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The Community Benefit Standard for Non-Profit Hospitals: Which Community, and for Whose Benefit?

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INTRODUCTION

Patients often distinguish hospitals based on whether the care provided will be covered under their health insurance policy, if a particular doctor has privileges, or if the hospital is close and easily accessible to them. Many patients need not worry about the financial impact of their choice of hospital beyond ensuring that their care will be covered by insurance.

However, for patients without insurance or with inadequate insurance, choosing a hospital based only on doctors' privileges or location can have far-reaching and severe financial and legal consequences. For these patients, the hospital's corporate form and whether it qualifies as a charity for tax purposes can be most important. Non-profit hospitals and other health care facilities (non-profit health care organizations) that qualify as charities receive beneficial tax treatment from federal, state and local governments. These tax benefits are intended to support and encourage non-profit health care organizations to provide charitable health care to those in need and unable to pay.

1. A list of the issues which patients should consider in choosing a hospital is available at http://www.thehealthpages.com/articles/ar-hosps.html.

2. Tax-Exempt Hospital Sector, Hearing Before the H. Comm. on Ways & Means, 109th Cong. 46 (2005) (statement of Rep. Bill Thomas, Chairman, H. Comm. on Ways & Means) ("The principal historical reason for establishing not-for-profit hospitals was to serve those who otherwise wouldn't have care, principally the indigent.")
Despite the apparent quid pro quo between the non-profit health care organizations and the tax collector, the value of the federal tax benefits to non-profit health care organizations has increased while the charity care provided to patients unable to pay has decreased. At what point does the divergence between the cost of providing federal tax exemption and the value of the charity care received become too great? Must the cost and value balance? Is it acceptable that the cost of the tax exemption to the federal government greatly exceed the charity care provided to the indigent? Should the federal government require non-profit health care organizations to provide charity care equal to or in excess of the tax benefits they receive? Unfortunately, despite being asked many times over the years, these questions have yet to be answered.

This paper will first review the history of charity care and the statutes, regulations and case law governing the tax exemptions granted to non-profit health care organizations. The second part of this paper reviews the problems arising from the tax exemption, including its failure to require minimum levels of charity care and the inability of non-profit health care organizations to properly categorize uncompensated care. Part three analyzes and evaluates the problems

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3. Utah County v. Intermountain Health Care, Inc., 709 P.2d 265, 278 (Utah 1985) ("The basis for the tax exemption is a quid pro quo: 'private charities perform functions that the state would be required to undertake and tax exemption is granted as a quid pro quo for the performance of these functions and services.'" (quoting EDITH L. FISCH, DORIS JONAS FREED & ESTHER R. SCHACTER, CHARITIES AND CHARITABLE FOUNDATIONS § 787, at 602 (1974))). See also 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." (citing Geisinger Health Plan v. Comm'r, 985 F.2d 1210, 1215 (3d Cir. 1993))).

of the tax exemption. Part four discusses the major weaknesses of the current tax exemption for non-profit health care organizations, and recommends changes to the tax exemption.

This paper advocates that non-profit health care organizations be required to provide a minimum amount of charity care to patients in need. Additionally, standards for determining what qualifies as charity care and how it is to be quantified must be created and enforced by the Internal Revenue Service (IRS). Additional guidance must be provided to hospitals on how to account for the community benefits provided, and what qualifies as a community benefit. Unless the amount of charity care provided by non-profit health organizations is ascertainable, the question of whether health care for patients without insurance or with inadequate insurance, is available at non-profit health care organizations will remain unanswered.

BACKGROUND

History of Support and Encouragement of Charity Care

The current state of non-profit health care organizations should be viewed in light of their development from the earliest forms of charity. With an understanding of the history, it is easier to understand the expectation that charity care be available for uninsured and inadequately insured patients from non-profit health care organizations. Only after taking into account these historical nuances can one attempt to amend the tax code to better enable the non-profit health care organizations to meet, if not exceed, these demands and expectations.

Ancient History

The history of modern charity dates at least from ancient Egypt and the Code of Hammurabi, in which people are encouraged to "'protect the less fortunate and to care for the poor, widowed and orphaned.'" The underpinnings of today's charity care are also in the foundations

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5. For an in-depth discussion of the historical development of charity from ancient Egypt through modern America, including the theories and forces behind it, see Thomas Kelley, Rediscovering Vulgar Charity: A Historical Analysis of America's Tangled Nonprofit Law, 73 FORDHAM L. REV. 2437 (2005).

6. Id. at 2440.

7. Id. at 2440-41.

of Buddhism, Hinduism and Judaism. These teachings were adopted by early Europeans, and this led to "charity becoming cemented in Anglo-American culture and law." The concept of charity in medieval England underwent various changes, as government and private entities became more involved. Although this secularized charity and allowed it to be used for social engineering, one of the underlying motivations remained the spiritual rewards.

**Early American History**

In Colonial America, religious charities operated primarily to provide medical treatment and related care for those unable to afford private doctors. Another source of medical care for the poor was almshouses, "many of which ultimately became tax-supported municipal hospitals run by local governments." Throughout the nineteenth century, "whether municipally or privately owned, hospitals were primarily charitable institutions." During this time, hospitals were "often . . . the only professional medical care available" to the poor. However, hospital care was a last resort for many rather than the initial point of care, as there was a high risk of infection and death. Because the hospitals of this era attracted primarily indigent patients, few hospitals "charged a significant amount above the relatively low cost . . . ." That era's nonprofit hospitals were tax-exempt charities, as they "provided custodial care for those who were both sick and poor [and their] income was derived largely or entirely from voluntary charitable donations, not government subsidies, taxes, or patient fees."

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10. *Id.* at 2441-42.
11. *Id.* at 2443-51.
12. *Id.*
13. *Id.* at 2451-2458.
15. *Id.*
16. *Id.*
18. *Id.*
19. Utah County v. Intermountain Health Care, Inc., 709 P.2d 265, 270 (Utah 1985). Voluntary hospitals, like public hospitals (which evolved from almshouses for the dependent poor), performed a 'welfare' function rather than a medical or curing function: the poor were housed in large wards, largely cared for themselves,
**Turn of Century**

Non-profit health care organizations underwent drastic changes in their "function and status" in the late nineteenth century through the 1920s. Instead of charities, which were "dependent on voluntary gifts," the twentieth century non-profit health care organizations were "institutions financed increasingly out of payments from patients." The "traditional charitable hospital," that existed solely to provide care for the poor, "gradual[ly] disappear[ed]."

and often were not expected to recover. See Paul Starr, _The Social Transformation of American Medicine_ 145, 149, 160 (1982). Early voluntary hospitals had paternalistic, communal social structures in which patients entered at the sufferance of their benefactors, 'had the moral status of children,' and received more moralistic and religious help than medical treatment. _Id._ at 149, 158. Voluntary hospitals were charities for the quite obvious reason that they housed and tended to those who were both sick and poor, i.e., those without resources and in need of charity. Because hospitals performed no medical treatment function and because they were largely institutions for the poor, the nonpoor in need of medical treatment and their treating private physicians overwhelmingly avoided them. _Id._

20. _Utah County_, 709 P.2d at 270.

21. See _id._ at 270 n.9 ("Hospitals had gone from treating the poor for the sake of charity to treating the rich for the sake of revenue. . . .") (quoting Paul Starr, _The Social Transformation of American Medicine_ 159 (1982)).

It was in this same time period that charity hospitals were becoming affected by federal tax laws, through the 1913 federal income tax law.\textsuperscript{23} That law exempted non-profit charities from income taxes and allowed deductions for charitable donations.\textsuperscript{24}

A widespread interest in health insurance also arose during this time.\textsuperscript{25} The first proponents of health insurance focused on compulsory insurance,\textsuperscript{26} but opposition by the American Medical Association (AMA) prevented its implementation.\textsuperscript{27} The predecessor to the current form of health insurance developed during the Great Depression, when a hospital in Texas offered to "sell hospitalization plans to the city's school teachers for fifty cents a month."\textsuperscript{28} Numerous hospitals followed suit and "band[ed] together to offer [such insurance]."\textsuperscript{29} This network became Blue Cross insurance.\textsuperscript{30} Although the AMA opposed these insurance plans, it developed Blue Shield insurance, which focused on paying physicians for medical care provided rather than the hospitals.\textsuperscript{31}

\textit{Second Half of Last Century}

Health insurance development dramatically changed the payment systems for health care, from direct payment for services to payment by insurance.\textsuperscript{32} At the same time, "the role of private philanthropy in

170. All of the above factors indicate a substantial change in the nature of the hospital; a part of that change was the gradual disappearance of the traditional charitable hospital for the poor. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 159 (1982).

23. Kelley, supra note 5, at 2468.

24. Id. at 2470.

25. OXFORD COMPANION TO UNITED STATES HISTORY, supra note 14, at 333.

26. This plan "required the enrollment of most manual laborers earning a hundred dollars a month or less and provided for both income protection and medical care." Id.

27. Id.

28. Id.

29. Id.

30. Id.

31. Id. (AMA's "physician-controlled plan . . . provide[d] medical . . . not hospital [] insurance.").

32. Id. ("Well beyond 1900, paying for medical care, with few exceptions, remained a private activity between patients and their physicians and hospitals."); U.S. GEN. ACCOUNTING OFFICE, NONPROFIT HOSPITALS: BETTER STANDARDS NEEDED FOR TAX EXEMPTION, GAO/HRD-90-84, at 13 (1990) ("By the late 1950s,
financing hospitals was also reduced." These changes resulted in problems with the cost of and access to health care. Congress attempted numerous times to rectify these problems by encouraging charitable contributions and activities. One of these, the Hill-Burton program, provided construction loans and grants for government-owned and nonprofit hospitals. In exchange for these loans and grants, "the hospitals were required to provide a reasonable amount of uncompensated services to the indigent population."

Last Thirty Years

The non-profit health care sector has undergone further changes in the last thirty years, yet problems still exist in providing health care to uninsured patients. The number of patients without insurance, or with inadequate insurance, continues to rise. This increase has resulted

some form of insurance payment was made for about 75 percent of patients in nonprofit hospitals.

33. Id.
34. OXFORD COMPANION TO UNITED STATES HISTORY, supra note 14, at 348.
36. Id. at 12.
Between 1946 and 1974, the Hill-Burton program provided federal grants for constructing public and nonprofit hospitals. In return, the hospitals were required to give assurance that they would make available, in the facility constructed with financial assistance, a reasonable volume of services to persons unable to pay for medical services, if this was financially feasible.

For further discussion of the Hill-Burton program, see U.S. GEN. ACCOUNTING OFFICE, HOSPITAL LOAN ASSISTANCE PROGRAMS: ACTIONS NEEDED TO REDUCE ANTICIPATED DEFAULTS, HRD-79-64, at 2 (1979).

As a condition for receiving loan assistance [via Hill-Burton], the borrower must agree to provide a reasonable amount of uncompensated care to persons unable to pay. In addition, each hospital must agree to provide a community service which includes the provision that individuals served by Federal Government third-party programs, such as Medicare and Medicaid, will not be denied admission to any facility because of these reimbursement mechanisms. These requirements exist until the loans are repaid.

37. PRICEWATERHOUSECOOPERS' HEALTH RESEARCH INSTITUTE, ACTS OF CHARITY: CHARITY CARE STRATEGIES FOR HOSPITALS IN A CHANGING LANDSCAPE 6 (2005). See also Sara R. Collins, Karen Davis, Alice Ho, A Shared Responsibility: U.S. Employers and the Provision of Health Insurance to
from many things, but there are three primary factors: businesses dropping coverage due to higher costs; employees opting out of coverage due to high premiums; and increasing unemployment, which results in loss of employer-provided coverage.  

Meanwhile, as the number of uninsured patients was increasing, the "number of hospitals with outstanding Hill-Burton debt and obligations [were] decreasing." These hospitals were required, if "financially feasible," to provide "uncompensated services to the indigent population" equal to a percentage of either their operating costs or the assistance received. However, this program was only funded between 1946 and 1974. Therefore, a non-profit health care organization's obligations for grants made in 1974 would have expired in 1994. Although there was no expiration date for loan recipients,

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Between 2000 and 2003, the number of Americans without health insurance coverage grew by 5 million, with nearly the entire increase attributed to a decline in employer-sponsored coverage. . . . 35.9 million of 112.8 million working Americans do not have coverage from their employers at any time during the year. Most of these - 22 million - lack coverage because their employers do not offer it to them, while 11.2 million are offered insurance but decline to take it. Nearly 13 million workers are uninsured and most of them, 9.5 million, were not offered coverage by their employers.

38. PRICEWATERHOUSECOOPERS' HEALTH RESEARCH INSTITUTE, supra note 37, at 6.

39. NON-PROFIT HOSPITALS, supra note 35, at 12 n.5.

The number of hospitals with outstanding Hill-Burton debt and obligations is decreasing. Hill-Burton obligated hospitals are presumed to have met their obligation if they make available annually the lower of (1) a dollar volume of services equal to 3 percent of the sum of operating costs minus Medicare and Medicaid payments or (2) 10 percent of the federal assistance received. The length of the obligation is 20 years (in the case of grand recipients), or for the duration of the hospital's indebtedness (in the case of recipients of loans, loan guarantees, or interest subsidies.

40. Id. at 12, n.4.

41. Id. at 12.

42. Id. at 12, n.5.

43. Id. at 12, n.4. See also HOSPITAL LOAN ASSISTANCE PROGRAMS, supra note 36, at 1 ("The Hill-Burton program was enacted in 1946. . . ." "This loan program ended in September 1976").

44. NON-PROFIT HOSPITALS, supra note 35, at 12, n.5 (recipients of Hill-Burton grants obligated to provide medical services to persons unable to pay for 20 years).
the non-profit health care organization was obligated only "for the duration of the . . . indebtedness." Once the Hill-Burton obligations have expired, these non-profit health care organizations are no longer required to provide a certain amount of charity care. Instead, they need only provide an amount that satisfies their internal requirements and the minimum standards for maintaining their charity status.

**Federal Government Support of Charity Care**

The federal government encourages health care organizations to provide charity care through the Internal Revenue Code. However, the inducements are restricted to non-profit health care organizations that qualify as charitable organizations. These hospitals receive tax benefits not available to for-profit hospitals by virtue of their charity status. The benefits arising from the Internal Revenue Code include, \textit{inter alia}, federal income tax exemption, ability to issue tax free

45. \textit{Id.} (recipients of Hill-Burton "loans, loan guarantees, or interest subsidies" obligated to provide medical services to persons unable to pay for duration of indebtedness).

46. This paper will not address non-tax benefits provided to health care organizations by the federal, state and local governments. Nor will this paper address the benefits accruing to non-profit health care organizations via state or local governments.

47. 26 U.S.C. §501(c)(3) (2006); see also \textit{Tax-Exempt Hospital Sector, supra} note 2, at 11-12 (statement of Mark Everson, Comm'r, Internal Revenue Service) ("[H]ospitals must meet the general requirements for exemption under section 501(c)(3). . .").

48. U.S. GEN. ACCOUNTING OFFICE, NONPROFIT HOSPITALS: BETTER STANDARDS NEEDED FOR TAX EXEMPTION, GAO/HRD-90-84, at 10 n.1 (1990) ("The tax advantages that nonprofit hospitals may receive include (1) exemption from income tax; (2) exemption from property and other local taxes; (3) access to charitable donations, which are tax deductible for the individual or corporate donor; and (4) tax-exempt bond financing.").

49. 26 U.S.C. § 501(c)(3). During a recent Congressional hearing, Representative Fortney Pete Stark described one state that estimated that if the hospitals within that state had their exemption withdrawn, $117 million in revenue would be paid to the United States, and $35 million in sales tax and $90 million in real estate taxes would be received by the state. \textit{Tax-Exempt Hospital Sector, supra} note 2, at 6 (statement of Rep. Fortney Pete Stark). Additionally, "$4.3 billion [in] tax-exempt bonds . . . would come due." \textit{Id.} However, the hospitals in that state provided "$525 million of uncompensated care." \textit{Id.}
bonds,° and receipt of charitable contributions. The tax code also encourages charity care via the deduction available for individual and corporate donations to non-profit health care organizations.° It is estimated that these federal benefits are currently worth $50 billion annually.

Additionally, the federal government utilizes non-tax programs to encourage charity care. Medicare and Medicaid payments to non-profit health care organizations are estimated to have been approximately $30 billion in 2005.° Non-profit health care organizations are also eligible for insured mortgages to finance construction or renovation from the Department of Housing and Development (HUD).° Non-profit health care organizations that provide care to a large number of low-income patients also receive cash grants from the federal government, in the form of disproportionate share payments.

50. Morrisey et al., supra note 4 at 133. "Tax-exempt debt allows hospitals to borrow money at rates that are typically two to three percentage points below those paid by equally risky enterprises." Id. at 132.
54. Tax-Exempt Hospital Sector, supra note 2, at 37, 45 (statement of Mark McClellan, Admn'r, Centers for Medicare and Medicaid Services).

Hospitals may receive direct payments from different government sources to help cover their unreimbursed costs, including those for charity care, bad debt, and low-income patients. For example, Medicare and Medicaid make payments to hospitals that serve a disproportionate share of low-income patients under their respective disproportionate share hospital (DSH) programs. Medicare bad debt reimbursement partially reimburses hospitals for bad debt incurred for Medicare patients.
Statutes, Regulations, and Case Law Governing Tax Exemption

Qualification as Charity

Under section 501(c)(3) of the Internal Revenue Code, an entity organized and operated exclusively for charitable, scientific, educational, religious, or literary purposes is exempt from federal income taxation.57 No stand-alone category automatically conferring tax-exempt status exists for health care organizations. Rather, health care organizations "achieve[] that status only by qualifying as ‘charitable’ organizations under the [Internal Revenue] Code."58

Tax exemptions for charitable institutions are justified by the public benefit the institutions provide to the community and society.59 To determine if an organization does confer this public benefit, the organization must first satisfy two tests: the organizational test and the operational test.60

The organizational test61 requires that the organization’s purpose be expressly limited in its governing instrument62 to at least one of the

59. Bob Jones Univ. v. United States, 461 U.S. 574, 591 (1983) ("Charitable exemptions are justified on the basis that the exempt entity confers a public benefit - a benefit which the society or the community may not itself choose or be able to provide, or which supplements and advances the work of public institutions already supported by tax revenues.").
60. 26 C.F.R. § 1.501(c)(3) (2005) (providing guidance on both tests: in order to be exempt as an organization described in section 501(c)(3), an organization must be both organized and operated exclusively for one or more of the purposes specified in such section. If an organization fails to meet either the organizational test or the operational test, it is not exempt.). See also 25 U.S.C. § 501(c)(3) (2006) ("Corporations . . . organized and operated exclusively . . .").

(i) An organization is organized exclusively for one or more exempt purposes only if its articles of organization (referred to in this section as its articles) as defined in subparagraph (2) of this paragraph:

(A) Limit the purposes of such organization to one or more exempt purposes; and
(B) Do not expressly empower the organization to engage, otherwise than as an insubstantial part of its activities, in activities which in themselves are not in furtherance of one or more exempt purposes.

(ii) In meeting the organizational test, the organization’s purposes, as stated in its articles, may be as broad as, or more specific than, the purposes stated in section 501(c)(3).
specific purposes under I.R.C. § 501(c)(3). The organizational test is the easier test to satisfy, achieved through careful drafting of the governing instrument.

The operational test is the more difficult test, as it examines the organization's activities and requires that it must be engaged primarily in the activities that it has identified as its exempt purpose. A charitable organization is barred from lobbying legislative or regulatory authorities. Although charitable organizations are not absolutely forbidden from engaging in activities that do not further its non-profit purpose, these activities cannot be a major part of its organization, but rather are limited to insubstantial amounts.

62. Id.

63. 26 U.S.C. § 501(c)(3) (2006) (stating that the governing instrument must also provide for distribution of the non-profits assets in the event of dissolution in furtherance of the specific purpose).

64. 25 C.F.R. § 1.501(c)(3)-1(c) (2005)

   (1) *Primary activities.* An organization will be regarded as operated exclusively for one or more exempt purposes only if it engages primarily in activities which accomplish one or more of such exempt purposes specified in section 501(c)(3). An organization will not be so regarded if more than an insubstantial part of its activities is not in furtherance of an exempt purpose.

   (2) *Distribution of earnings.* An organization is not operated exclusively for one or more exempt purposes if its net earnings inure in whole or in part to the benefit of private shareholders or individuals.

   . . .

   (3) *Action organizations.* (i) An organization is not operated exclusively for one or more exempt purposes if . . . (ii) . . . a substantial part of its activities is attempting to influence legislation by propaganda or otherwise . . .

65. 26 C.F.R. § 1.501(c)(3)-1(c) (2005).


67. 26 C.F.R. § 1.501(c)(3)-1(c)(3)(ii) (2005) This limitation will not be addressed in this paper.
Community Benefit Test for Health Care Organizations

In addition to the tests outlined above, since 1969 a non-profit health care organization must also prove that its services are for the benefit of the community as a whole. This test, known as the community benefit test, is a subpart of the operational test specifically applied to non-profit health care organizations.

Prior to 1969, for a non-profit health care organization to obtain and maintain the exemption, it needed to "be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay."69 The courts approved health care organizations charging patients for the health care they received and to cover the costs incurred by the organization, as long as they did not "deny[] treatment to others unable to pay anything."70 These organizations could still qualify as charities and thereby be exempt from taxation71 but had to do more than merely operate a hospital or provide "the diagnosis and cure of

68. This section deals only with the federal tests for non-profit health care organizations. States can impose additional requirements for the exemption of income from state taxes. See, e.g., Utah County v. Intermountain Health Care, Inc., 709 P.2d 265 (Utah 1985) (Utah Supreme Court set out six-point test for charitable hospitals: 1) purpose of entity, 2) means of financial support of entity, 3) whether hospital requires recipients of services to pay, 4) whether the income received produces a profit, 5) whether the hospital restricts beneficiaries' services, and whether that restriction relates to the charitable objective, and 6) whether financial benefits are available to private interests, and whether the hospital has subordinate commercial activities). See also Sean Nicholson & Mark V. Pauly, Community Benefits: How Do For-Profit and Nonprofit Hospitals Measure Up?, LDI ISSUE BRIEF (Leonard Davis Institute for Health Economics, Philadelphia, PA) Dec. 2000 - Jan. 2001, at 1:

Since 1990, at least 8 states have enacted requirements expanding upon the federal community benefit standard. Five of these states have taken a process-oriented approach, with community benefit planning and reporting provisions, while the others have taken a more prescriptive approach, imposing minimum charity care or community benefit expenditures on tax-exempt hospitals.


71. Id.

72. Sonora Community Hospital v. Comm'r, 46 T.C. 519, 525-6 (1966), aff'd, 397 F.2d 814 (9th Cir. 1968) (Where hospital was operated primarily for the benefit of the physician owners and not the public, "mere fact" of operating hospital "does
disease . . . .” 73 Even if the hospital’s “charity record [was]... comparatively low,” 74 its “charitable operation” must have been more than “inconsequential.” 75

The IRS modified this standard in 1969 by removing “the requirement[] relating to caring for patients without charge or at rates below cost.” 76 The revised standard, known as the “community benefit” standard, 77 allowed health care organizations that only promoted health to qualify for the exemption if their promotion of health care benefited the community as a whole. 78

However, after Revenue Ruling 69-545, “the provision of free or below cost service to those unable to pay is no longer essential.” 79 Instead, this ruling “broadly defines ‘charitable’ in terms of community benefit and holds that the promotion of health constitutes a ‘charitable purpose’ in the ‘generally accepted legal sense of that term’ and within the meaning of § 501(c)(3) of the Code.” 80

The community benefit standard was modified again in 1983, when the IRS determined that operation of an emergency room open to all was not required to meet the community benefit test, as long as there were other significant factors indicating the organization was operated for the public benefit. 81 This ruling addressed whether a hospital could

73. Id. at 525-26.
74. Id. at 526.
75. Id.
76. Rev. Rut. 69-545, 1969-2 C.B. 117 (This revision was based on a hospital that, although not open to the public for regular admissions, did operate an emergency room open to all persons regardless of their ability to pay, and financed medical training, education, and research. Based on the emergency room access and the additional factors, the IRS found that the hospital was “promoting the health of a class of persons ... broad enough to benefit the community.”).
77. Id.
78. Id.
80. Id. at 1280-81.
qualify for exemption despite not operating an emergency room, when
the operation of an emergency room by that hospital was determined
by state officials82 to be "unnecessary because it would duplicate
emergency services and facilities that are adequately provided by
another medical institution in the community."83 However, additional
factors84 indicating community benefit are still required, even though
an emergency room is not.85 The IRS also determined that specialty
hospitals,86 which are not expected to operate emergency rooms due to
the nature of their specialized practice, can qualify for the exemption
"if there are present similar, significant factors that demonstrate that
the hospitals operate exclusively to benefit the community."87

With the additional guidance provided by the Revenue Rulings, a
non-profit health care organization is required to "make its services
available to all in the community plus provide additional community or
public benefits."88 The additional benefits "must be sufficient" to show
"that the public benefit is the primary purpose for which the
organization operates."89 The additional community benefits have also
been characterized as "benefit[s] which the society or the community
may not itself choose or be able to provide, or which supplement[] and
advance[] the work of public institutions already supported by tax
revenues."90

82. Id.
83. Id.
84. However, not all activities promoting health, standing independently, will
qualify an organization for tax-exempt status. "[S]elling prescription
pharmaceuticals certainly promotes health, but pharmacies cannot qualify ... on
Other significant factors, however, including a board of directors drawn
from the community, an open medical staff policy, treatment of persons
paying their bills with the aid of public programs like medicare and
medicaid, and the application of any surplus to improving facilities,
equipment, patient care, and medical training, education, and research,
indicate that the hospital is operating exclusively to benefit the
community.
86. Such as those specializing in certain conditions, e.g. "eye hospitals and
cancer hospitals." Id.
87. Id.
88. IHC Health Plans, Inc. v. Comm’r, 325 F.3d 1188, 1198 (10th Cir. 2003).
89. Id.
90. Id. at 1195 (quoting Bob Jones Univ. v. United States, 461 U.S. 574, 591
(1983)).
At its broadest definition, community benefit "include[s] such services as the provision of health education and screening services to specific vulnerable populations within a community, as well as activities that benefit the greater public good, such as education for medical professionals and medical research." The services and activities accepted towards community benefit are broad, and include almost any activity that is outwardly directed.

As discussed above, the community benefit test does not require that non-profit health care organizations provide free or reduced cost health care, although doing so would qualify as providing a community benefit. Instead, non-profits may provide health education, health


92. See e.g., id. at 16. A recent GAO report identified the following services as being reported by hospitals as community benefit:

- community health education such as parenting education, smoking cessation, fitness and nutrition, health fairs, and diabetes management;
- health screening services such as screening for high cholesterol, cancer, and diabetes;
- clinic services, including clinics targeted to specific groups in the community, such as indigent patients;
- medical education for physicians, nurses, and other health professionals;
- coordination of community events and in-kind donations, such as food, clothing, and meeting room space, to community organizations; and
- hospital facility and other infrastructure improvements.

93. 26 C.F.R. § 1.501(c)(3)-1 (2005). However, community benefit policies alone are not sufficient to obtain an exempt status. I.R.S. Field Service Advisory 200110030 (Feb. 5, 2001). Rather, the non-profit health care organization "must meet both the organizational test and the operational test to qualify for exemption under section 501(c)(3)." Id. at *5 (citing Levy Family Tribe v. Comm'r, 69 T.C. 615, 618 (1978)). In sum, non-profit health care organizations must have appropriate community benefit policies in addition to providing actual community benefit. Questions identified by the Internal Revenue Service to distinguish the appropriateness of tax exempt status based on "charitable care policies and activities" include:

- Does the hospital have a specific, written plan or policy to provide free or low-cost health care services to the poor or indigent?
- Under what circumstances may, or has, the hospital deviated for (sic) its stated policies on providing free or low-cost health care services to the poor or indigent?
screening services, clinic services, education for physicians, nurses, and other health care professionals, financial contributions to community organizations, coordination of community events, or hospital infrastructure improvements.\textsuperscript{94}

\textit{Problems with Current Exemption}

The lack of specific criteria has been identified as a major problem concerning tax exemption for non-profit health care organizations.\textsuperscript{95}

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Does the hospital broadcast the terms and conditions of its charity care policy to the public?

Does the hospital maintain and operate a full-time emergency room open to all persons regardless of their ability to pay?

What directives or instructions does the hospital provide to ambulance services about bringing poor or indigent patients to its emergency room?

What inpatient, outpatient, and diagnostic services does the hospital actually provide to the poor or indigent for free or for reduced charges?

Under what circumstances does the hospital deny health care services to the poor or indigent?

Does the hospital operate with the expectation of receiving full payment from all persons to whom it renders services?

How and when does the hospital ascertain whether a patient will be able to pay for the hospital's services?

What documents or agreements does the hospital require poor or indigent patients to sign before receiving care?

What is the hospital's policy on admitting poor or indigent patients as inpatients and outpatients?

Under what circumstances does the hospital refer poor or indigent individuals who require services to other hospitals in the area that do admit poor or indigent patients?

Does the hospital maintain separate and detailed records about the number of times, and circumstances under which, it actually provided free or reduced-cost care to the poor or indigent?

Does the hospital maintain a separate account on its books that segregates the costs of providing free or reduced-cost care to the poor or indigent?

Does this account include any other items, such as write-offs for care to patients who were not poor or indigent?

I.R.S. Field Service Advisory 200110030 at **12 – 14.


95. Id. at 19 (One of the GAO's main findings was "that current tax policy lacks specific criteria with respect to tax exemptions for charitable entities and detail on how that tax exemption is conferred.").
Since 1969, the IRS has had increasing difficulty in differentiating between non-profit and for-profit hospitals based on their activities and provision of charitable health care.\textsuperscript{96} Unfortunately, this allows "for-profit entities [to] masquerade as charities in order to escape taxation and regulation."\textsuperscript{97}

Further complicating matters is that many non-profit health organizations have trouble accounting for what qualifies as community benefit, due to the inadequacy of the tax code, regulations and guidance. Additionally, critics have categorized the IRS' revenue rulings and other guidance as "greatly expand[ing] the federal tax definition of charitable" without Congress' approval.\textsuperscript{98} Although this definition "apparently was at odds with what Congress intended,\textsuperscript{99} Congress made no attempt to rein in the IRS' expanded definition.\textsuperscript{100}

\textit{No Minimum Requirements For Provision of Charity Care}

As discussed above, in 1969 the IRS eliminated the requirement that non-profit health care organizations "operate[] to the extent of its financial ability for those not able to pay for the services rendered."\textsuperscript{101} In doing so, the IRS eliminated the requirement that these organizations provide charity care to patients unable to pay.

Although the elimination of this requirement has reduced the cost of uncompensated care at particular hospitals,\textsuperscript{102} on a nationwide level the

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\item \textsuperscript{96} Tax-Exempt Hospital Sector, supra note 2, at 9 (statement of Mark Everson, Comm'r, Internal Revenue Service) ("[C]onvergence of practices between the for-profit and nonprofit hospital sectors" make it difficult to differentiate. These practices include "complex joint ventures with profit-making companies, excessive executive compensation, operating for the benefit of private interest rather than the public good, unrelated business income and employment taxes."). See also House Tax Panel Chairman Says Exemption for Hospitals Becoming Difficult to Justify, 73 U.S.L.W. 2718 (2005).
\item \textsuperscript{97} Tax-Exempt Hospital Sector, supra note 2, at 8 (statement of Mark Everson, Comm'r, Internal Revenue Service).
\item \textsuperscript{98} Kelley, supra note 5, at 2471.
\item \textsuperscript{99} Id. at 2472.
\item \textsuperscript{100} Id.
\item \textsuperscript{102} U.S. GEN. ACCOUNTING OFFICE, NONPROFIT HOSPITALS: BETTER STANDARDS NEEDED FOR TAX EXEMPTION, GAO/HRD-90-84, 30 (1990). GAO found that:
\begin{quote}
In the communities where the numbers of medically indigent people in need of services outstripped the capacity or willingness of the nonprofit
\end{quote}
\end{itemize}
result has been the opposite: when "charitable care is . . . lacking[] . . . [t]he uninsured do not receive the same quality or access to care as the insured."103 This results in uninsured patients not seeking health care,104 or having it withheld, and ultimately "result[s] in needless teaching hospitals to meet the demand, the amount and distribution of uncompensated care was a significant issue among hospital administrators. In these communities, some hospitals were undertaking actions to reduce the amount of treatment provided to those who could not pay. (emphasis added). See also id. at 32 (GAO "found that some nonprofit hospitals' admissions, transfer, and physician staffing policies generally discouraged the provision of nonemergency care to those unable to pay for treatment."); id at 35 (GAO identified one hospital in Florida which "adopted several policies to stem its indigent care costs.." These practices included: "refusing to treat patients unable to pay except those needing urgent medical treatment and those residing in the hospital's catchment area, encouraging indigent patients to go to a hospital in the area covered by the zip code of their residence. . . ."); GAO found that an investor owned hospital adopted policies to reduce their indigent care costs, including plans to close its emergency room, after calculating that:

75 percent of 3,000 emergency room visits monthly involved people with no insurance or inadequate insurance.

... [A]nother investor-owned hospital closed its emergency room to ambulance traffic by downgrading it to an urgent care center . . . and chose not to contract with the state to provide inpatient services for Medicaid patients and did not contract with the county to provide emergency services to county-sponsored indigent patients.

Id. at 36.


104. ROBERT WOOD JOHNSON FOUNDATION, CHARACTERISTICS OF THE UNINSURED: A VIEW FROM THE STATES Fig. 6 (2005) ("Nationally, 41.3% of adults without health care coverage, compared to 8.6% of adults with health care coverage, were unable to see a doctor when needed due to cost in the past twelve months."), See also ROBERT WOOD JOHNSON FOUNDATION, UNINSURED AMERICANS WITH CHRONIC HEALTH CONDITIONS: KEY FINDINGS FROM THE NATIONAL HEALTH INTERVIEW SURVEY 1 (2005) ("Almost half of uninsured adults with chronic conditions forgo needed medical care or prescription drugs, due to cost.").
Moreover, when these patients were able to obtain health care, high out-of-pocket costs resulted in medical debt beyond their ability to repay. In 2003, approximately one-third of adults reported problems paying for medical care, and approximately one in six had problems with medical debt. Difficulty paying for incurred medical debts can dissuade patients from seeking additional health care. However, not all patients who are unable to afford medical care are uninsured.

105. Spitz & Abramson, supra note 103, at 328 (citing COMMITTEE ON THE CONSEQUENCES OF UNINSURANCE, INSTITUTE OF MEDICINE, CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE (2002) and JACK HADLEY, KAISER COMMISSION ON MEDICAID AND THE UNINSURED, SICKER AND POORER: THE CONSEQUENCES OF BEING UNINSURED (2002)). See also Michelle M. Doty, Jennifer N. Edwards, and Alyssa L. Holmgren, Seeing Red: Americans Driven into Debt by Medical Bills, ISSUE BRIEF (Commonwealth Fund), Aug. 2005, at 1 (“Medical bill[s] and debt problems not only create financial hardship but can deter people from seeking further health care.”).

106. ROBERT WOOD JOHNSON FOUNDATION, UNINSURED AMERICANS WITH CHRONIC HEALTH CONDITIONS: KEY FINDINGS FROM THE NATIONAL HEALTH INTERVIEW SURVEY 5 (2005) (“Despite having fewer contacts with the health care system, uninsured adults with chronic conditions still face large out-of-pocket expenditures for their care. More than one out of five (21 percent) uninsured adults with chronic conditions reported spending at least $2,000 out of pocket on medical care in the 12 months prior to the survey.”).

107. Doty et al., supra note 105, at 1 (“High out-of-pocket expenses are contributing to the rise of medical debt, which now accounts for as much as 40 to 50 percent of personal bankruptcies.” Additionally, “77 million Americans age 19 and older - nearly two of five (37%) adults - have difficulty paying medical bills, have accrued medical debt, or both.”).

108. Id. at 1 (“Nearly one in three U.S. adults - an estimated 61 million people - reported problems paying medical bills in 2003 . . . [and] an estimated 29 million adults, or 14 percent of the adult population, had current or accrued medical debt.”). See also id. at 3 (“[A]n estimated 16 million adults [] had currently or in the past three years amassed medical bills or medical debt that they could not pay right away and were paying off over time.”).

109. Id. at 5-6 (“Sixty-three percent of adults with any medical bill or debt problem went without needed care in the past 12 months because of cost, compared with 19 percent of adults without such problems.”). See also id. at 6 (“[T]he link between medical bills, debt, and access problems may reflect a more hostile reception of patients with outstanding bills, or fears among patients that their medical bills and debt will prevent them from receiving subsequent care.”).

110. Julie Appleby, Even the Insured Can Buckle Under Health Care Costs, USA TODAY, Aug. 31, 2005 at 1A (“Sixty-two percent of those struggling to pay medical bills have health insurance . . .”). See also Liz Szabo, Child's Cancer Can
Inability to Properly Categorize Charity Care

The Internal Revenue Code and related regulations do not provide sufficient guidance on calculating the amount of charity care provided by non-profit health care organizations. This lack of guidance forces hospitals to estimate the amount of charitable care given to patients, and "inconsistencies in the ways hospitals identify charity care" make it difficult to measure the amount of charity care provided. Typically, non-profit health care organizations combine "[c]harity care, policy discounts and bad debt" together into "uncompensated care." Although a recent study by PriceWaterhouseCoopers indicates that hospitals are "absorbing higher levels of charity care and bad debt," much of the bad debt might actually be charity care that was not appropriately characterized or categorized. Another study examined the amount of uncompensated care and taxes paid by for-profit hospitals, theorizing that this amount should comport with the amount of uncompensated care provided by nonprofit hospitals. However, this study instead identified that nonprofit hospitals provided only twenty-five to thirty-six percent of the expected amount of uncompensated care.

Although the authors of this study recognized that the difference in care provided and care expected could be due, inter alia, to "subsidies

Batter Family's Finances, USA TODAY, Aug. 31, 2005 at 1B (One family, despite having insurance through the father's employer, quickly reached a coverage cap for their health insurance after one son was diagnosed with cancer. It was estimated that "[k]eeping him alive... cost more than $3 million... [but the insurance company] limited payments [for one procedure to] $500,000." Because "[t]he family wasn't poor enough to qualify for Medicaid" the family applied for "Social Security Disability Insurance" for their son.).


112. PRICEWATERHOUSECOOPERS' HEALTH RESEARCH INSTITUTE, supra note 37, at 9.

113. Id.


115. Id. at 3.
of medical research and price discounts,” after accounting for these additional benefits, the authors calculated that the nonprofits provided community benefits equal to only eighty-three percent of the uncompensated care and taxes paid by the for-profit hospitals.\textsuperscript{116} The authors theorized that this apparent discrepancy could be due to the nonprofit providing benefits “that the community does not value[,] or for purposes the community does value but are not measured,” or could be due to the hospital “accumulating profit to provide community benefits in the future.”\textsuperscript{117}

\textit{Charity Care vs. Bad Debt}

Neither Congress nor the IRS have provided adequate guidance for determining a “patient’s qualifications for charity care.”\textsuperscript{118} Because “many hospitals frequently write off bad debt as charity care,”\textsuperscript{119} considering the hospital’s or tax collector’s point of view, there is little difference between charity care and bad debt, as both are uncompensated care. One study concluded that the “[c]harity care numbers reported by hospitals may be underestimated because of the difficulty in qualifying patients . . . .”\textsuperscript{120}

It is in this qualifying of patients that non-profit health care organizations must decide whether the patient will receive charitable care.\textsuperscript{121} Because categorization of care as bad debt can be devastating

\begin{itemize}
\item \textsuperscript{116} \textit{Id.}
\item \textsuperscript{117} \textit{Id.}
\item \textsuperscript{118} \textit{PRICEWATERHOUSECOOPERS’ HEALTH RESEARCH INSTITUTE, supra note 37, at 2. See also id. at 15 (“60% of hospitals include in their [charity care] policy a provision for eligibility based on medical indigence or catastrophic care costs. Catastrophic care provisions limit a patient’s financial liability, typically to a percent of their annual income.”}).
\item \textsuperscript{119} William P. Elliott, \textit{The Beginning of a New Era in Tax-Exempt Healthcare?}, 49 EXEMPT ORG. TAX REV. 69, 71 (2005).
\item \textsuperscript{120} \textit{PRICEWATERHOUSECOOPERS’ HEALTH RESEARCH INSTITUTE, supra note 37, at 10. See also id. at 2 (“[H]ospitals provide an average of 5% of net operating income in charity care, though some provided a substantially higher amount. . . . [H]ospital industry bad debt as a percentage of net revenue increased from 7.6% in 1999 to 9.9% in 2003.”}).
\item \textsuperscript{121} \textit{Id. at 9}
\end{itemize}

Traditionally, accounting for charity care and bad debt has been based on expectations. If there is no expectation of collecting payment from a patient because they have no ability to pay then the healthcare services are classified as charity care. However, if the hospital does not qualify a patient for charity care and has an expectation of payment, then any non-payment results in a bad debt classification.
for the patient, non-profit health care organizations need stronger guidance on how to categorize patients, to reduce the severe financial and legal consequences that result from miscategorization.

However, even when hospitals do have well-defined internal guidelines for qualifying patients for charity care, there are still problems in implementation. If a patient is unable to provide documentation of need requested by the organization, what should be qualified as charity care instead becomes bad debt. Not only do few people carry the required financial paperwork with them, "[s]ometimes patients will not respond to questions and don't give or provide information to make correct decisions about classification." This means that although health care organizations inform the patients about their ability to qualify for charity care or other financial assistance with paying their medical bills, not all the patients who would qualify actually will qualify.

Some hospitals hire collection agencies to pursue unpaid accounts, sending bill collectors after the uninsured patients for the cost of

122. The pursuit of payment by those unable to pay can have a severe financial impact on those patients, as "[m]edical debt is the leading cause of bankruptcies." James Unland, Two Years Into the Storm Over Pricing To and Collecting From The Uninsured A Hospital Valuation Expert Examines the Risk/Return Dynamics, 3 (2005), http://www.healthbusinessandpolicy.com/Documents/TwoYearsOutInTheCharityHospControversiesFINAL.pdf. See also Doty et al., supra note 105, at 1 ("High out-of-pocket expenses are contributing to the rise of medical debt, which now accounts for as much as 40 to 50 percent of personal bankruptcies.").

123. PRICEWATERHOUSECOOPERS' HEALTH RESEARCH INSTITUTE, supra note 37, at 23.

Most hospitals have complex and cumbersome paperwork that must be filled out prior to qualification for financial assistance. In addition, patients must supply a wide range of supporting documentation that could include pay check stubs, tax returns, notarized letters from employers, bank account information, and other asset verification information. This process can intimidate and in some cases deter eligible patients from applying for charity care.

124. Id. at 10 ("Without cooperation of the patient providing documentation, hospitals cannot correctly classify patients. Difficulty in classifying patients often results in charity cases becoming a bad debt.").

125. Id. at 23 ("A lot of people could qualify [for charity care] but don't follow through.").

126. Id. ("[S]ome hospitals have documentation compliance rates that hover around 50%, meaning that many people who may qualify for discounts aren't getting them because they can't or won't complete the paperwork.").
health care provided. Hospitals in some states even press charges and seek jail time for patients unable to pay. Yet even with these aggressive collection tactics, the average amount collected through these practices is "only seven cents on the dollar."

Critics have accused hospitals of using these collection tactics as a cost-saving and preventative measure. By using aggressive collection methods and high charges, critics say hospitals are hoping to "discourage[e] the uninsured from showing up at the emergency room" and "ward off uninsured patients." The purpose, according to these critics, is to dissuade those patients from returning for additional medical care, in hopes that the next time these patients need medical attention they will seek out hospitals that will qualify these patients as charity care or that do not use aggressive collection methods for unpaid accounts. Indeed, one study identified "medical bills, debt, and access problems" with "a more hostile reception of patients with outstanding bills . . . ."

However, some of the hospitals' collection practices can be traced to federal laws and regulations. For example, Medicare reimburses hospitals for "bad debt resulting from an inability to collect deductibles


128. John G. Carlton, Editorial, Charity Care and the Bottom Line: The Culture of Profit, ST. LOUIS POST-DISPATCH, Dec. 13, 2004 (discussing hospitals that had "sought . . . arrest warrants for debtors who missed court appearances" related to debt incurred for health care. These hospitals included Provena Covenant Medical Center, the Carle Foundation Hospital, the teaching hospital for the University of Illinois, and Yale University's Yale-New Haven Hospital.).


130. Id.

131. Id.

132. Id.

133. Doty et al., supra note 105, at 6 ("[T]he link between medical bills, debt, and access problems may reflect a more hostile reception of patients with outstanding bills, or fears among patients that their medical bills and debt will prevent them from receiving subsequent care.").
and copayments from Medicare beneficiaries.' These payments are estimated at approximately $1.6 billion for 2005. However, until recently hospitals interpreted Medicare rules to require that the hospitals "use the same level of reasonable collection efforts as they do to secure collection of debts by non-Medicare patients." This parity requirement led hospitals to aggressively seek payment of unpaid medical debt for all patients with outstanding bills, not just the uninsured, in order to abide by Medicare requirements.

How to Calculate the Value of Charity Care Provided

Another aspect of the charity care issue is how to calculate the amount of care provided. No consensus is available on whether the value should be "charitable care at sticker price or what they actually collect from insurance companies." Although not directly affecting the ability of non-profit health care organizations to provide charity care, the lack of guidance can result in incorrect estimates of the health care provided.

The primary source of guidance concerning accounting for community benefit and charity care received by non-profit health care organizations is from nongovernmental health associations. Unfortunately, the guidance provided depends on the association providing the recommendations, with state associations either creating their own guidance, or adapting or adopting the AMA's. State hospital association billing guidelines vary widely on how hospitals should determine whether low-income patients qualify for charity care

134. Tax-Exempt Hospital Sector, supra note 2, at 35 (statement of Mark McClellan, Adm'r, Centers for Medicare and Medicaid Services).
135. Id. at 37.
136. Id. at 36.
137. The Department of Health and Human Services has clarified that despite the perception that the Department "requires hospitals to engage in vigorous collection efforts against uninsured patients," in fact no such "rule or regulation requires a hospital to engage in any particular collection practices." Memorandum from Office of Inspector Gen., Dep't of Health & Human Servs., Hospital Discounts Offered to Patients Who Cannot Afford to Pay Their Hospital Bills, 2 (Feb. 2, 2004), available at http://oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA021904hospitaldiscounts.pdf
138. Tax-Exempt Hospital Sector, supra note 2, at 6 (statement of Rep. Fortney Pete Stark). See also PRICEWATERHOUSECOOPERS' HEALTH RESEARCH INSTITUTE, supra note 37, at 9-10 (finding that there is little consensus within the industry on how to determine the amount of charity care provided, specifically whether the amount claimed as charity should be based on the Charge Description Master prices, i.e., list price, or the actual cost of the care given.).
or other financial assistance, with some state associations recommending only that hospitals follow "a consistent method based on need" while others peg the recommended financial assistance to the Federal Poverty Limit.\textsuperscript{139}

Guidelines on how to calculate the costs of provided care should also lessen the burden on uninsured and underinsured patients, as a common practice of non-profit health care organizations is to charge those patients an undiscounted rate for their services.\textsuperscript{140} Health insurance companies and government insurance programs, by contrast, have negotiated discounted rates for services.\textsuperscript{141} There are many

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\item \textsuperscript{139} \textsc{PriceWaterhouseCoopers' Health Research Institute}, \textit{supra} note 37, at 18. (A "sampling of state hospital association billing guidelines" found that both Louisiana and New Jersey hospital associations recommended that "[d]iscounts should be offered on a consistent method based on need." California's recommended assistance was for "[p]atients with incomes less than or equal to 300\% of the FPL should be eligible to apply for financial assistance under each hospital's charity care policy or discount payment policy." New York recommended assistance for "[p]atients with incomes less than 200\% of the FPL should be eligible for financial assistance [and] [h]ospitals may provide financial assistance to those earning more than or equal to 200\% of the FPL." Illinois recommended that "[p]atients with incomes between 100\% and 200\% of the FPL should be offered partial discounts." Maryland advises hospitals to "adopt AHA billing and collection practices." Minnesota recommended that "[p]atients with incomes of less than 200\% of the FPL [be] eligible for financial assistance, [and] [h]ospitals may provide financial assistance to those who earn more than 200\% of the FPL." The hospital association in New Mexico, a state with one of the highest rates of uninsured persons in the nation, advises hospitals that "[d]iscounts should be offered for patients who need financial assistance. Absent any regulatory prohibition, such patients should not be charged more than the hospital would receive from government sponsored programs." Pennsylvania's recommendation is almost identical to that of New Mexico, except that the comparison can be to government sponsored programs or commercial payers. Oregon advises that "[f]inancial assistance should be available for families below 150\% of the FPL, [and a] sliding scale fee should be available when family income exceeds 150\% of the FPL.").
\item \textsuperscript{140} \textsc{PriceWaterhouseCoopers' Health Research Institute}, \textit{supra} note 37, at 16 (noting that "insurance companies and managed care have negotiated contractual rates, uninsured or self-pay patients are often charged list price").
\item \textsuperscript{141} \textsc{Daily Health Policy Report}, Henry J. Kaiser Family Found., Hospitals Charge Uninsured Ohio Residents More for Health Services, Study Finds (March 10, 2005), available at http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=28588 (hospitals charged uninsured patients "more than twice the amount for health care as insured patients."). \textit{See also} Memorandum from Office of Inspector Gen., Dep't of Health & Human Servs., \textit{Hospital}
lawsuits currently pending against health care organizations for “overcharging uninsured patients” as well as for “relentlessly pursu[ing] the poorer or uninsured through aggressive collection techniques,” and earning profits through private interests. One large for-profit health care organization recently agreed to numerous changes in the way patients were counseled about paying for services, as well as how accounts were collected.

Discounts Offered to Patients Who Cannot Afford to Pay Their Hospital Bills, 2 (Feb. 2, 2004), available at http://oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA021904hospitaldiscounts.pdf (Memorandum clarifying that neither the Federal Antikickback Statute, 42. U.S.C. § 1320a-7b(b), nor the Social Security Act, 42 U.S.C. § 1320a-7(b)(6)(A), requires hospitals to charge uninsured and underinsured patients undiscouned rates for medical care. The Department of Health and Human Services found that “hospitals have the ability to provide relief to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing amounts.”).

142. Bilimoria, supra note 127, at 134-35.

143. Id. at 135. See also Kaiser Daily Health Policy Report, Group of Plaintiffs’ Attorneys File Suit Against Several Not-For-Profit Hospitals, Alleging Violation of Charity Care Guidelines (June 17, 2004), www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=24264 (discussing lawsuits filed in June, 2004 against not-for-profit hospitals) (hereafter Kaiser, Group of Plaintiffs’ Attorneys); Unland, supra note 122, at 2 (discussing allegations arising in the Wall Street Journal articles in 2003 about “hospital pricing, collection and charity care practices with respect to the uninsured and underinsured.” Mr. Unland identified three allegations that were consistent irrespective of the forum, be it city councils, county boards, state legislatures, state attorneys general, or Congress: that “[h]ospitals are charging their ‘list prices’ – prices no one pays – to the uninsured; . . . using onerous collection tactics, including against low-income people whom they know cannot pay; . . . and are not providing enough ‘charity care’ and, in some cases, conceal its availability.”).

144. Sara Hoffman Jurand, Major Hospitals Agree to Stop Overbilling Uninsured Patients, TRIAL (Nov. 2005) (A class action lawsuit against Tenet Healthcare Corp., which claimed that the hospital “routinely charged uninsured patients substantially higher rates than those charged to patients with health insurance,” was settled in late 2005 after the corporation agreed that “it would charge uninsured patients discounted prices comparable to managed care rates, disclose estimated costs in plain English (or Spanish), and treat all patients fairly, regardless of their ability to pay.” Tenet also “agreed to offer reasonable payment terms and simple, flexible payment plans with no interest for 120 days; provide free financial counseling to patients . . . delay billing or trying to collect from a patient who has a financial assistance application pending; and . . . pledged not to foreclose or place a lien on a patient’s house or garnish wages.”).
The Community Benefit Standard

Analysis

Society has supported charitable care for several millennia, and continues to do so today. Through our history, people have been encouraged to “protect the less fortunate and to care for the poor, widowed and orphaned.” With or without government support, charity care has survived.

However, the increased costs of medical care, along with an increase in the number of uninsured and inadequately insured patients, appear to be threatening this ancient mandate to help those who are sick and poor. Although government programs exist to assist patients with their health care costs, these fall short of effectuating low cost or free health care to those in need. As a result, patients who previously would have received medical care for free or at a very low cost are instead charged full price. Currently, many of those in need are at the mercy of the individual health care organizations for the determination of whether they qualify for the low cost health care or must pay the non-discounted rate for medical treatment.

Quid Pro Quo

The quid pro quo between the non-profit health care organizations and the tax collector, although negative if viewed cynically, is a powerful yet underutilized tool. Prior to 1969, the exchange of tax exemption for charitable care was linked; hospitals seeking charity status had to “be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those

145. See supra Part II(A).
147. Utah County v. Intermountain Health Care, Inc., 709 P.2d 265, 278 (Utah 1985) (“The basis for the tax exemption is a quid pro quo: private charities perform functions that the state would be required to undertake and tax exemption is granted as a quid pro quo for the performance of these functions and services.”) (quoting EDITH L. FISCH, DORIS JONAS FREED & ESTHER R. SCHACTER, CHARITIES AND CHARITABLE FOUNDATIONS § 787, at 602 (1974)). See also 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.”) (citing Geisinger Health Plan v. Comm’r, 985 F.2d 1210, 1215 (3d Cir. 1993)).
148. The cynical view of the quid pro quo would be that a benefiting organization would provide only the minimum amount required to receive the benefit.
who are able and expected to pay.\(^{149}\) The ensuing changes to the charity qualification requirements emaciated the quid pro quo model of charitable care for lower taxes.

One by one, major sources of charitable care were eliminated and undercut. First to go was the requirement that hospitals provide non-emergency charity care. The IRS determined that a private hospital which did not accept non-paying patients for regular admissions was granted charitable status because it provided open access to its emergency room to everyone, regardless of ability to pay, and provided medical training, education and research.\(^{150}\) Following this decision, "the provision of free or below cost service to those unable to pay [wa]s no longer essential."\(^{151}\)

The second source eliminated was emergency room charitable care. This was eliminated when the IRS determined that hospitals were not required to operate an open access emergency room to obtain charitable status, as long as there were other significant factors indicating the organization was operating for the public benefit.\(^{152}\) However, organizations without an emergency room must still meet the community benefit test.\(^{153}\) Although this determination is logical when applied to specialty hospitals\(^{154}\) or those with duplicative emergency rooms such as the hospital in Revenue Ruling 83-157, it is not appropriate when applied to general hospitals that do not otherwise provide charity care. Because the other factors considered in Revenue Ruling 83-157 did not include provision of free medical care to those in need,\(^{155}\) this action by the IRS eliminated what was left of the funded mandate to provide charity care.

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150. Rev. Rul. 69-545, 1969-2 C.B. 117 (This revision was based on a hospital that, although not open to the public for regular admissions, did operate an emergency room open to all persons regardless of their ability to pay, as well as financed medical training, education and research. Based on the emergency room access and the additional factors, the IRS found that the hospital was "promoting the health of a class of persons ... broad enough to benefit the community.").
153. Id.
154. Such as those specializing in certain conditions, e.g. "eye hospitals and cancer hospitals." Id.
155. Id.

Other significant factors, however, including a board of directors drawn from the community, an open medical staff policy, treatment of persons
Following these rulings, non-profit health care organizations were not required to provide either emergency or non-emergency charity health care. Instead, non-profit health care organizations can obtain charity status yet never provide charity care to patients in need, by providing health education, health screening services, clinic services, education for physicians, nurses, and other health professionals, financial contributions to community organizations, coordination of community events, or hospital infrastructure improvements.\textsuperscript{156}

\textit{Minimum Requirements for Charity Care}

Requiring minimum charity care in exchange for charity status would not only narrow the gap between the cost of providing the federal tax exemption and the value of the charity care received, but would also improve the IRS' ability to regulate non-profit health care organizations and distinguish true charities and hospitals from those masquerading as such.

Some for-profit health organizations provide more charitable services than similar non-profit health organizations in the same metropolitan area.\textsuperscript{157} Yet those non-profits are able to maintain their tax exempt status despite the minimal charity care provided, even when the value of the tax-exemption far exceeds the benefits returned to the community.\textsuperscript{158}

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\textsuperscript{157} See, e.g., Editorial, No Poor? No Problem, St. Louis Post-Dispatch, Dec. 12, 2004 at B2 (comparing charity care provided by two St. Louis area hospitals. The for-profit hospital, run by Tenet HealthSystems, provided $5.9 million of charity care during 2001, "2.36 percent of its operating revenue." This hospital paid $13.1 million in sales, property and income taxes for the same year, or "2.5% of its operating revenues." The non-profit health care organization provided only "$476,000 in charity care – just 22/100ths of 1 percent of its operating revenue," yet because of its tax-exempt status did not pay sales, property or income taxes. If it were not exempt, it "would have faced a $5.4 million tax bill.")
\textsuperscript{158} Id. (Non-profit hospital received $5.4 million in tax exemption benefits in 2001, yet provided only $476,000 in charity care that same year. By contrast, a for-
As discussed above, health care organizations can currently meet the community benefit test without providing any charity care. However, because the factors of the community benefit test could be met by many hospitals, the IRS has difficulty distinguishing between real non-profit health care organizations and imposters. Although the organizational test will prevent the extension of the exemption to private hospitals, without requiring minimum amounts of charity care, imposter non-profits will continue to inappropriately claim the tax exemption.

Imposing minimum charity care standards will increase access to medical care for patients without insurance or with inadequate insurance and the actual provision of medical care to those in need, as difficulties paying for previous health care can dissuade patients from seeking additional health care.\textsuperscript{159}

\textit{Categorization and Calculation of Uncompensated Care}

\textit{Increased Guidance on Compensation}

The current guidance provided to non-profit health care organizations on qualifying patients for charity care is insufficient. Neither Congress nor the IRS have provided adequate guidance for determining a “patient’s qualifications for charity care.”\textsuperscript{160} Because “many hospitals frequently write off bad debt as charity care,”\textsuperscript{161} considering the hospital’s or tax collector’s point of view, there is little difference between charity care and bad debt as both are uncompensated care.

\begin{itemize}
\item profit hospital in the same metropolitan area paid $13 million in taxes and provided $5.9 million in charity care).
\item 159. Doty et al., \textit{supra} note 105, at 5-6 (“Sixty-three percent of adults with any medical bill or debt problem went without needed care in the past 12 months because of cost, compared with 19 percent of adults without such problems.”). \textit{See also id.} at 6 (“[T]he link between medical bills, debt, and access problems may reflect a more hostile reception of patients with outstanding bills, or fears among patients that their medical bills and debt will prevent them from receiving subsequent care.”).
\item 160. PRICEWATERHOUSECOOPERS’ HEALTH RESEARCH INSTITUTE, \textit{supra} note 37, at 2. \textit{See also id.} at 15 (“60% of hospitals include in their [charity care] policy a provision for eligibility based on medical indigence or catastrophic care costs. Catastrophic care provisions limit a patient’s financial liability, typically to a percent of their annual income.”).
\end{itemize}
Additional guidance on categorization will allow better enforcement of the minimum charity care requirements recommended in this paper. The current lack of guidance forces hospitals to estimate the amount of charity care provided, and that amount is difficult to measure.\(^{162}\)

Additional guidance should also decrease bad debt\(^{163}\) and the resulting collection efforts,\(^{164}\) as well as prevent some of the bankruptcies that result from medical debt.\(^{165}\) Although a recent study indicated that hospitals are burdened with increasing amounts of charity care and bad debt, much of the bad debt might actually be charity care that was not characterized or categorized appropriately.\(^{166}\)

\(^{162}\). PriceWaterhouseCoopers' Health Research Institute, supra note 37, at 2 (The exact value of care is unknown, as hospitals calculate the amount provided either on charges or costs, or a mixture of both. Also, charity care is often mixed with bad debt and is therefore likely to be underestimated.), and id. at 9 (“Hospitals can calculate charity care using a variety of methods including[] costs, charges, unit of service statistics or a combination. . . .” This “makes it difficult to calculate the true cost of charity [and] . . . the numbers are often approximations. . . .”).

\(^{163}\). Id. at 9

Traditionally, accounting for charity care and bad debt has been based on expectations. If there is no expectation of collecting payment from a patient because they have no ability to pay then the healthcare services are classified as charity care. However, if the hospital does not qualify a patient for charity care and has an expectation of payment, then any non-payment results in a bad debt classification.

\(^{164}\). Hospitals Charge Uninsured Ohio Residents More for Health Services, Study Finds, Kaiser Daily Health Policy Report, March 10, 2005, http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=28588 (noting that hospitals use “aggressive collection practices that include garnishing [patients’] wages, placing liens on their homes and driving them into bankruptcy.”). See also Bilimoria, supra note 127, at 135.

\(^{165}\). The pursuit of payment by those unable to pay can have a severe financial impact on those patients, as “[m]edical debt is a leading cause of bankruptcies.” Unland, supra note 122, at 3 n.8. See also Doty et al., supra note 105, at 1 (“High out-of-pocket expenses are contributing to the rise of medical debt, which now accounts for as much as 40 to 50 percent of personal bankruptcies.”).

\(^{166}\). PriceWaterhouseCoopers' Health Research Institute, supra note 37, at 5, 9. See also id. at 2

The true value of the charity care provided by hospitals may be more than what's being reported. The burdensome and expensive process that hospitals must go through to classify a patient as charity care often means the amount of charity care blurs with bad debt. As a result, charity care numbers may be underestimated because 92% of hospitals surveyed said that at least part of their bad debt could be classified as charity care.
Since the average amount obtained through collection efforts is "only seven cents on the dollar," non-profit health care organizations will recognize financial benefits to qualify these patients for charity instead.

Finally, additional categorization guidance will increase the information available to patients about what hospitals require to qualify the patient for charity care. Because the charity care provided is likely "underestimated due to the difficulty in qualifying patients..." hospitals should increase their efforts to inform patients about the possibility of qualifying for charity care in order to attain the appropriate level of charity care, and may even assist patients in completing the paperwork.

**Calculation of Value of Charity Care Provided**

There is insufficient guidance available to hospitals on how to calculate the value of charity care provided, and thus hospitals over- or under-estimate the provided amount of charitable care. Additional guidance on calculating charity care will result in better enforcement of the minimum charity care requirements recommended in this paper, as hospitals will be able to better track the costs and no longer need to estimate the value of care provided.

**COMMENT**

This paper advocates that non-profit health care organizations be required to provide a minimum amount of charity care to patients in need. Additionally, standards for determining what qualifies as charity

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168. PRICEWATERHOUSECOOPERS’ HEALTH RESEARCH INSTITUTE, *supra* note 37, at 23

Most hospitals have complex and cumbersome paperwork that must be filled out prior to qualification for financial assistance. In addition, patients must supply a wide range of supporting documentation that could include pay check stubs, tax returns, notarized letters from employers, bank account information, and other asset verification information. This process can intimidate and in some cases deter eligible patients from applying for charity care.

169. *Id.* at 10. *See also* *id.* at 2 ("[H]ospitals provide an average of 5% of net operating income in charity care, though some provided a substantially higher amount." Additionally, "hospital industry bad debt as a percentage of net revenue increased from 7.6% in 1999 to 9.9% in 2003.")

170. *Id.* at 23 ("[S]ome hospitals have documentation compliance rates that hover around 50%, meaning that many people who may qualify for discounts aren't getting them because they can't or won't complete the paperwork.")
care and how it is to be quantified must be created and enforced by the IRS. Additional guidance must be provided to hospitals on qualifying patients for charity care, and all non-profit health care organizations should be encouraged to create internal policies for determining patient eligibility for charitable or reduced rate health care.\textsuperscript{171}

These changes will enable regulators to ascertain the amount of charity care provided by a non-profit health care organization. Ultimately, these changes will allow the question of whether health care for uninsured or inadequately insured patients is available at non-profit health care organizations to finally be answered and, if found lacking, to be remedied.

**Quid Pro Quo**

Unfunded mandates imposed on private entities are not favored. However, using the quid pro quo\textsuperscript{172} between the non-profit health care organizations and the tax collector to provide increased charity care would be a funded mandate, as the non-profit health care organization is provided with valuable federal tax benefits upon satisfying the requirements.

**Minimum Charity Care Requirements**

Non-profit health care organizations must be required to provide a minimum amount of charity care. This requirement will improve the IRS' ability to enforce the provisions of the tax exemption and to identify those organizations receiving the tax exemption that are not charitable organizations. Although the organizational test will prevent the extension of the exemption to private hospitals, without requiring

\textsuperscript{171} See, e.g., supra note 164 (noting internal policies developed by the Mayo Clinic); Betbeze, supra note 129 (describing plans of the Alliance of Catholic Health Care, Sutter Health, and Alegent Health).

\textsuperscript{172} Utah County v. Intermountain Health Care, Inc., 709 P.2d 265, 278 (Utah 1985) ("The basis for the tax exemption is a quid pro quo: 'private charities perform functions that the state would be required to undertake and tax exemption is granted as a quid pro quo for the performance of these functions and services.'" (quoting EDITH L. FISCH, DORIS JONAS FREED & ESTHER R. SCHACTER, CHARITIES AND CHARITABLE FOUNDATIONS § 787, at 602 (1974))). See also 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.") (citing Geisinger Health Plan v. Comm'r, 985 F.2d 1210, 1215 (3d Cir. 1993)).
minimum amounts of charity care imposter non-profits will continue inappropriately to claim the tax exemption.

**Categorization and Calculation of Uncompensated Care**

More guidance must be provided to hospitals on how to account for the community benefits provided, and what qualifies as a community benefit. The IRS must promulgate clearer regulations and guidance regarding what qualifies as community benefit, and specifically how to quantify the charity care provided.

**Categorization of Charity Care Provided**

Currently, no nationwide guidelines exist for determining whether a patient should qualify for charity care. As a result, even though non-profit health care organizations receive federal tax benefits in exchange for providing benefits to patients in need, whether a particular patient in need receives these benefits will depend more on the location of the health care organization than on his need for financial assistance.

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173. PriceWaterhouseCoopers' Health Research Institute, supra note 37, at 18 (A “[s]ampling of state hospital association billing guidelines” found that both Louisiana and New Jersey hospital associations recommended that “[d]iscounts should be offered on a consistent method based on need.” California’s recommended assistance was for “[p]atients with incomes less than or equal to 300% of the FPL should be eligible to apply for financial assistance under each hospital’s charity care policy or discount payment policy.” New York recommended assistance for “[p]atients with incomes less than 200% of the FPL should be eligible for financial assistance [and] [h]ospitals may provide financial assistance to those earning more than or equal to 200% of the FPL.” Illinois recommended that “[p]atients with incomes between 100% and 200% of the FPL should be offered partial discounts.” Maryland advised hospitals to “adopt AHA billing and collection practices.” Minnesota recommended that “[p]atients with incomes less than 200% of the FPL [be] eligible for financial assistance [and] [h]ospitals may provide financial assistance to those who earn[] more than 200% of the FPL.” The hospital association in New Mexico, a state with one of the highest rates of uninsured persons in the nation, advises hospitals that “[d]iscounts should be offered for patients who need financial assistance. Absent any regulatory prohibition, such patients should not be charged more than the hospital would receive from government sponsored programs.” Pennsylvania’s recommendation is almost identical to that of New Mexico, except that the comparison can be to government sponsored programs or commercial payers. Oregon advises that “[f]inancial assistance should be available for families below 150% of the FPL [and a] sliding fee scale should be available when family income exceeds 150% of the FPL.”).
However, to allow for regional variations in the cost of living, the non-profit health care organizations themselves should create internal policies for determining patient eligibility for charitable or reduced rate health care. Following the lead of selected hospitals’ policies, non-profit health care organizations should identify a fixed percentage of the income for the metropolitan statistical area where the hospital is located, below which patients without private or public health insurance coverage would be eligible to receive charity care. Non-profit health care organizations should be similarly encouraged to provide discounted health care to patients who are either not eligible for the charitable health care described above or cannot afford adequate private health insurance.

Calculation of Value of Charity Care Provided

Hospitals are provided with insufficient guidance on how to calculate the value of charity care provided, and as a result the true amount of charity care provided by hospitals is unknown. Additional

174. Due to a higher cost of living in larger metropolitan areas and the attendant higher salaries, hospitals located therein might provide charitable care to patients with a higher multiple of the federal poverty level than those in rural, impoverished areas. See, e.g., Mayo Clinic to Offer Discounts to Uninsured Patients, supra note 171 (noting that the Mayo Clinic recently announced that it “will charge uninsured patients with annual household incomes of less than $125,000 the lowest prices offered to managed care plan members.”). Alliance of Catholic Health Care does not “accept payments from patients [below] 300 percent of the federal poverty level.” Betbeze, supra note 129. Additionally, Alliance will not charge more than what “the hospital would receive for the same service from Medicare or workers’ comp” to those patients earning more than 300 percent of the federal poverty level. Id. Another hospital group, Sutter Health, provides “charity care to patients earning less than 200 percent of the [federal poverty level] and sliding-scale discounts up to 400 percent [of the federal poverty level].” Id. And a Midwestern hospital, Alegent Health, has created a trust fund to “pay for health-related community projects aimed at ‘vulnerable populations’” Id. In addition to “$14 million in initial funding,” the hospital donates 10 percent of their annual cash flow, expected to be “between $5 and $7 million annually.” Id. Alegent also offers discounts to patients “earn[ing] up to 400 percent of the federal poverty level,” and via a “catastrophic clause,” discounts bills which are more than 20 percent of a family’s income. Id.

175. Id.

176. Tax-Exempt Hospital Sector, supra note 2, at 6 (statement of Rep. Fortney Pete Stark). See also PriceWaterhouseCoopers’ Health Research Institute, supra note 37, at 9-10 (finding that there is little consensus within the industry on how to determine the amount of charity care provided, specifically whether the amount
guidance on calculating charity care will result in better enforcement of the minimum charity care requirements recommended in this paper, as hospitals will be able to track the costs and will no longer need to estimate the value of care provided. Any attempt to impose minimum charity care requirements that does not specify how the value of the charity care is to be calculated is incomplete. Without guidelines, hospitals will be allowed to choose how to calculate the value. This will result in some hospitals overstating the value, basing the amount on the list price rather than the actual cost of care given, while other hospitals may select a more conservative amount based on the average amount charged to insurance or to Medicare. In the long run, this will allow one hospital to access greater tax benefits than the other, even if both were to provide identical charitable care.

Should the Exemption Be Eliminated?

The current state of charity care provided by non-profit health care organizations have led some to call for the elimination of the tax exemption. However, the elimination of the exemption and related benefits would have widespread and catastrophic effects on the healthcare industry. The most significant effect would be immediate and extreme financial distress as these organizations scrambled to pay their new tax bills while facing the elimination of charitable contributions and the involuntary refinancing of bonds. This financial distress will drive some non-profit health care organizations into bankruptcy or otherwise out of business, and some non-profit health care organizations will switch to for-profit form rather than accept such changes. These changes would negatively impact the overall availability of health care, and make it especially scarce for those in need of charity care.

Elimination of the tax exemption would also sharpen the dynamics of health care coverage and access: uninsured patients will be relegated to non-profit health care organizations while those able to afford health care will be welcome at any hospital. However, this dichotomy of coverage and hospital choice already exists, and is getting worse each year.

The problems critics have identified with the tax exemption can be reduced through changes in the minimum charity care, and better guidance for the categorization of patients and calculation of care claimed as charity should be based on the Charge Description Master prices, i.e., list price, or the actual cost of the care given).

177. See generally Tax-Exempt Hospital Sector, supra note 2.
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provided. Therefore, the tax exemption should not be eliminated, as the negative effects of doing so would far outweigh the benefits obtained.

Likely Criticisms

The increased regulatory and accounting requirements might induce some non-profit health care organizations to switch to for-profit form rather than accept these changes. However, because hospitals typically have accounting programs in place to provide similar accounting for insurance companies and public insurance programs, the increased accounting burden resulting from this proposal is not expected to be significant. It is very unlikely that the cost of the increased accounting burden would exceed the additional tax benefits obtained. Additionally, the increased costs for paperwork associated with qualifying patients for charity care should be less than the benefits received from successfully qualifying those patients.

Similar to elimination of the tax exemption, the proposed changes would affect the dynamics of health care coverage and access. However, instead of uninsured patients being forced to the non-profit health care organizations via bad debt collection practices and high list price charges for medical care, uninsured patients will be encouraged to seek treatment from non-profit health care organizations. Although this proposal might exacerbate this dynamic in areas with several hospitals, overall it would allow non-profit health care organizations to better measure the community benefit they provide and in so doing allow patients to plan for the cost of the care that they will incur.

Conclusion

The recommended changes set out in this paper will allow non-profit health care organizations to better meet the main goal of the tax exemption: health care access to those in need. Requiring minimum amounts of charity care by non-profit health care associations furthers this goal directly. These changes will improve the IRS’ ability to enforce the Internal Revenue Code and associated regulations, and help the IRS identify imposter non-profits.

Additionally, without specific guidance on how to account for the community benefits provided, non-profit health organizations are left to their own interpretations on how to best achieve the requisite level of community benefit. This has resulted in uneven access to charitable services.

Through these changes, charitable donations can be directed towards organizations that support charity care, non-profit health care
organizations can ensure compliance with the Internal Revenue Code, and patients without insurance or with inadequate insurance will be able to obtain health care without the threat of financial ruin. Unless these changes are made, the question of whether charity health care is available at non-profit health care organizations will remain unanswered.