¹¹³ and the Federal Anti-

¹¹¹ *Id.* § 1.501(r)-2(a) (Factors the Commissioner will take into consideration include: “(1) Whether the organization has previously failed to meet the requirements of section 501(r), and, if so, whether the same type of failure previously occurred. (2) The size, scope, nature, and significance of the organization's failure(s). (3) In the case of an organization that operates more than one hospital facility, the number, size, and significance of the facilities that have failed to meet the section 501(r) requirements relative to those that have complied with these requirements. (4) The reason for the failure(s). (5) Whether the organization had, prior to the failure(s), established practices or procedures (formal or informal) reasonably designed to promote and facilitate overall compliance with the section 501(r) requirements. (6) Whether the practices or procedures had been routinely followed and the failure(s) occurred through an oversight or mistake in applying them. (7) Whether the organization has implemented safeguards that are reasonably calculated to prevent similar failures from occurring in the future. (8) Whether the organization corrected the failure(s) as promptly after discovery as is reasonable given the nature of the failure(s). (9) Whether the organization took the measures described in paragraphs (a)(7) and (a)(8) of this section before the Commissioner discovered the failure(s).”).

¹¹² Allison Simpson & David Williams, *The How's and Why's of A Community Health Needs Assessment: A Project Guide for Health Care Attorneys*, Health Lawyers (2012), https://www.healthlawyers.org/Events/Programs/Materials/Documents/Tax12/f_simpson_williams.pdf.

¹¹³ See 42 USC § 1395nn (2018) (For Stark law enacted for the purpose of curbing physician self-referral which lead to increasing healthcare prices).

Kickback Statute,¹¹⁴ hospitals have conducted similar types of assessments for years and are likely already familiar with assessing the healthcare needs of their communities.¹¹⁵ In fact, in order to develop compliance plans, most—if not all—hospitals have already analyzed the demographics, as well as accessibility to healthcare facilities and physician services within their community.¹¹⁶

The feasibility of conducting and implementing a valid CHNA is further demonstrated by the release of the IRS' final rule clarifying the implementation and requirements of Section 501(r).¹¹⁷ According to the final rule, published by the Federal Register on Dec. 31, 2014, hospitals are allowed to collaborate with each other to produce a single, joint CHNA report and implementation strategy.¹¹⁸ Meaning, hospitals are free to collaborate and consolidate resources, so long as the hospitals have defined their communities to be the same, and the leadership teams from each hospital agree to adopt and implement the CHNA strategy.¹¹⁹ As a result, in addition to a host of useful information available to the hospital online (*i.e.*, CHNA templates, assessment and implementation plans posted online by other hospitals, *etc.*), the hospital may have been able to seek the assistance of another hospital to produce a valid CHNA.

Finally, further signaling the uniqueness of the situation at hand—and why this particular revocation action is unlikely to signal a change in regards to the IRS' willingness to rely on revocation as a realistic option—is the fact that the hospital operated as a “dual status” hospital.¹²⁰ “Dual status” hospitals are government-run hospitals that do not require 501(c)(3) status to qualify for exemptions as charitable organizations.¹²¹ As a “dual status”

¹¹⁴ See *id.* § 1320a-7b(b) (For the Anti-Kickback Statute, making it a criminal offense—unless a safe harbor applies—to knowingly and willfully exchange any remuneration, or anything of value, in order to induce or receive a reward for referring items of service payable by federal health care programs).

¹¹⁵ For an example of a typical hospital compliance plan see *Iredell Health System (IHS) Compliance Plan*, (2015), <https://www.iredellhealth.org/documents/2015-Iredell-Compliance-Plan.pdf>.

¹¹⁶ See *id.*

¹¹⁷ See generally I.R.C. § 501(r).

¹¹⁸ See Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return, 79 Fed. Reg. 78, 954-01, 2015-5 I.R.B. 337 (Dec. 31, 2014).

¹¹⁹ *Id.*

¹²⁰ F.A.D.L., *supra* note 82, at 2.

¹²¹ Marc Berger, *IRS Revokes Hospital's Tax-Exempt Status, Shedding Light on Section 501(r) Compliance Concerns*, BDO (Aug. 17, 2017), <https://www.bdo.com/blogs/healthcare/august-2017/irs-revokes-hospital%E2%80%99s-tax-exempt-status> (“A dual status hospital is a government hospital that would be exempt from tax because of its relation to the government. Forty or so years ago, many government hospitals applied for

hospital, the loss of tax-exempt status is unlikely to affect the hospital's bottom line in any meaningful way.

This begs the question: *would the IRS have revoked the hospital's tax-exemption status had the hospital not qualified as a "dual status" hospital?* On the one hand, the answer to this question is: *maybe*. Considering the hospital's complete lack of action, as well as the statements made by the hospital's administrators to the Revenue Agent, it is clear that the hospital was operating in willful violation of Section 501(r)—undoubtedly. On the other hand, however, due to the hospital's "dual status," the facts tend to indicate there is a strong possibility the IRS would not have acted in the same way had the hospital had more to lose, or, at the very least, demonstrated a willingness and good faith effort to comply.

With that said, depending on how much value a particular hospital places on its tax-exempt status, there is also a good chance that had the situation involved a non "dual status" hospital, the hospital would have done more to work with the IRS in order to keep its tax-exempt status intact. As a result, outside of the unique circumstances this particular situation presents, it is hard to imagine a situation in which a hospital would willingly give up its tax-exempt status without at least contesting the revocation action in some way or another.

Nevertheless, Despite the unique circumstances surrounding the revocation action, tax-exempt hospitals would be well served to acknowledge the potential implications of such a decision. Recognizing there are challenges associated with implementing the new Section 501(r) regulations,¹²² there are ways in which tax-exempt hospitals can ensure revocation of their tax-exempt status never occurs.

First, tax-exempt hospitals' policies must be up-to-date.¹²³ That is, to comply with the final rule, tax-exempt hospitals must ensure their financial assistance, billing, and collection policies are all up-to-date.¹²⁴ According to health law attorney, Andrew Kloeckner, if a hospital has not updated these policies since

section 501(c)(3) status so they could take advantage of offering certain pension plans to their employees that were only available to the employees of section 501(c)(3) organizations, and to make it easier to solicit charitable contributions with the familiar 501(c)(3) status.”).

¹²² See Michael Wyland, *Hospital Loses IRS Tax Exemption for Noncompliance with ACA*, NONPROFIT QUARTERLY (Aug. 18, 2017), <https://nonprofitquarterly.org/2017/08/18/hospital-loses-irs-tax-exemption/> (Initial cost estimates for conducting and implementing a valid CHNA can range anywhere from \$60,000 to \$150,000 depending on the size of the hospital, as well as the complexity of the community it serves).

¹²³ 26 C.F.R. § 1.501(r)(4)(b)(1)(i).

¹²⁴ Andrew Kloeckner, *IRS Actively Auditing Hospitals For 501(r) Compliance*, Baird Holm, LLP (Jun. 14, 2017), <https://www.bairdholm.com/in-the-news/entry/irs-actively-auditing-hospitals-for-501-r-compliance.html>.

December 29, 2014, the hospital is unlikely to be compliant with the new regulations.¹²⁵ Additionally, it is important to note, these policies can only be approved by the Board of Directors for the hospital, or, in some cases, a subcommittee of the Board.¹²⁶

Second, it is not enough that a CHNA was conducted. In fact, there is evidence that the “dual status” hospital discussed above had in fact completed a CHNA before losing its tax-exemption status.¹²⁷ According to the IRS’ revocation letter, the hospital claimed to have conducted a CHNA.¹²⁸ The letter goes on to state, however, that “[t]he CHNA report was never made widely available for the public via a website.”¹²⁹ Consequently, in addition to conducting a CHNA, to ensure compliance, tax-exempt hospitals must upload their CHNA reports to their websites.¹³⁰ It is not enough that these reports merely exist and are available upon request.¹³¹

Third, tax-exempt hospitals must act on the information produced in these CHNAs.¹³² In addition to conducting CHNAs and making them widely available to the public, tax-exempt hospitals’ leadership teams must develop, implement, and put into action plans that address the community needs identified in each hospital CHNA.¹³³ Lastly, using Form 990,¹³⁴ tax-exempt hospitals are required to report a description of how they are addressing these needs, and “provide a description of any needs their CHNAs are not addressing, and the reasons for why those needs are not being addressed.”¹³⁵

IV. EVALUATING 501(R): DOES IT GO FAR ENOUGH?

As previously mentioned, Congress—by enacting Section 501(r) into the ACA—altered the legal framework surrounding hospital tax-exemption.¹³⁶ This change, although not perfect, is a step in the right direction. Now, for the first time, due mainly to Section 501(r)’s “Schedule H” requirement, hospitals must justify

¹²⁵ *Id.*

¹²⁶ § 1.501(r)(4)(d)(1).

¹²⁷ F.A.D.L., *supra* note 82, at 2.

¹²⁸ *Id.*

¹²⁹ *Id.*

¹³⁰ § 501(r)-3(b)(7)(i)(A).

¹³¹ F.A.D.L., *supra* note 82, at 2.

¹³² § 1.501(r)-3(a)(2).

¹³³ *Id.*

¹³⁴ *About Form 990, Return of Organization Exempt from Income Tax*, IRS <https://www.irs.gov/forms-pubs/about-form-990> (“Tax-exempt organizations, nonexempt charitable trusts, and section 527 political organizations file this form to provide the IRS with the information required by section 6033.”).

¹³⁵ Kloeckner, *supra* note 125.

¹³⁶ Tahk, *supra* note 32, at 35.

their tax-exempt status by demonstrating that they are benefiting their communities.¹³⁷ And, using the answers provided through these Schedule H filings, we now have hard, concrete data by which we can quantify the “benefits” being provided by tax-exempt hospitals.¹³⁸ In turn, this information can be used to hold the tax-exempt hospital community more accountable.

The results of these Schedule H filings may come as a surprise. Taken together, the data suggests that, although the manner and mode by which hospitals have chosen to benefit their communities varies, tax-exempt hospitals *are*, on the whole, responding to the needs of their communities.¹³⁹ In fact, the data from the Schedule H filings revealed that the median amount of charity care provided by tax-exempt hospitals is 5.04% of total operating budget, with a mean of 6.01%.¹⁴⁰ And, after adding in other community benefit variables such as “bad debt,” the mean rises to 8.58% of total expenses, or a median of 7.45%—a higher percentage than the mandatory charity care minimum of 5% advocated for by Senator Grassley, and others.¹⁴¹

Keeping this in mind, of concern, however, is the large gap between hospitals that far exceed 7.5% in community benefit expenditure and those that fall far below—with hospital expenditures on community benefits ranging anywhere from some hospitals spending as little as 1% to some hospitals spending as much as 20% of their entire budgets on providing these services.¹⁴² Again, requiring that hospitals spend a mandatory minimum of 5% on charity care is not the answer. Imposing a mandatory minimum, however well-intentioned, although likely to help ameliorate the disparity between hospital charity care spending on some level, would result in an even more undesirable outcome: A decline in overall charity care spending across the board.¹⁴³ A mandatory minimum would only incentivize hospitals at the high end of the charity care decile to reduce their charity care spending—as was demonstrated to be the case in Texas after the passage of its own mandatory minimum law¹⁴⁴—in order to more closely conform to the minimum statutory requirement.

¹³⁷ *Id.*

¹³⁸ *Id.*

¹³⁹ *Id.* at 36.

¹⁴⁰ *Id.* at 61.

¹⁴¹ *Id.*

¹⁴² Young, *supra* note 35, at 1522.

¹⁴³ Tahk, *supra* note 32, at 53.

¹⁴⁴ See Tahk, *supra* note 32, at 53 (1993 Texas law requiring that the State’s nonprofit hospitals spend a fixed percentage of net revenue (generally 4%) on charity care actually resulted in an overall decrease in charity care spending across the board).

Unfortunately, there are no easy policy answers to address, what appears to be, the proclivity of some hospitals to provide substantially far less charity care than their peers.¹⁴⁵ However, all is not lost. As Susannah Tahk, Assistant Professor of Law at the University of Wisconsin Law School points out, there are a few viable options that could easily be implemented that would immediately help to even the playing field and more closely align hospital charity care spending, without causing a reduction in overall charity care spending.¹⁴⁶

First, Congress should define, for purposes of the CHNA requirement, the communities in which each hospital operates by taking geographic location into account. Ironically, this was the original approach taken by the IRS before altering its position in response to public comments that recommended that geographical boundaries not be included in the definition of community.¹⁴⁷ As a result, under the current regulations, hospitals are free to define their communities as they see fit, applying a “facts-and-circumstances approach.”¹⁴⁸ Consequently, although a hospital may not define its community in a way that excludes “medically underserved, low-income, or minority populations who are part of its patient populations,”¹⁴⁹ there is very little oversight into how hospitals define their individual communities. This lack of oversight, as well as a clear definition of community, incentivizes hospitals to define their communities in ways that are most advantageous to themselves. Adopting a clear definition of community, based on geographical boundaries, as part of the CHNA requirement would ensure that tax-exempt hospitals actually service their communities.

Second, Section 501(r)’s FAP requirement should be more clearly defined. At present, under Section 501(r)’s FAP requirements, tax-exempt hospitals are free to determine the substance of their own individual FAPs, so long as the FAPs are responsive to hospitals’ self-performed CHNAs.¹⁵⁰ Under the current regulations, because tax-exempt hospitals are free to establish their own FAPs, a hospital could hypothetically speaking, implement a FAP that essentially states that the hospital does not offer any free or discounted care. As a result, the hospital would still be able to charge indigent patients chagemaster—*i.e.*, highly inflated—rates.¹⁵¹ If, in response, the indigent patient could not afford to pay these rates a hospital could, after first making a

¹⁴⁵ *Id.* at 81.

¹⁴⁶ *Id.*

¹⁴⁷ *See* Community Health Needs Assessments for Charitable Hospitals, 78 Fed. Reg. 20523 (proposed Apr. 5, 2013).

¹⁴⁸ *Id.* at 20529.

¹⁴⁹ *Id.*

¹⁵⁰ *See* Tahk, *supra* note 32, at 46.

¹⁵¹ *Id.*

determination that the patient is not eligible for any free or discounted care under the hospital's FAP, foreclose, without recourse, on the indigent patient's home for nonpayment.¹⁵² Due to the flexibility Congress has afforded tax-exempt hospitals to determine the substantive details of their own FAPs, the disparity in charity care being provided amongst tax-exempt hospitals should not come as a surprise.

To help resolve this issue, and ultimately close the disparity gap in charity care spending, Congress should require that all hospital FAPs include certain baseline specifications: For example, all FAPs should calculate aid eligibility using patients' income as the determining factor. At present, over 25% of hospitals do not currently use income as a means for determining aid eligibility, relying instead on some other metric (*i.e.*, insurance status, medical indigence, Medicare/Medicaid recipient, *etc.*).¹⁵³ Incorporating a requirement that hospitals look at patient income to determine aid eligibility will result in uniformity across hospital FAPs—making it easier to calculate each hospital's charity care output.

Not only should income be the universal determinant for whether a patient qualifies for aid eligibility, but the income eligibility line should be unambiguous and consistent across the board. Although this Note does not presume to know where this line should be drawn, looking at a patient's income as a percentage of the federal poverty line (FPL) seems to be the most logical and clear-cut solution. Hypothetically speaking—and for purposes of illustration—the line for free care could be drawn at 200-300% of the Federal Poverty Line (FPL). This number would increase, on the other hand, for determining whether a patient is eligible for discounted care—*e.g.*, 300-400% of FPL. No matter where the line is ultimately drawn, a clear-cut rule would not only make it easier for hospitals to implement but would help to ensure that the most indigent patients are the first to receive these free or discounted health services.

Incorporating these changes, while still understanding they are not the be-all-end-all to every issue of concern, will—taken in conjunction with the other requirements of Section 501(r)—help to improve the disparity gap in charity care spending between tax-exempt hospitals; thus, help to ensure that hospitals receiving the benefits of tax-exemption are also contributing their fair share back into their communities.

¹⁵² *Id.*

¹⁵³ *Id.* at 71.

V. CONCLUSION

In conclusion, the historically amorphous nature of the regulations surrounding hospital tax-exemption, taken in conjunction with IRS' lax enforcement, have caused many to question the efficacy of tax-exempt hospitals. Section 501(r), however, is a step in the right direction. Section 501(r), for the first time, places unambiguous and quantifiable requirements on hospitals seeking tax-exempt status. Because of Section 501(r), specifically the Schedule H filing requirement, we now have the ability to take a closer look at hospital expenditures on charity care. Nevertheless, the reality of the situation remains, despite the introduction of Section 501(r) and the IRS' recent revocation action, there has been little substantive change. As a result, the new regulations (as written and presently enforced) do not pose a serious threat that loss of tax-exempt status will occur to hospitals that demonstrate an interest—even to the slightest degree—in maintaining tax-exempt status.

Based on the findings of the Schedule H filings, however, there are certain measurable steps Congress can take to improve upon Section 501(r), and thus ensure every hospital receiving the benefits of tax-exemption are contributing their fair share of charity care services to their communities. These steps include, but are not limited to: (1) Adopting a clear definition of community that is based on geographical boundaries; and (2) Expanding Section 501(r)'s existing FAP requirement to also include a requirement that hospitals determine financial assistance eligibility by looking at patients' income, as a percentage of the FPL. Implementing these relatively simple changes into the Code will help to ensure that Section 501(r) accomplishes its intended purpose.