

**TURNING BACK THE CLOCK ON THE HEALTH CARE
ORGANIZATION STANDARD FOR FEDERAL TAX
EXEMPTION**

HOW RECENT IRS LITIGATION POSITIONS, FEDERAL COURT DECISIONS,
AND CONGRESSIONAL PROPOSALS HAVE ABANDONED THE
“COMMUNITY BENEFIT STANDARD” OF REVENUE RULING 69-545 AND
RETURNED TO A “CHARITY CARE” FOCUS AND WHAT THIS MEANS FOR
THE FUTURE OF THE HEALTH CARE ORGANIZATION EXEMPTION
STANDARD

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I. ABSTRACT

From 1969 to present day, the Internal Revenue Service (IRS) and federal courts have provided that the method for nonprofit health care organizations (including hospitals, HMOs, clinics, and other health organizations) to obtain and retain their tax-exempt status under §501(c)(3) of the Internal Revenue Code is through compliance with Revenue Ruling 69-545’s “Community Benefit Standard.” The “Community Benefit Standard,” which essentially requires that health care organizations “promote health” for a broad cross-section of the community, replaced a 1956 IRS ruling that required health care organizations to provide “charity care” (free or low cost health care for the indigent) up to the level of their financial ability in order to obtain tax-exempt status.

Despite the IRS’s shift from a “charity care” focus to a broader

“promotion of health” criterion in its 1969 ruling, by 1978, both IRS litigation positions and federal court rulings began to suggest that “charity care” was once again a requirement for health care organization federal tax-exemption. However, despite ironically ignoring its plain language (which does not include a “charity care” requirement) in practice, both the IRS and federal courts continue to assert that the Revenue Ruling 69-545 “Community Benefit Standard” is the current state of the law.

The consequence of the “charity care” requirement’s revival, despite the lack of a new ruling or legislation overruling the 1969 “Community Benefit Standard,” is that nonprofit health care organizations are left with very little guidance as to how to maintain valuable federal tax exemptions. Both the existing confusion about the IRS’s current requirements (namely, “charity care”) for health care organization federal tax-exempt status and the current lack of governmental guidance has left many nonprofit health care organizations nervous about potential loss of exemption.

The ambiguity surrounding the exemption standard has also drawn the interest of Congress and IRS officials in the last year. Senator Grassley and Representative Thomas, two influential congressmen, are currently investigating the possibility of enacting a federal nonprofit health care statute that would replace the 1969 ruling and provide guidance on issues such as “charity care.” Recently, during the summer of 2006, the IRS responded to Congressional pressure to fix the ambiguities of Revenue Ruling 69-545’s “Community Benefit Standard” by mailing a “Community Benefit Compliance Check” questionnaire to over 600 tax-exempt hospitals which, in large part, asks nonprofit hospitals to describe the “charity care” they provide. In addition to the questionnaire, in late July of 2006, the IRS agreed to provide Senator Grassley with a timeline for expediting its review and consideration of proposed changes to Revenue Ruling 69-545. Most recently, in a September 2006 Senate Finance Committee hearing, Grassley announced that a “Community Benefit” reporting system form is being drafted that will act as a supplemental report on nonprofit health organizations’ annual filing of Form 990 with the IRS.

While the future is uncertain, with the IRS and federal courts contradicting the IRS’s own established guidance and Congress considering a new health care exemption statute, all signs point to a forthcoming reform or repeal of Revenue Ruling 69-545’s “Community Benefit Standard.” This article offers what I believe to

be the first critical analysis of what IRS officials and members of Congress are currently proposing in terms of clarifying and or changing the health care organization tax exemption standard. This examination, which introduces and scrutinizes a few popular proposals for reforming the “Community Benefit Standard,” is intended to inform nonprofit health care organizations in a manner that may assist them in preemptively preparing for feasible changes in the exemption standard. Specifically, if the IRS, federal courts, and Congress continue to focus on the pre-1969 requirement of “charity care,” knowledge of current governmental proposals regarding mandated charity care levels may help nonprofit health care organizations to prepare both financially and structurally for such new obligations before they are enacted.

II. INTRODUCTION

In the last few years, the tax-exempt sector has seen an increase in scrutiny from both the Internal Revenue Service and Congress that has made many organizations, such as churches and nonprofit hospitals, nervous about losing valuable federal tax exemptions. Chief in this recent oversight has been the question of what nonprofit health care organizations must do to receive and retain tax exempt status under §501(c)(3) of the Internal Revenue Code. The tax exemption for nonprofit hospitals exempts more than \$500 billion in gross receipts annually from federal taxation.¹

In an October 24, 2005 Conference on the tax-exempt hospital sector, Senate Finance Committee Chairman, Charles Grassley (Republican-Iowa), explained that his own probe into the operations of nonprofit health care organizations was due to the need to ensure “the public [has] confidence that the significant tax breaks received by tax-exempt hospitals are balanced by community benefits.”² Although Congressional members such as Senator Grassley and Representative William Thomas (Republican-California and Chairman of the House Ways and Means Committee) continue to make nonprofit health care organizations nervous about possible

1. *Hearing on the Tax-Exempt Hospital Sector Before the H. Comm. on Ways and Means*, 109th Cong. (2005) (statement of Hon. Mark Everson, Commissioner, Internal Revenue Service), available at <http://waysandmeans.house.gov/Hearings.asp?congress=17> (last visited Sept. 7, 2006) [hereinafter *Hearing*].

2. Senator Charles Grassley, Chairman, Sen. Comm. on Finance, Remarks at 2005 Independent Sector Annual Conference, CEO Summit (Oct. 24, 2005), available at <http://finance.senate.gov/press/Gpress/2005/prg102405b.pdf> (last visited Sept. 7, 2006).

revocation of tax-exempt status, this sector is no stranger to uneasiness. Due to inconsistent guidance from the IRS subsequent to the pronouncement of the Revenue Ruling 69-545 “Community Benefit Standard” in 1969, the tax-exempt health care industry chronically questions how to meet the health care exemption standard.³ While the IRS continues to insist that Revenue Ruling 69-545 is the governing law for health care organization tax exemption, both IRS litigation positions and court decisions beginning in 1978 have directly contradicted the language of Revenue Ruling 69-545 and have appeared to return hospitals to the “charity care” standard that existed before 1969.⁴

III. “CHARITY CARE” UNDER THE 1956 “FINANCIAL ABILITY STANDARD” AND THE EVOLUTION OF THE “COMMUNITY BENEFIT STANDARD” OF REVENUE RULING 69-545

Prior to 1969, the clear path to tax-exemption for health care organizations was through providing “charity care” to the community of people the organization served.⁵ The governing standard was issued in Revenue Ruling 56-185, which mandated that a health care organization be “operated to the extent of its financial ability for those not able to pay for the services rendered.”⁶ This “financial ability standard” justified tax-exemption for health care organizations through reliance on the law of charitable trusts, which has long recognized “relief of the poor” as a charitable purpose.⁷ During this period, if a health care organization lacked a substantial charity care program commensurate with its financial ability to serve the indigent, it would lose its exemption upon audit by the IRS.⁸

The movement toward a new standard for exemption began in the 1960s due to hospital objections that the standard requiring “charity care” to the extent of “financial ability” was no longer relevant following the advent of the new Medicare and Medicaid legislation.⁹ In response, a young IRS attorney named Robert

3. See *id.*; see also *Hearing, supra* note 2 (advisory announcement of Sen. Bill Thomas, Chairman, H. Comm. on Ways and Means).

4. See Rev. Rul. 69-545, 1969-2 C.B. 117; see, e.g., *Geisinger Health Plan v. Comm’r*, 985 F.2d 1210 (3d Cir. 1993).

5. See Rev. Rul. 56-185, 1956-1 C.B. 202-03.

6. *Id.* at 203.

7. See *id.*; see also RESTATEMENT (SECOND) OF TRUSTS § 368(d) (1959).

8. See Rev. Rul. 56-185, at 204.

9. Douglas M. Mancino, *The Impact of Federal Tax Exemption Standards on Health*

Bromberg began drafting a new ruling based on the misguided notion that Medicare and Medicaid would lead hospitals to experience a substantial drop in demand for charity care.¹⁰ With twenty-twenty hindsight, the present day reality is that Medicare and Medicaid programs do not come close to meeting the massive need for health care services for indigent, poor, and elderly patients.¹¹ Bromberg's erroneous perception that "charity care" would become obsolete led to the 1969 issuance of Revenue Ruling 69-545.¹²

In contrast to the "charity care" standard of the 1956 ruling, Revenue Ruling 69-545, branded the "Community Benefit Standard," turned its focus to "promotion of health" for the benefit of the community.¹³ Similar to the "relief of the poor," the established law of charitable trusts also recognized the "promotion of health" as a charitable purpose.¹⁴ Under the explicit language of the "Community Benefit Standard" of Revenue Ruling 69-545, the IRS did not require a level of "charity care" so long as the hospital provided benefits to the community in other ways.¹⁵ The ruling provided an unexhausted list of other "community benefits" such as (a) having a governing board consisting of a broad cross-section of the community, (b) using surplus profits to improve facilities, training, and patient care, (c) acceptance of Medicare and Medicaid patients, (d) operating a full time emergency room open to all regardless of ability to pay, and (e) having an open medical staff policy.¹⁶ Under both the plain language of the ruling and recent IRS guidance, these potential factors are to be considered as a whole under a "facts and circumstances" test, meaning that failure to fulfill one factor "does not preclude exemption."¹⁷

Furthermore, the issuance of Revenue Ruling 83-157 in 1983 provided additional guidance in deciphering the "Community Benefit

Care Policy and Delivery, 15 HEALTH MATRIX 5, 7-8 (2005).

10. John D. Colombo, *The Role of Access in Charitable Tax Exemption*, 82 WASH. U. L.Q. 343, 348-349 (2004).

11. See John D. Colombo, *The Failure of Community Benefit*, 15 HEALTH MATRIX 29, 30-31 (2005).

12. See *id.*

13. See *id.* at 31.

14. Rev. Rul. 69-545, 1969-2 C.B. 118; see also *Hearing*, *supra* note 2 (statements of John Colombo, Professor, University of Illinois College of Law and The Hon. Mark Everson, Commissioner, Internal Revenue Service).

15. 1969-2 C.B. 118-19.

16. *Id.* at 118.

17. *Id.*

Standard.”¹⁸ Under the 1983 ruling, the IRS clarified that a health care organization could receive exempt status even if it did not operate an emergency room. The IRS recognized that medical care centers providing services such as eye care were able to promote health for a large percentage of the community, even without the operation of an emergency room. However, the ruling makes it clear that, in the case of a full service hospital, the operation of an emergency room is only unnecessary if it would duplicate emergency care facilities already made available by another hospital in the community.¹⁹

IV. AFTER NINE YEARS OF “COMMUNITY BENEFIT”: THE IRS AND COURTS BEGIN TO UNDERMINE REVENUE RULING 69-545

Despite insistence by the IRS in its 2004 Continuing Professional Education (CPE) text that Revenue Ruling 69-545’s “Community Benefit Standard” is the state of the law today, the IRS began to ignore it only nine years after Bromberg and the IRS issued the ruling.²⁰ A 1978 Tax Court case, *Sound Health Association v. Commissioner*, involving a staff model HMO, was the first such attack on the “Community Benefit Standard.”²¹ Despite the organization’s acceptance of all patients, operation of an open emergency room, and its community-based board, the IRS argued that because “preferential treatment will be accorded to . . . member-subscribers,” *Sound Health* violated §1.501(c)(3)-(1)(d)(1)(ii) of the Income Tax Regulations.²² These Regulations require that the “organization serve a public rather than a private interest in order to qualify under §501(c)(3).”²³

Although the IRS was ready to ignore Revenue Ruling 69-545, the plain language of which prescribes an exemption for merely “promoting health” for a large cross-section of the community, the courts did not abandon the “Community Benefit Standard” quite so

18. See Rev. Rul. 83-157, 183-2 C.B. 94-95.

19. *Id.*

20. See Janet E. Gitterman & Marvin Friedlander, *Health Care Provider and Reference Guide*, EXEMPT ORGANIZATIONS CONTINUING PROFESSIONAL EDUCATION (CPE) TECHNICAL INSTRUCTION PROGRAM FOR FISCAL YEAR 2004 10-15 (IRS 2004), available at <http://www.irs.gov/pub/irs-tege/eotopic04.pdf> (last visited Sept. 7, 2006).

21. *Sound Health Ass’n v. Comm’r*, 71 T.C. 158 (1978); see also Colombo, *supra* note 11, at 32.

22. *Sound Health*, 71 T.C. at 168.

23. *Id.* at 168.

quickly. The Tax Court highlighted the charitable class (membership) of Sound Health, noting it was vast and that there was “neither a closed staff, nor restricted emergency room, nor any insider benefit of the sort that would disqualify the association under section §501(c)(3).”²⁴ Despite Sound Health’s victory, this litigation marked the beginning of an IRS position suggesting that health care organizations need to do more than simply provide for free health care to a large portion of the community to maintain tax-exempt status.²⁵

While the IRS’s position in *Sound Health* increased the uncertainty about whether “promoting health” under Revenue Ruling 69-545’s “Community Benefit Standard” was sufficient for tax exemption, a Third Circuit Court of Appeals decision in 1993 marked the first time the federal courts would abandon the “Community Benefit Standard.”²⁶ In *Geisinger Health Plan v. Commissioner*, the taxpayer was an HMO, but unlike the staff model HMO entity in *Sound Health*, Geisinger operated under a contract model.²⁷ Under this contract model, Geisinger’s services were available to literally everyone in the community, but Geisinger did not directly employ doctors nor did it operate its own facilities for health care services.²⁸ The IRS argued to the Tax Court that the contract model served private rather than public interests by “primarily benefiting itself,” and also questioned Geisinger’s worthiness for tax exemption due to its almost complete lack of a “charity care” program.²⁹ In keeping with the plain language of Revenue Ruling 69-545, the Tax Court rejected the IRS’s arguments and upheld Geisinger’s tax-exempt status. In its reasoning, the Tax Court saw little difference between Geisinger and the HMO in *Sound Health*, as Geisinger’s charitable class was “practically unlimited,” serving over 70,000 individuals in the community.³⁰ Additionally, the Tax Court dismissed the IRS argument regarding Geisinger’s lack of a “charity care” program as Revenue Ruling 69-545 described no such requirement and only

24. *Id.* at 186-187.

25. *See* Colombo, *supra* note 11, at 32.

26. *See id.*; *see also* *Geisinger Health Plan v. Comm’r*, 985 F.2d 1210 (3d Cir. 1993).

27. *Geisinger Health Plan v. Comm’r*, 62 T.C.M. (CCH) 1656, 1658 (1991), *rev’d*, 985 F.2d 1210 (3d Cir. 1993).

28. *See id.* at 1658-59.

29. *See id.* at 1662.

30. *Id.* at 1663.

mandated “promoting health” for the benefit of the community.³¹

Nevertheless, the Third Circuit Court of Appeals adopted the IRS’s position and ultimately denied Geisinger §501(c)(3) status. The Third Circuit reasoned that Geisinger’s lack of charity care, undeveloped Medicaid program, and contract model structure benefited only “subscribers” and not “the community at large.”³² In its conclusion, the court went beyond the requirements of Revenue Ruling 69-545, as serving 70,000 individuals in the community undoubtedly constituted “promoting health” for a broad base of the community.³³ Furthermore, the court distinguished the decision in *Sound Health* on the basis of “charity care,” stating that Sound Health “most notably [provided] free or reduced-cost care to people who were not subscribers.”³⁴

If the IRS had not yet sufficiently worried the tax-exempt hospital sector in its litigation position in *Sound Health* and its new focus on “charity care” in its *Geisinger* victory, a Field Service Advice (FSA) memorandum issued in 2001 raised even larger questions about the viability of the “Community Benefit Standard.”³⁵ Due to the lack of a new ruling or other guidance by the IRS, FSA 200110030 shocked nonprofit health care organizations by suggesting that a “charity care” standard had returned to replace the “Community Benefit Standard.”³⁶ FSA 200110030, which was designed to assist IRS field officers in determining if specific health care organizations warranted exemption, provided that “a hospital’s stated policies to provide health care services to the indigent are not sufficient to satisfy the charity care requirement of the community benefit standard . . . unless the hospitals demonstrate that such policies actually result in the delivery of significant health care services to the indigent.”³⁷ In essence, the FSA proclaimed that the “charity care” requirement, which was the hallmark of the 1956 “financial ability” ruling, was now resurrected as a necessary element of the “Community Benefit

31. *Id.* at 1663.

32. *Geisinger*, 985 F.2d at 1219-20; *see also* Colombo, *supra* note 11, at 33-34.

33. *See* Colombo, *supra* note 11, at 33-34.

34. *Geisinger*, 985 F.2d. at 1220.

35. *See generally*, IRS, Field Service Advisory, FSA 200110030 (Feb. 5, 2001), available at <http://www.hortyspringer.com/data/Misc/IRSFieldServiceAdvice.pdf> (last visited Sept. 7, 2006).

36. James R. King & Travis L. Blais, *Nonprofit Billing Litigation Highlights Fundamentals of Section 501(c)(3)*, 17 TAX’N OF EXEMPTS 24, 26-27 (2005).

37. IRS, *supra* note 35, at 2; *see also* Mancino, *supra* note 9, at 19.

Standard,” despite no mention of “charity care” in Revenue Ruling 69-545.³⁸

Field Service Advice (FSA) is not legal precedent and is “not intended to be guidance in any way” for health care organizations, according to Sarah Ingram Hall, division counsel to IRS Tax Exempt and Governmental Agencies.³⁹ Nevertheless, the issuance of FSA 200110030 was significant for two reasons.⁴⁰ First, as the IRS has provided no new guidance on the health care organization standard for exemption since 1969, a 2001 FSA requiring a minimum level of “charity care” will likely be taken seriously by IRS field agents and hospitals alike. Second, despite the IRS’s contention in its 2002 Continuing Professional Education (CPE) text that charity care is a “significant factor, but only a factor” in the “Community Benefit Standard,” the irony exists that the IRS’s litigation position in 2002 and beyond has almost precisely followed the FSA’s “charity care” focus.⁴¹

In addition to the 2001 FSA’s diversion from the plain language of Revenue Ruling 69-545, both a 1998 Revenue Ruling and the IRS’s own guidance to its field agents in its 2002 Continuing Professional Education (CPE) text indicated that providing health care to a sizable portion of the community would not, by itself, qualify a hospital for exemption under §501(c)(3).⁴² The 1998 ruling, Revenue Ruling 98-15, which dealt primarily with joint ventures between nonprofit hospitals and for-profit health care organizations, unequivocally provided that something *in addition* to providing health care to the community was needed for nonprofit status.⁴³ While the ruling did not explicitly provide “charity care” to be the additional component necessary for exemption, the only example cited in the ruling as a hospital that should not receive exempt status highlighted the fact that the hospital in question did not have a “charity care” program.⁴⁴ Furthermore, the 2002 FSA provides only two examples

38. See Mancino, *supra* note 10, at 19.

39. See King & Blais, *supra* note 36, at 27.

40. See *id.*

41. See *id.*

42. See Rev. Rul. 98-15, 1998-1 C.B. 718, 719; see also LAWRENCE M. BRAUER ET. AL., UPDATE ON HEALTH CARE, IN EXEMPT ORGANIZATIONS CONTINUING PROFESSIONAL EDUCATION (CPE) TECHNICAL INSTRUCTION PROGRAM FOR FISCAL YEAR 2002, 173-74 (IRS 2002). For further discussion, see Colombo, *supra* note 11, at 34-35.

43. Rev. Rul. 98-15, 1998-1 C.B. 718, 719.

44. See *id.*

of hospitals that would qualify for tax exemption, both having significant charity care programs (one such example includes free medical screening for low income individuals).⁴⁵

V. THE “PLUS” STANDARD AND A RETURN TO REVENUE RULING 56-185: *IHC HEALTH PLANS, ST. DAVID’S*, AND THE DEATH OF THE “COMMUNITY BENEFIT STANDARD”

While the IRS had been pushing nonprofit health care organizations to provide more than required under Revenue Ruling 69-545’s “health care for the benefit of the community” standard since 1978, the “Community Benefit Standard” took its final breath after two 2003 federal court cases. In *IHC Health Plans v. Commissioner*, three subsidiary HMOs brought separate actions in the United States Tax Court contesting the denials of tax-exempt status by the IRS.⁴⁶ The Tax Court upheld their adverse determination letters⁴⁷ and the three IHC subsidiaries jointly appealed the decisions to the Tenth Circuit Court of Appeals.⁴⁸ This marked the first time the Tax Court agreed with the IRS’s position regarding the need for something more (like “charity care”) rather than simply providing health care to a broad cross-section of the Community.⁴⁹ Subsequently, the court held that providing health services to a substantial part of the community was insufficient to warrant exemption without also having a “subsidized premiums program, conduct[ing] research, or offer[ing] free education programs to the public.”⁵⁰

However, the Tax Court’s primary justification for the denials was the HMOs’ lack of “charity care” programs. Tax Court reasoned: [D]espite petitioner’s open enrollment policy and wide acceptance of its plans by individuals and groups alike . . . petitioner did not offer free medical care to the needy. Additionally, petitioner did not institute any program whereby individuals were permitted to

45. See BRAUER, *supra* note 42, at 173-74.

46. 82 T.C.M. 593 (2001).

47. *IHC Care v. Comm’r*, 82 T.C.M. 617 (2001); *IHC Group, Inc. v. Comm’r*, 82 T.C.M. 606 (2001); *IHC Health Plans, Inc. v. Comm’r*, 82 T.C.M. 593 (2001).

48. *IHC Health Plans, Inc. v. Comm’r*, 325 F.3d 1188 (10th Cir. 2003).

49. See *IHC Care v. Comm’r*, 82 T.C.M. 617 (2001); see also *IHC Group, Inc. v. Comm’r*, 82 T.C.M. 606 (2001); see also *IHC Health Plans, Inc. v. Comm’r*, 82 T.C.M. 593 (2001).

50. See Mancino, *supra* note 9, at 18 (quoting *IHC Group, Inc. v. Comm’r*, 82 T.C.M. 606, 615 (2001)).

become members while paying reduced premiums, and aside from the few health screenings that petitioner conducted in 1999, petitioner did not provide or arrange to provide any free or low cost health care services.⁵¹

The Tax Court was far less interested in the other contributions the hospitals made to their communities, noting that “the record does not reflect whether petitioner applied surplus funds to improve facilities, equipment, patient care, or to enhance medical training, education, and research.”⁵²

On consolidated appeal, the Tenth Circuit affirmed the Tax Court’s holding, denying tax-exempt status for the three IHC subsidiaries.⁵³ Instead of simply stating that the “Community Benefit Standard” of Revenue Ruling 69-545 was not met, the Tenth Circuit announced a rule that required an additional “plus” to the “promotion of health for benefit of the community” under Revenue Ruling 69-545.⁵⁴ In particular, the court held that in order to earn exempt status, a “health care provider must make its services available to all in the community plus provide additional community or public benefits.”⁵⁵

While this new standard appeared to supersede the “promotion of health” concept of Revenue Rulings 69-545 and 83-157, the Tenth Circuit nevertheless contended that those rulings were still the applicable law and that the court was applying the same standard for hospital tax exemption employed since 1969. In interpreting the rulings, the court concluded that “the IRS rulings in 69-545 and 83-157 demonstrate that an organization cannot satisfy the community-benefit requirement based solely on the fact that it offers health-care services to all in the community in exchange for a fee.”⁵⁶ Without citing any direct language from either Revenue Ruling, the court required that the “organization provide some additional ‘plus.’”⁵⁷ It reasoned that “although providing health care products or services is necessary under those rulings, it is insufficient, standing alone, to qualify for tax exemption under §501(c)(3).”⁵⁸

51. IHC Health Plans, Inc. v. Comm’r, 82 T.C.M. 593, 605 (2001).

52. *Id.*

53. *See* IHC Health Plans, Inc. v. Comm’r, 325 F.3d 1188 (10th Cir. 2003).

54. *Id.* at 1198.

55. *See* Mancino, *supra* note 9, at 18 (quoting *Health Plans, Inc.*, 325 F.3d at 1198).

56. IHC Health Plans, Inc. v. Comm’r, 325 F.3d 1188, 1197 (10th Cir. 2003); *see also* Colombo, *supra* note 11, at 37.

57. IHC Health Plans, Inc. v. Comm’r, 325 F.3d 1188, 1197 (10th Cir. 2003).

58. *Id.*

Consistent with the IRS's push for a "charity care" requirement, the Tenth Circuit went so far as to cite Revenue Ruling 56-185 (the 1956 "financial ability" charity care ruling) in labeling provisions for "free or below-cost services" as the quintessential "plus."⁵⁹ Nevertheless, the Tenth Circuit's opinion in *IHC Health Plans* confusingly states that such "positive externalities" as providing an open emergency room for all and "devoting surpluses to research, education, and medical training" may suffice in warranting health care organization tax exemption even in the absence of a substantial "charity care" program.⁶⁰ Finally, if the Tenth Circuit's "health care plus" standard did not completely turn back the clock to a true "charity care" standard due to the possibility that "pluses" other than "charity care" may warrant exemption, the IRS's litigation position in a contemporaneous district court case indicated that the government was still intent on re-adopting the "financial ability standard" of Revenue Ruling 56-185.⁶¹

In the 2002 case, *St. David's Health Care System v. United States*, a whole hospital joint venture (partnership between a tax-exempt hospital and a for-profit health care organization) brought an action in federal district court to demand a refund of income taxes paid after the revocation of its tax exempt status by the Internal Revenue Service.⁶² While the case centered on the issue of the tax-exempt partner's level of control over the governing board of the whole hospital joint venture,⁶³ the IRS nonetheless took a litigation position that demanded even more than the holding in *IHC Health Plans* on the issue of "charity care." In its motion for summary judgment, the government specifically relied on the "financial ability" standard of Revenue Ruling 56-185 in suggesting that compliance with the "Community Benefit Standard" of Revenue Ruling 69-545 is insufficient for tax-exemption under § 501(c)(3).⁶⁴ Specifically, the IRS argued that "the promotion of health is not per se charitable" and that under Revenue Ruling 56-185, an exempt hospital must 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

59. *See id.* at 1197-98.

60. *See id.*

61. *See St. David's Health Care Sys. v. United States*, 2002 WL 1335230 (W.D.Tex. June 7, 2002), *vacated and remanded*, 249 F.3d 232 (5th Cir. 2003).

62. *Id.* at *1.

63. *See id.*

64. *See id.* at *3.

and expected to pay and must not . . . refuse to accept patients in need of hospital care who cannot afford such services.”⁶⁵

The government’s argument regarding the present applicability of Revenue Ruling 56-185’s “financial ability standard” was not adopted by the district court.⁶⁶ In fact, the district court identified the complete lack of any charity care reference in Revenue Ruling 69-545’s “Community Benefit Standard,” stating that “[Revenue Ruling 69-545] does go on to say that more is required to be tax-exempt under [Section] 501(c)(3), but the promotion of health is clearly a charitable purpose.”⁶⁷ In addition, the court rejected the possibility that Revenue Ruling 69-545 failed to overrule the application of Revenue Ruling 56-185, reasoning that “the government also overlooks the final paragraph of 69-545, which expressly removes the requirement of giving care to patients without charge or at rates below cost.”⁶⁸ The Court continued to invalidate the applicability of the “financial ability standard” by stating that “the government relies on this requirement as stated in Revenue Ruling 56-185, but this paragraph in 69-545 even cites that prior ruling when removing that requirement.”⁶⁹ While *St. David’s* summary judgment motion was granted by the district court, the Fifth Circuit remanded the issue of the tax-exemption revocation upon appeal.⁷⁰ However, the Fifth Circuit largely ignored the issue of charity care—stating Revenue Ruling 69-545 as not “directly on point”—and concluding only that there existed a “material issue of fact” with respect to whether the non-profit hospital’s ceding of control to its for-profit partner warranted revocation of exemption.⁷¹ Nevertheless, despite the district court’s rejection (and the Fifth Circuit’s lack of commentary) concerning a return to a “financial ability” charity care standard, the *St. David’s* series of cases clearly indicate that the IRS is not satisfied with the more strict “health care plus” application of the “Community Benefit Standard” adopted in *IHC Health Plans*.

By the end of 2003, the one-two punch of *IHC Health Plans* and the IRS’s position in the *St. David’s* cases caused nonprofit health care organizations to question whether the “Community Benefit

65. *Id.*

66. *See id.* at *4.

67. *Id.* at *3.

68. *Id.* at *4.

69. *Id.*

70. *See St. David’s Health Sys. v. United States*, 349 F.3d 232, 239 (2003).

71. *See id.*

Standard” of Revenue Ruling 69-545 would continue to provide any useful guidance.

VI. THE 2004 CPE TEXT: THE IRS ATTEMPTS TO CLARIFY ISSUES OF “CHARITY CARE” AND THE VIABILITY OF THE “COMMUNITY BENEFIT STANDARD”

Other than making statements at Congressional hearings and mailing “Community Benefit Compliance Check” questionnaires to nonprofit hospitals in May 2006, the IRS published its most recent guidance on the health care organization standard for tax-exemption in its 2004 Exempt Organizations Continuing Professional Education text.⁷² In contrast to the strong positions the IRS took with *IHC Health Plans* and *St. David’s* regarding the “health care plus” standard and the necessity of “charity care,” it nevertheless continued—ironically—to identify the “Community Benefit Standard” as the applicable law for health care organization exemption in 2004.⁷³ Specifically, the IRS instructed its officers that “to qualify as a health care provider that promotes health as its charitable purpose, the organization must meet the community benefit standard described in Rev. Rul. 69-545 . . . as well as the other requirements of IRC §501(c)(3) and its regulations.”⁷⁴

Furthermore, the IRS contradicted its position in *St. David’s* and denied the existence of a “charity care” requirement for health care organization tax exemption. Instead, it instructed that while “a formal policy to provide charity care is still relevant, the new standard [meaning Revenue Ruling 69-545] also takes into account a number of additional factors indicating that the operation of the hospital benefits the community as a whole.”⁷⁵ Some of the “additional factors” the IRS referred to, which are also listed in Revenue Ruling 69-545, include a community represented board, an open medical staff, a full-time emergency room available regardless of ability to pay, Medicare and Medicaid programs, and medical research for the benefit of the community.⁷⁶

Despite the recent nature of the IRS’s direction in the 2004 EO CPE Text, a substantial inconsistency continues to exist between the

72. See Gitterman & Friedlander, *supra* note 20.

73. *Id.* at 10-15.

74. *Id.* at 2.

75. *Id.* at 9.

76. *Id.* at 10; *see also* 1969-2 C.B. 117-119.

position that the IRS is taking in federal court and the guidance it provides in the CPE. The CPE states that the “Community Benefit Standard” is the present applicable standard, but notes that “a formal policy to provide charity care is still relevant.”⁷⁷ It adds that Revenue Ruling 69-545 “modified” the “financial ability standard” by introducing additional considerations.⁷⁸ In other words, the CPE does not state that the “plus” required under *IHC Health Plans* is necessary for health care organization tax-exemption and it certainly does not follow the IRS’s litigation position in *St. David’s*, where the IRS unsuccessfully argued to revive the application of the “financial ability standard” of Revenue Ruling 56-185.

As a result of this disconnect between the IRS’s litigation positions and its CPE guidance, nonprofit hospitals would be unwise to take much comfort in simply adhering to the 2004 CPE requirements. Due to victories in *IHC Health Plans* and *St. David’s*, it is a reasonable inference that the IRS will continue to push for more “charity care” as long as it keeps prevailing on the issue. Further, the confusion as to what exemption standard and what level (if any) of “charity care” is necessary for tax-exemption is only the tip of the iceberg. At present, two influential Congressmen are investigating nonprofit health care organizations in an effort to determine if the tax-exempt health care sector is “earning” its federal exemption under current law.⁷⁹

VII. THE “COMMUNITY BENEFIT” DEBATE IN CONGRESS: QUESTIONS OF “CHARITY CARE,” EARNING HEALTH CARE TAX EXEMPTION, AND REFORMATION OF THE “COMMUNITY BENEFIT STANDARD”

Thomas Edison once said that “restlessness and discontent are the first necessities of progress.”⁸⁰ If Edison was correct, the uneasiness and confusion experienced by the tax-exempt health care sector due to mixed signals from the IRS and federal courts will serve as necessary preludes to the eventual clarification and reform of its

77. See Gitterman & Friedlander, *supra* note 20, at 9.

78. *Id.*

79. Press Release, U.S. Senate Committee on Finance, Grassley Asks Non-Profit Hospitals to Account for Activities Related to Their Tax-Exempt Status (May 25, 2005), available at <http://finance.senate.gov/press/Gpress/2005/prg052505.pdf> [hereinafter *Press Release*]; see Robert Pear, *Nonprofit Hospitals Face Scrutiny Over Practices*, N. Y. TIMES, Mar. 19, 2006, § 1, at 118.

80. Thomas Edison, <http://www.democracy.ru/english/quotes.php> (last visited Sept. 7, 2006).

standard for tax exemption. Following a 12 month period in which an unprecedented number of hospitals lost state tax-exemption under new state “charity care” statutes (such as two Illinois hospitals),⁸¹ Congress is now questioning which nonprofit hospitals deserve *federal* tax-exempt status.⁸²

Beginning in May of 2005, both the Senate Finance Committee and the House Ways and Means Committee actively began to debate whether or not nonprofit health care organizations should be afforded tax exemptions and whether these organizations were meeting applicable standards under the law. The two major players in this investigation continue to be House Ways and Means Chairman, Representative William Thomas, and Senate Finance Committee Chairman, Senator Charles Grassley.⁸³ On May 26, 2005, Thomas convened a hearing on the “tax exempt hospital sector” before the Ways and Means Committee.⁸⁴ In contrast to the unhelpfulness of the 2004 EO CPE (which at the time was the most recent guidance provided by the IRS on the health care standard for exemption), the testimony provided at the hearing may be a strong indication of what nonprofit hospitals will be required to do to retain their valuable federal exemption.

Whether Congress is preparing to legislate a new exemption rule to replace the ignored “Community Benefit Standard” or simply pressuring the IRS to draft a new ruling with useful guidance for health care organizations, Thomas’s hearing is a valuable reference for foreshadowing the future of the exemption standard. Thomas asked a list of witnesses (including executives from major nonprofit health systems, legal experts in the area of tax-exempt health care organizations, and the Commissioner of the Internal Revenue Service) the broad question: “What is the taxpayer getting in return for tens of billions of dollars per year in tax subsidy?”⁸⁵ Thomas followed this question by asking the panel the two questions every nonprofit health care organization wants the answers to, namely: “What does the current standard require of hospitals?” and “Is there adequate

81. See Lucette Lagnado, *A Nonprofit Hospital Fights To Win Back Charitable Halo*, WALL ST. J. ONLINE, June 24, 2004, available at <http://online.wsj.com/article/SB108845342848449424.html>.

82. See Pear, *supra* note 79.

83. *Id.*

84. See generally *Hearing*, *supra* note 1.

85. *Hearing*, *supra* note 1.

oversight of the so-called community benefit standard?”⁸⁶ Finally, Thomas narrowed his interest to “how we define charitable care,” and stated his overall goal as making sure “that the taxpayers are given at least some commensurate relationship or benefit for the tax exemption amounts.”⁸⁷

A. IRS Commissioner Testifies at Ways and Means Hearing: Admits Weakness in the “Community Benefit Standard” and Invites Congress to Legislate

Undoubtedly, the most important witness to respond to Thomas’s questions at the hearing was IRS Commissioner, Mark Everson. Everson shed light on the IRS’s position on the health care organization exemption standard for the first time since the 2004 EO CPE text.⁸⁸ In responding to a 2002 study suggesting that for-profit hospitals provide uncompensated care at an average rate of 4.5% of their budget, compared to 4.4% by nonprofit hospitals, Everson agreed that it is “increasingly difficult to differentiate for-profit from not-for-profit health care providers.”⁸⁹ Furthermore, consistent with the IRS’s guidance in the 2004 EO CPE, Everson assured the committee that Revenue Ruling 69-545’s “Community Benefit Standard” was still the applicable law.⁹⁰

Nevertheless, Everson’s testimony strongly suggested that even the IRS may soon be ready to abandon the “Community Benefit Standard” for a rule that can more convincingly distinguish for-profit health organizations from nonprofits. Specifically, he argued that the Revenue Ruling 69-545’s “factors” are now “less relevant in distinguishing tax-exempt hospitals from their for-profit counterparts” as both nonprofit and for-profit hospitals now commonly “have an open medical staff, participat[e] in Medicare and Medicaid, and treat all emergency patients without regard to ability to pay.”⁹¹ Everson explained that “more and more, the IRS looks to the independent board exercising its fiduciary duty to operate for the benefit of the community to differentiate the tax-exempt hospital from

86. *Id.*

87. *Id.*

88. *See generally id.*

89. *Id.*

90. *Id.*

91. *Id.*

a for-profit operation.”⁹² Everson suggested that non-profits should adopt a conflict of interest policy to ensure board members and officers do not receive an improper benefit.⁹³ This fiduciary duty includes the responsibilities of nonprofit board members to both assess the specific needs of the community being served and to enact policies that address these needs as part of the health care organization’s charitable purpose.⁹⁴

Despite Commissioner Everson’s candid responses regarding how tax-exempt health care organizations can differentiate themselves from their for-profit counterparts, serious doubts remain regarding the true standard for health care tax exemption in light of the positions taken by the IRS in *IHC Health Plans* and *St. David’s*. Are nonprofit health care organizations really to believe that having an independent board of directors and adopting a conflict of interest policy will protect them from exemption revocation when they lack a substantial charity care program? The answer is that simply following the guidance in Everson’s testimony seems ill-advised based on the recent IRS victory regarding the necessity of meeting a “health care plus” standard in *IHC Health Plans* and the IRS’s demand for a significant level of “charity care” in the *St. David’s* case. In fact, even Everson identified serious weaknesses in the “Community Benefit Standard,” suggesting that “flexibility in approach may be exactly what is needed” as a result of the “constantly changing health care market.”⁹⁵

In addition, Everson offered to pass the buck by inviting Congress to enact a new law concerning health care tax-exemption, stating: “[G]o ahead, we will implement whatever you put in there.”⁹⁶ He went so far as to offer suggestions for reform, such as implementing “better intermediary sanctions . . . so that you don’t just have a *de minimis* penalty or that very strong option.”⁹⁷ However, at the conclusion of his testimony concerning the limited utility of current IRS rulings for health care organizations, Everson paradoxically held to the same line the IRS has been following for the

92. *Id.*

93. *Id.*

94. James R. King & Keith W. Hearle, *Documenting the Quid Pro Quo of Community Benefit*, 17 TAX’N OF EXEMPTS 29, 35 (July/August, 2006).

95. *Hearing, supra* note 1 (statement of The Honorable Mark Everson, Commissioner, Internal Revenue Service).

96. *Hearing, supra* note 1.

97. *Id.*

last 28 years, rejecting the opinion that the exemption standard has changed or that “writing another bright-line rule into the law” is the answer.⁹⁸ Consistent with the 2004 CPE guidance, he refused to condemn the utility of Revenue Ruling 69-545, stating: “[T]his is not to say that the IRS believes the community benefit standard should be modified, but simply that many years have passed since 1969.”⁹⁹

B. Senator Grassley’s Nonprofit Health Care Legislation Movement: Investigating Whether Health Care Organizations are Earning Their Exemption and the Push to Finally Identify the Necessary Level of “Charity Care”

One day before Representative Thomas convened his hearing on the health care standard for tax-exemption, Senate Finance Committee Chairman, Charles Grassley, decided to go right to the source of the issue and sent letters to ten of the largest nonprofit health care systems in America asking them to justify their tax exemption.¹⁰⁰ As stated in his May 25, 2005 press release, the purpose of the detailed questionnaire was to “advance legislation . . . to prevent abuse of the federal tax laws that created non-profit organizations”¹⁰¹

However, after reviewing the answers provided by the ten hospitals in October of 2005, Grassley made it clear that his concerns related mostly to a lack of “common policy among hospitals” regarding “such critical areas as charity care.”¹⁰² It is unclear if his action is due to a belief that many nonprofit hospitals are not earning their exemption or if he is responding to the general anxiety in the tax-exempt health care sector following the decision in *IHC Health Plans* and the IRS’s litigation position in *St. David’s* (where the IRS argued unsuccessfully that Revenue Ruling 56-185’s “charity care” standard is still applicable). Either way, it is apparent that Grassley will continue to investigate the level of “charity care” provided by nonprofit health care organizations given his announcement that more

98. *Id.*

99. *Hearing, supra* note 1 (statement of The Honorable Mark Everson, Commissioner, Internal Revenue Service).

100. Stokely Baksh, *Non-Profit Hospitals Face More Questions*, UNITED PRESS INTERNATIONAL, May 27, 2005, <http://web.lexis-nexis.com/universe> (search “Quick News Search” for “Stokely Baksh” and “Non-profit hospitals” under date range of “Previous two years”; then click on the first result).

101. *Press Release, supra* note 79.

102. Grassley, *supra* note 2, at 4.

targeted investigations will occur in the near future.

Beyond the understandable anxiety nonprofit health care organizations are experiencing due to these investigations, Grassley's probe may nevertheless prove to be helpful for the tax-exempt health care sector. First, Grassley is aiming to identify a "common definition" of "such critical areas as charity care" and determine the level of such care that is necessary for exemption.¹⁰³ Second, instead of imploring the IRS to draft a new ruling proscribing a specific "charity care" requirement, he is encouraging each nonprofit health care organization to "come forward with its own substantive proposals for common definitions and reforms in . . . charitable care."¹⁰⁴

What this proposal means for the tax-exempt health care sector is that it may finally receive some clarity on what, if any, level of "charity care" is required. Also, new legislation would at last put Revenue Ruling 69-545's "Community Benefit Standard" to rest. Finally, Grassley's insistence that the tax-exempt health care sector propose "charity care" standards of its own to Congress may calm nonprofit hospitals concerned that a "charity care" statute may contain uncompensated care financial expectations they cannot meet.

Nevertheless, despite the definitiveness that a "charity care" statute would provide nonprofit health care organizations, many critics fear that such legislation could be even more financially devastating to health care organizations than the holdings in *IHC Health Plans* and *St. David's*. IRS Commissioner Everson voiced his concerns regarding the "temptation to write another bright-line rule into the law," explaining that a "very serious step could have real ramifications on the community."¹⁰⁵ Furthermore, with the possibility of legislation requiring hospitals to provide charity care, some fear that the unreasonable financial demands that a "charity care" statute could impose would "threaten the survival of many hospitals."¹⁰⁶

Dr. Spencer Forman, President of Montefiore Medical Center, believes that a universal charity care statute would disproportionately affect the economic viability of hospitals in low income communities.¹⁰⁷ He comments that it is "totally unrealistic" to apply

103. *See id.*

104. *Id.*

105. *Hearing, supra* note 1.

106. Pear, *supra* note 79.

107. *See id.*

the same mathematical formula to nonprofit hospitals in destitute urban neighborhoods and affluent suburbs.”¹⁰⁸ However, Foreman believes that “Congressional interest in this area is quite appropriate.”¹⁰⁹ Foreman further states that “if a hospital provides a benefit proportional to the community’s needs and the institution’s resources, it meets the community benefit test.”¹¹⁰

Tiffany Himmelreich of the Ohio Hospital Association echoes Foreman’s concerns, contending that “any national charity care requirement would sink some hospitals.”¹¹¹ However, unlike Foreman, she believes “small and rural hospitals” would be hit the hardest and “would just fold.”¹¹² Additionally, Richard Schrock, CFO of the Ohio State University Health System, cautions that federal legislation over “charity care” is not the answer and states that because “hospitals are not as strong as they economically were . . . most won’t be able to comply” with the requirements.¹¹³

Outside of the reactions from nonprofit hospital executives, investment banks have also raised concerns about the effect of a bright-line “charity care” statute. For example, in March of 2006, Standard and Poors warned that an Illinois “charity care” standard could severely hurt the health care organizations’ credit ratings within the state, which would make it “more expensive and harder for [hospitals] to borrow money.”¹¹⁴ However, an increase in the cost of capital for nonprofit hospitals would not necessarily be a fatal reform. Health care organizations that retain their tax exempt status would still be immune from paying income taxes, property taxes, or sales taxes and would retain the ability to borrow at below market rates through selling tax-exempt bonds.¹¹⁵ Nevertheless, an inability to meet the requirements of a “charity care” statute could result in loss of exemption, which would create an enormous tax liability for the hospital in addition to the acceleration of tax exempt debt

108. *Id.*

109. *Id.*

110. *Id.*

111. Susan Hoholik, *Tax-Exempt Hospitals Need Checkups—Iowa Senator Says*, THE COLUMBUS DISPATCH, Mar. 22, 2006, at 1A.

112. *Id.*

113. *Id.*

114. Editorial, *Hospitals Protest Too Much Over Charity Care*, ST. LOUIS DISPATCH, Mar. 24, 2006, at D14.

115. *See id.*; *see also* I.R.C. § 103 (2006) (pertaining to state and municipal tax-exempt bond financing).

outstanding.¹¹⁶

A recent stimulus in relationship to a potential federal “charity care” statute arose in the context of a letter Senator Grassley sent the American Hospital Association (AHA) on March 8, 2006.¹¹⁷ Despite arguing that “imposing more requirements could put some out of business,”¹¹⁸ the AHA had previously provided three legislation proposals “to improve care provided by not-for-profit hospitals.”¹¹⁹ The proposals included: (1) providing “discounts to all uninsured individuals of limited means and then mak[ing] [the] discount publicly available,” (2) requiring “not-for-profit hospitals to implement a common definition of the ‘community benefit’ they provide and disclose the amount of the benefit,” and (3) including provisions for “strengthening transparency, governance, and accountability of charitable organizations.”¹²⁰ In his March 8 letter, Grassley “praised the [AHA] for [its] decision to show leadership [in] an effort to draft legislation,” but asked the AHA to further clarify its suggestions.¹²¹

Grassley asked the AHA specific questions about how Congress should define “care for the needy.”¹²² In response to the letter, AHA’s Senior Vice President for Federal Regulations, Thomas Nickels, said in an interview that “Congress needs to be careful not to go too far in writing new laws.”¹²³ Nickels’ concerns centered on his belief that “a third of the nation’s hospitals are losing money” and that “federal payments for health care for the very poor and elderly are often not enough to cover the hospital’s costs of treating them.”¹²⁴ In addition, Nickels seemed to argue that nonprofit hospitals were already doing their job under the broader “Community Benefit

116. See Harold L. Kaplan & Linda S. Moroney, *Hospitals Face New Financial Threat of Charity Care Legislation*, 25-5 AM. BANKR. INST. J., June 2006, at 28, 59.

117. Letter from Charles E. Grassley, Chairman, U.S. Senate Comm. on Fin., to Richard J. Davidson, President, Am. Hosp. Ass’n (Mar. 8, 2006) (on file with journal).

118. Elizabeth Schwinn, *Senator Questions Practices of Nonprofit Hospitals, Asks for Changes*, CHRONICLE OF PHILANTHROPY, Apr. 6, 2006, at 48.

119. *Senator Grassley Asks American Hospital Association to take ‘More Active’ Role in Not-for-Profit Hospital Legislation*, MEDICAL NEWS TODAY, Aug. 25, 2006, available at <http://medicalnewstoday.com/medicalnews.php?newsid=39582> (last visited Aug. 25, 2006).

120. *Id.*

121. Schwinn, *supra* note 118.

122. *Id.*

123. *Id.*

124. *Id.*

Standard.”¹²⁵ He pointed out that nonprofit hospitals have been “providing \$27 billion worth of free care annually, in addition to many other benefits, to the cities and towns where they are located.”¹²⁶

With the backdrop of the IRS’s litigation positions and federal court holdings contradicting the IRS’s own guidance and the foreground of Congress’s increasing interest in a new “charity care” statute, all signs point to a reform or repeal of Revenue Ruling 69-545’s “Community Benefit Standard.” However, many questions remain. Should Congress legislate on hospital “charity care” or would all parties be best served by a new and more objective Revenue Ruling from the IRS? If Congress does legislate, how soon may health care organizations have to worry about complying with a new law that many believe will put numerous tax-exempt health care organizations out of business due to the financial burden?

Although these troubled times have left the tax-exempt health care sector in a state of unrest about the near future, nonprofit health care organizations are not strangers to ambiguity. As discussed above, Revenue Ruling 69-545 continues to be the only legal guidance for nonprofit health care organizations, despite the fact that the IRS began ignoring the ruling in 1978 and the federal courts began to disregard the ruling in 1983.¹²⁷ While tax-exempt health care reform advocate Representative Bill Thomas has announced he will not run for reelection in the fall of 2006, there is no indication that either his Ways and Means Committee or Grassley’s Senate Finance Committee will put the breaks on the “charity care” issue.¹²⁸ In fact, according to an unnamed Senate Finance Committee staff member in late March of 2006, “Congress could pass new rules . . . outlining the responsibility of nonprofit hospitals to provide charity care or discounted fees for the uninsured” by the end of the year.¹²⁹

VIII. THE IRS’S CURRENT ANSWER TO CHAIRMAN GRASSLEY’S CALL TO ACTION: THE “COMMUNITY BENEFIT” COMPLIANCE CHECK AND A UNIFORM “COMMUNITY BENEFIT” REPORTING SYSTEM

Perhaps the best evidence that the tax-exempt health care sector

125. *Id.*

126. *See id.*

127. *See generally* BRAUER, *supra* note 42.

128. Schwinn, *supra* note 118.

129. *Id.*

should prepare for a new federal tax-exemption standard in the very near future is the IRS's May 2006 issuance of Form 13790 "Compliance Check Questionnaire for Tax-Exempt Hospitals"¹³⁰ and Senator Grassley's September 2006 statement that the IRS is already developing a supplemental report to IRS Form 990 which will require nonprofit health care organizations to annually report the "community benefits" provided.¹³¹

The "Compliance Check Questionnaire," which originated as an objective of the IRS FY 2006 Exempt Organizations Implementing Guidelines (announced on October 25, 2005), was mailed to approximately 600 tax-exempt hospitals in May of 2006.¹³² In the October "Implementing Guidelines," then Director of the IRS Exempt Organizations Division, Martha Sullivan, stated the forthcoming "compliance project" would, among other things, help the IRS ascertain how hospitals "meet the community benefit standards for purposes of [Section] 501(c)(3)."¹³³ The questionnaire, which consists of nine pages of detailed questions organized into three sections, addresses health care organization "community benefit" compliance in the second section.¹³⁴

The Community Benefit Programs section is the most extensive portion of the questionnaire, and contains 25 questions related to the organization's policies regarding "uncompensated care" or "charity care."¹³⁵ One such question inquires whether the nonprofit health care organization has "a written policy stating the circumstances under which it would provide uncompensated care."¹³⁶ However, despite its primary concentration on the "charity care" issue, the "Compliance Check Questionnaire" does not rule out the possibility of other community activities satisfying the IRS's possible reform of

130. IRS, FORM 13790, OMB NO. 1545-2015 (2006), available at www.irs.gov/pub/irs_tege/eo_hospital_questionnaire_sample.pdf (last visited Sept. 3, 2006).

131. See Statement of U.S. Senate Committee on Finance Chairman Charles Grassley, Memorandum Re: Nonprofit Hospital Responses to Senate Finance Committee (Sept. 12, 2006), available at <http://www.senate.gov/~finance/press/Gpress/2005/prg091206.pdf#search=%22non-profit%20hospital%20responses%20to%20Finance%20Committee%20%22> [hereinafter *Statement*].

132. See King & Hearle, *supra* note 94, at 32.

133. IRS, FY 2006 EXEMPT ORGANIZATIONS IMPLEMENTING GUIDELINES, 12, 21 (2005) available at www.irs.gov/pub/irs_tege/fy_2006_implementing_guidelines.pdf (last visited Sept. 3, 2006).

134. IRS, *supra* note 133, at 4-8.

135. *Id.*

136. *Id.* at 4.

the “Community Benefit Standard.”¹³⁷ Specifically, Form 13790 asks the health care organization about other beneficial activities such as “professional medical education and training programs” and its operation of community programs.¹³⁸

While completion of the “Compliance Check Questionnaire” is optional and is not an audit by the IRS, acquiescence to the IRS’s request to complete the form is recommended for several reasons.¹³⁹ First, as with Grassley’s requests for information from the tax-exempt health care sector, nonprofit health care organizations should view the questionnaire as a valuable opportunity to demonstrate the many different “community benefits” they provide. This exhibition of various community contributions may be an important step in preventing the enactment of a health care tax-exemption standard that is unreasonably focused on “charity care.” Second, while the questionnaire is not yet a mandatory audit, the identities of the tax-exempt health care organizations who fail to complete the form will be contained in public record.¹⁴⁰ As a result, noncompliance with the questionnaire may increase the likelihood of a thorough audit by the IRS if and when the reporting of “charity care” and other “community benefits” becomes compulsory.¹⁴¹

Finally, while the IRS only recently mailed the “Compliance Check Questionnaires,” nonprofit tax practitioners, tax-exempt hospital representatives, and Congress have all offered insights into the content and likely effectiveness of the questionnaire in furthering necessary reform of the “Community Benefit Standard.” Several practitioners contacted by Tax Analysts commented that “while the survey asks worthwhile questions, some issues, including the definition of ‘community benefit,’ still require clarification.”¹⁴² Doug Mancino, of the Los Angeles office of McDermott, Will, and Emery, identified as one weakness the fact that a few questions are not resolved easily with a “yes” or “no” answer.¹⁴³ Specifically, the form asks questions about “uncompensated care” provided by the health

137. *See id.* at 7-8.

138. *See id.* at 3-4.

139. *See* Michael W. Peregrine & Robert C. Louthian, *Update: IRS “Community Benefit” Compliance Check*, HEALTH LAWYERS NEWS, July 2006, at 5.

140. *See id.*

141. *See id.*

142. Christopher Quay, *Practitioners Seek Clarification of Community Benefit Standard*, 53 EXEMPT ORG. TAX REV. 158 (2006).

143. *Id.*

care organization without clarifying if bad debts, Medicaid services, and Medicare services should be defined as “uncompensated.”¹⁴⁴ Despite ambiguities and disagreement regarding technical distinctions, some responses from the tax-exempt health care community include optimism about the utility of the “Compliance Check.”¹⁴⁵ Bonnie Brier, general counsel for Children’s Hospital of Philadelphia, applauded the IRS’s invitation to “attach additional sheets” of information if more space is needed to fully articulate the hospital’s beneficial activities in its community.¹⁴⁶

However, despite receiving mixed praise from practitioners and tax-exempt health care organizations, the IRS’s initial step in mailing the “Compliance Check Questionnaire” is unlikely to be its final action due to increased pressure from Congress in July of 2006.¹⁴⁷ At Eric Solomon’s nomination hearing for Deputy Treasury Secretary for Tax Policy, Chairman Grassley voiced his concern that the questionnaire is “just a fact-gathering exercise,” as opposed to an effective effort at ensuring nonprofit health care organizations are earning their exemption.¹⁴⁸

Furthermore, Grassley identified past shortcomings of the IRS as the primary reason why “hospitals are all over the map when it comes to providing charity care, community benefit, and charges to the uninsured.”¹⁴⁹ In particular, Grassley blamed the deficiencies of Revenue Ruling 69-545 on the readiness of the IRS and Treasury to “listen to the lobbyists [who provided the] extremely inaccurate information [that] inability to afford medical care was a problem of the past.”¹⁵⁰ As a result of these prior miscalculations, Grassley emphatically asked the IRS to commit to “going to look at the real facts” this time around as “[p]oor people shouldn’t have to suffer because the Treasury and IRS got the facts wrong in 1969.”¹⁵¹

Finally, Grassley requested that the IRS take a step beyond the mere “fact-gathering exercise” in the “Compliance Check

144. *Id.*; see IRS, *supra* note 133, at 4.

145. See Quay, *supra* note 142.

146. *Id.*

147. See Memorandum from Jill Gerber to Charles Grassley, Chairman, U.S. Senate Comm. on Fin., Grassley Asks IRS To Improve Charity Hospital Requirements, 29 EXEMPT ORG. TEXT 8 (July 19, 2006).

148. *Id.*

149. See *id.*

150. *Id.*

151. *Id.*

Questionnaire” and provide him with: (1) “a timeline for review and proposals for reforming guidance” in the area of “charity care” and “community benefit,” (2) “a copy of all submissions from the hospitals that the IRS receives as well as the names of any hospitals that did not respond,” and (3) “a copy of all documents, memorandums, material in the possession or control of Treasury and IRS related to” Revenue Ruling 69-545.¹⁵²

While the “fact-gathering” nature of the “Compliance Check Questionnaire” might initially indicate that the IRS’s long awaited reform of the tax-exemption standard for health care organizations (the most recent reform occurred 37 years ago) may take months or even years to be enacted, very recent Congressional pressure suggests that the IRS may move much more quickly.¹⁵³ In particular, a Senate Finance Committee hearing on September 13, 2006, entitled “Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals,” shed light on just how fast the process of establishing new guidelines for the nonprofit health care exemption may be completed.¹⁵⁴ At the hearing, Grassley released the responses he received from ten major nonprofit health care systems regarding the “community benefits” they provide and how they “measure community benefits.”¹⁵⁵ In explaining the responses, Grassley expressed great concern over the fact that there were “enormous differences in answers to the same questions” and that “it was rare to get the same answer from even two hospitals.”¹⁵⁶ As a result of this lack of commonality in how nonprofit health care organizations report and define “community benefit,” Grassley announced that the IRS is already in the process of drafting a “community benefit” information form that will become a mandatory supplement to nonprofit health care organizations’ annual filing of IRS Form 990.¹⁵⁷ Grassley’s immediate goal, which is a common reporting system amongst nonprofit hospitals through this supplemental form, will begin by creating a reporting system that is based on the Catholic Health Association’s (CHA) existing “community benefit” accounting

152. *Id.*

153. *See id.*

154. *See Statement, supra* note 131; *see also* Cinda Becker, *Charity Care with an Arm Twist*, MODERNHEALTH.COM, Sept. 18, 2006, <http://www.modernhealthcare.com/article.cms?articleId=41533>.

155. *See Statement, supra* note 131.

156. *See id.*

157. *See id.*

guidelines. While Grassley is not completely convinced that the CHA guidelines will become the final federal guidelines for nonprofit health care organizations, he suggests that it may “serve as a starting point” as hundreds of hospitals already abide by its guidelines.¹⁵⁸

With Congress and the IRS implementing both “Compliance Checks” and a soon-to-be mandatory “community benefit” reporting system on annual returns all within a couple of months, nonprofit health care organizations should be ready for the certain forthcoming reform of the “Community Benefit Standard.”

IX. PROPOSED METHODS FOR REFORMING THE “COMMUNITY BENEFIT STANDARD” AND HOW NONPROFIT HEALTH CARE ORGANIZATIONS CAN PREPARE TODAY FOR FUTURE CHANGE

While neither the IRS nor Congress have provided a strong indication of how a new nonprofit health care tax-exemption standard may operate, many government officials and experts on the nonprofit sector have voiced their recommendations for reform of the “Community Benefit Standard.” Many of these individuals have common suggestions regarding the major issues of “charity care,” record keeping, and accountability. As a result, nonprofit health care organizations may be able to preemptively defend their exempt status by making adjustments to their business structures before a new law or ruling comes into effect.

A. *Reviewing the Problems with Revenue Ruling 69-545’s “Community Benefit Standard”*

Regardless of whether you ask the IRS or a tax-exempt health care organization executive about the usefulness of the “Community Benefit Standard,” you will get the same answer: there are significant problems with the test set forth in Revenue Ruling 69-545. First of all, as voiced by both Congress and John Colombo of the University of Illinois School of Law, the “Community Benefit Standard” “lacks accountability.”¹⁵⁹ Specifically, in an era where *most* health care organizations are serving Medicare/Medicaid patients, operating community boards, and instituting open medical staff policies, Revenue Ruling 69-545 makes no measurable distinction between

158. See Becker, *supra* note 154.

159. See *Hearing*, *supra* note 1 (statement of John Colombo, Professor, University of Illinois College of Law).

nonprofit and for-profit health care organizations.¹⁶⁰ In fact, Colombo believes that the IRS's decision to litigate inconsistently with Revenue Ruling 69-545 in the HMO cases (*IHC Health Plans* and *St. David's*) was due to the "lack of substantive criteria to differentiate an exempt hospital from a for-profit one."¹⁶¹ While Colombo may be correct regarding the IRS's decision-making, his view begs the question of why the IRS did not decide to simply issue a new ruling that provided for a "charity care" requirement, instead of surprising nonprofit health care organizations in court with its litigation positions.

In addition to the IRS's and Congress's clear dissatisfaction with Revenue Ruling 69-545, the "Community Benefit Standard" has left tax-exempt health care organizations in a perpetual state of unease. This unrest is due to the reality that health care organizations are in the dark about the type and quantity of community benefits they must provide in order to retain exempt status. Without any guidance from the IRS, some nonprofit health care groups such as the Catholic Health Association (CHA) have nevertheless been proactive by instituting comprehensive "community benefit" evaluation and review programs.¹⁶² In May of 2006, the CHA released "A Guide For Planning and Reporting Community Benefit," which has been applauded by both Chairman Grassley and the American Hospital Association (AHA).¹⁶³ Specifically, Grassley identified the CHA's "work in the area of defining and reporting charity care" as "praiseworthy."¹⁶⁴

Additionally, in response to a March 8 letter from Grassley asking for suggestions for "community benefit" and "charity care" requirements, the American Hospital Association (AHA) encouraged

160. *See id.*

161. *Id.*

162. *See* Colombo, *supra* note 11, at 42.

163. For a citation to the Guide, see *A Guide For Planning and Reporting Community Benefit* (2006), available at <http://www.chausa.org/Pub/MainNav/ourcommitments/CommunityBenefits/TheGuide/> (last visited Sept. 7, 2006) (the Guide was developed in conjunction with Lyon Software, a company that is currently developing a computer application to account for "community benefits" as defined under the Catholic Health Association (CHA) system); *see also* King & Hearle, *supra* note 94, at 35.

164. Letter from Charles Grassley, U.S. Senator, to Sr. Carol Keehan of the Catholic Health Association of the United States (Mar. 8, 2006) available at <http://www.chausa.org/pub/MainNav/News/CHW/Archive/2006/0501/Articles> (last visited Sept. 7, 2006).

Grassley to consider the CHA's "Guide."¹⁶⁵ However, the CHA's May 2006 Guide fails to provide the objectivity needed to effectively advise nonprofit health care organizations. It neither suggests specific levels of "charity care" or "community benefit" necessary for tax-exemption.¹⁶⁶ As a result, despite diligence in adhering to the CHA Guide or similar "community benefit" reporting models, many nonprofit health care organizations remain uneasy. Under such models, they know they are at best guessing what specific "community benefits" will satisfy the IRS's increasing level of scrutiny.

In commenting on this uncertainty, Colombo warns that what hospitals may believe are "community benefits" may be viewed as "too commercial" by the IRS.¹⁶⁷ For example, he suggests that beneficial activities such as community health education and free health exams may be viewed as mostly "serv[ing] marketing and promotional purposes for hospitals, just as sponsoring of sporting events or the arts does for many non-profit corporations."¹⁶⁸

In retrospect, it is clear that the "Community Benefit Standard" was flawed from the beginning as it was not drafted to objectively differentiate nonprofit health care organizations from for-profit providers. As a result, both the IRS and federal courts have been falsely relying on an unhelpful Revenue Ruling and have essentially promulgated new rules without providing clear and consistent direction to the tax-exempt health care sector. The only guidance available to nonprofit health care organizations is the reality that no IRS ruling or court case in over 15 years has granted tax-exemption to a health care organization that lacked a "significant charity care" program.¹⁶⁹ With Congress, the IRS, and nonprofit health care

165. See Dick Davidson, *American Hospital Association, Hospital Group Responds to Grassley on Reform*, 2006 EOT 19-11, 6 (2006) (stating the American Hospital Association's position that the Catholic Health Association Guidelines "capture the range and diversity of how hospitals benefit their communities and provide a standard platform for identifying, describing, quantifying and reporting this benefit.").

166. See *Questions and Answers Regarding the Guide*, available at <http://www.chausa.org/Pub/MainNav/ourcommitments/CommunityBenefits/TheGuide/GuideQA.htm> (explaining how the Catholic Health Association Guide "does provide suggestions of how organizations should establish their budgets, by assessing a community need, considering resources available, and comparisons with past activity and the contribution of others.") (last visited Sept. 21, 2006).

167. See Colombo, *supra* note 11, at 42.

168. *Id.*

169. *Id.* at 43.

organizations all choosing not to rely on the “Community Benefit Standard,” the time for reform is now.

*B. Reform Options for the “Community Benefit Standard”:
Possibilities Nonprofit Health Care Organizations Should Consider*

As is consistent with the early stages of any reform proposal, the suggestions as to what Congress and the IRS should do to correct the health care organization standard for tax-exemption are numerous. The common agreement amongst government officials, academics, and nonprofit hospitals is that “current tax policy lacks specific criteria with respect to tax exemptions for charitable entities and detail on how that tax exemption is conferred.”¹⁷⁰ Furthermore, the common solution that all parties are seeking is generally stated by United States Government Accountability Office Comptroller General, David M. Walker. Walker explains that if these “specific criteria” are “articulated in accordance with desired goals, standards could be established that would allow nonprofit hospitals to be held accountable for providing services of benefit to the public commensurate with their favored status.”¹⁷¹ Where the many suggestions diverge is on the question of what “criteria” should be deemed necessary and how much of that “criteria” will suffice in warranting tax-exemption for health care organizations.

One popular suggestion for reform of the health care exemption standard is to follow the lead of the state legislatures that have already enacted “charity care” statutes to determine if health care organizations deserve exemption from state and local taxation. One such statute, the Texas Nonprofit Hospital Community Benefits Law, has been applauded by many as it proscribes measurable benchmarks that nonprofit health care organizations must meet.¹⁷² John T. Thomas, the senior vice president of the Baylor Health Care System, comments that the “Texas charity care law is a fair, objective standard for determining if a hospital is meeting its mission as a nonprofit organization.”¹⁷³

170. *Hearing, supra* note 1 (statement of the Honorable David M. Walker, Comptroller General, U.S. Government Accountability Office).

171. *See id.*

172. *See Hearing, supra* note 1 (statement of John Colombo, Professor, University of Illinois College of Law); *see also* Texas Health & Safety Code, Texas Community Benefits Law §§ 311.041-.048 (Vernon 2006).

173. *See Baksh, supra* note 100, at 4.

Perhaps the most attractive feature of the Texas “charity care” statute is the flexibility it offers. Instead of offering one largely subjective method of earning exemption, as in Revenue Ruling 69-545, the Texas statute provides two objective ways to receive exempt status in addition to a third subjective option.¹⁷⁴ Specifically, a Texas health care organization can “objectively” show: (1) that it provides charity care in the amount that is equivalent to 100% of the benefit it receives from its state tax exemption; or (2) that it provides charity care and community benefits equal to at least 5% of the hospital’s net patient revenues (4% of which must be for “charity care” and/or government sponsored indigent health care).¹⁷⁵ In addition, if the health care organization is not able to meet these benchmarks (for example in the case of a hospital operating in a rural area with limited financial resources), it has the third option of earning exemption under a “reasonableness standard” that takes all the facts and circumstances of the particular health care organization into account.¹⁷⁶

Although instituting a federal standard similar to the Texas statute may necessitate additional oversight and record keeping by the IRS, Congress should take note of the fact that, since its inception in 1993, the Texas law has been overwhelmingly embraced by the Texas health care organization community due to its objective nature.¹⁷⁷ Furthermore, the Texas statute aligns with the IRS’s clear agenda to return to a “charity care” formula similar to that of Revenue Ruling 56-185.

John Colombo, a professor at the University of Illinois School of Law, proposed another possibility for reform, focusing on “access” to health care services.¹⁷⁸ Colombo contends that the most severe weakness of the “Community Benefit Standard” is that it does not provide an “outputs-based method for judging when a provider should be exempt.”¹⁷⁹ However, in recognizing that that health care organizations vary in size, location, and financial constraints, he believes that health care organizations should be evaluated based on the “access” to health care they provide. Under his proposed test, the

174. *Hearing, supra* note 1 (statement of John T. Thomas, Senior Vice President and General Counsel, Baylor Health Care System, Dallas-Forth Worth, Texas).

175. *Id.*

176. *Id.*

177. *See* Baksh, *supra* note 100, at 4.

178. Colombo, *supra* note 9, at 347-348.

179. *Id.* at 375.

IRS would grant exempt status to any health care organization that: (1) brings “substantial new services to the community that previously were unavailable from for-profits,” or (2) that serves a “targeted population that otherwise was previously underserved.”¹⁸⁰

The value of Colombo’s “access-based” test is in its ability to fairly evaluate small and rural health care organizations in a fashion that neither the “Community Benefit Standard” nor a standard like the Texas “charity care” statute can do. Under Colombo’s approach, large metropolitan hospitals would have to do more than the rural hospitals that are already providing a large benefit by supplying health care that would not otherwise exist in the community.¹⁸¹ However, on the flip side, the weakness of the “access-based” standard is that its lack of objective criteria may not go far enough to solve the measurement problems that have plagued the “Community Benefit Standard.”

The most extreme option is to completely repeal the “Community Benefit Standard” and revoke tax-exemption from most existing nonprofit health care organizations.¹⁸² While this argument is most commonly made by those who believe that hospitals are big businesses that do not need additional help from the federal government, even a complete abolishment of the health care tax exemption may not be as bad as it sounds. For example, as opposed to providing tax exemption under §501(c)(3), health care organizations could be taxed as for-profit businesses and the tax revenues received by the government could then be used to provide “direct benefits” to the health care institutions that do provide “charitable” services.¹⁸³ This option could be the best of all worlds as the goals—hospital accountability, objective guidelines, and reimbursing the hospitals that provide “charitable” relief—would all be met.

However, while this proposal may seem like a logical solution in theory, such an extreme change lacks political viability. Upon revocation of their exemption, many nonprofit health care organizations would go bankrupt immediately and the “direct incentives” would come far too late to save them. No member of

180. *Id.* at 376.

181. *Id.* at 375-376.

182. *See* Colombo, *supra* note 11, at 52-60.

183. *See Hearing, supra* note 1 (statement of John Colombo, Professor, University of Illinois College of Law).

Congress would be bold enough to propose such legislation as its short-term effect would be catastrophic to the present tax-exempt health care sector and the communities the sector serves.

Furthermore, as IRS Commissioner Everson indirectly suggested at the May 2005 Ways and Means Committee hearing, the tax-exempt health care sector may be best regulated by a form of “intermediate sanctions.”¹⁸⁴ Under Section 4958 of the Internal Revenue Code, all tax-exempt organizations (including nonprofit health care organizations) are subject to excise taxes for providing “excess benefits,” such as excessive compensation to nonprofit executives (the excise taxes are imposed directly on the executives and managers as opposed to the organization itself).¹⁸⁵ Congress’s objective in enacting the “intermediate sanctions rules” of Section 4958 was to create a system that would deter nonprofits from excessively benefiting private individuals without taking the drastic step of revoking tax exemption.¹⁸⁶

In order to avoid taking the “very serious step” of revoking exemptions, which Commissioner Everson warns will have “real ramifications on a community,” Senator Grassley and Representative Thomas should consider including intermediate penalties for nonprofit health care organizations in any legislation they propose. For example, a nonprofit health care organization could be required to pay an excise tax for failure to meet a specific percentage of charity care per year (the percentage mandated could be a function of the health care organization’s annual revenue).

Finally, as discussed above, the some of the most recent recommendations for reform of the “Community Benefit Standard” have come from Chairman Grassley’s encouragement of individual health care organizations and the American Hospital Association (AHA) to “come forward with its own substantive proposals.”¹⁸⁷ In a letter to Grassley dated May 1, 2006, the AHA suggested that Congress implement a liberal “community benefit” definition and reporting requirement that would employ most of the Catholic Health Association’s May 2006 “Community Benefit Guidelines.”¹⁸⁸

184. *Hearing, supra* note 1 (statement of The Hon. Mark Everson, Commissioner, Internal Revenue Service).

185. *See id.*; *see generally*, I.R.C. § 4958 (West 2006).

186. *See* JAMES J. FISHMAN & STEPHEN SCHWARZ, *TAXATION OF NONPROFIT ORGANIZATIONS*, 234-235 (3d ed. 2003).

187. *See* Davidson, *supra* note 165.

188. *Id.*

Despite its similarity to the CHA's "Community Benefit Guidelines," the AHA proposal would be even more advantageous to nonprofit health care organizations. Specifically, it would allow them to include as a form of "charity care" the "indirect costs of health care services" such as bad debts and unpaid Medicare and Medicaid costs.¹⁸⁹ Finally, the AHA advocates that the reporting of these "community benefits" should be effectuated by an annual accounting on the nonprofit health care organization's filing of IRS Form 990 (as mentioned above, the IRS is already drafting a "community benefit" compliance information return that will eventually be an attachment to IRS Form 990).¹⁹⁰

As for the merits of the AHA proposals, it is undeniable that the AHA's cooperation with Grassley should serve as a model for all nonprofit health care organizations as every organization has the important opportunity to influence the future state of the tax-exemption standard. However, as it presently exists, the AHA's requested exemption standard fails to provide objective benchmarks for levels of "charity care" and other "community benefits." As a result, it is unsuccessful in remedying the problems of uncertainty inherent in Revenue Ruling 69-545's "Community Benefit Standard."

There is a fine line between achieving the government's objective of reforming the "charity care" policies of nonprofit health care organizations and the over-regulating of health care organizations to the extent that communities are severely hurt following the bankruptcy of critically needed hospitals that lose their tax exemption. For this reason, both Congress and the IRS must be very careful in drafting any new rule to replace the "Community Benefit Standard." An unreasonable standard could have dire consequences to tax-exempt hospitals and the communities they serve.

X. CONCLUSION

In recent years, through litigation positions and court decisions, the IRS and federal courts have essentially returned nonprofit health care organizations to the "charity care" requirement of the 1950's. This return to a focus on "relief of the poor" comes despite the absence of any "charity care" prescription in Revenue Ruling

189. *See id.*

190. *Id.*

69-545's "Community Benefit Standard," which the IRS contends is the current standard for health care exemption. With health care organizations such as those in *IHC Health Plans* and *St. David's* losing federal tax-exemption despite clearly "promoting health" for the benefit of their communities as required under Revenue Ruling 69-545, nonprofit health care organizations have entered an era of palpable uncertainty about what they must do in order to retain valuable exemptions. While indications from two prominent Congressmen suggest that the uncertainty may soon be over as the result of a new ruling or legislation, the concerns of tax-exempt health care organizations have not dissipated as a precipitously applied federal "charity care" requirement could put many hospitals in financial dire straits.

This recent Congressional interest in the tax-exempt health care sector can and should be viewed as a valuable opportunity for all nonprofit health care organizations to once and for all establish some certainty in what they must do to retain their tax exemption. Recently, Senate Finance Committee Chairman, Charles Grassley, explicitly invited nonprofit health care organizations to set a "charity care" standard for the industry.¹⁹¹ He continues to insist that Congress will only enact a new standard if the tax-exempt health care sector "does not do it for itself."¹⁹²

As a consequence of this invitation, it should be the immediate goal of every nonprofit health care system board to take an active role in the federal exemption standard debate as Grassley contends that in the case of "charities who have failed their mission . . . poor board governance unites them all."¹⁹³ Through voicing what valuable community contributions they have been providing, tax-exempt health care organizations can help reform the "Community Benefit Standard" in a way that holds them accountable for the benefits of exemption without subjecting them to unreasonable financial burdens that could eventually devastate the communities they serve.

191. See Hoholik, *supra* note 111.

192. See Pear, *supra* note 79.

193. Memorandum of Senator Charles Grassley Re: GAO survey on nonprofit hospitals' executive compensation (July 28, 2006) available at <http://www.senate.gov/~finance/press/Gpress/2005/prg072806a.pdf#search=%22Grassley%20July%2028%2C%202006%20GAO%22> (last visited September 26, 2006).