
"Community Benefit Standard" in Play—Again

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The long-running debate about the future of the community benefit standard for hospital tax-exempt status (Community Benefit Standard, or the Standard) has been re-ignited by the Senate Finance Committee. Revising this forty-year-old exemption standard was one of a series of policy options presented by the Committee on Monday, May 18, as a means of financing forthcoming healthcare reform options.¹ Among other options presented were restructuring the tax exclusion for employer-provided health insurance, reducing payments to Medicare providers, codifying current regulations stating that medical residents cannot be students for employment tax purposes, and making program beneficiaries pay more for their coverage.²

The Community Benefit Standard has been the principal means by which hospitals obtain tax-exempt status since it was first implemented by the Internal Revenue Service (IRS) in 1969 through the revenue ruling process.³ Indeed, the

1 See Description of Policy Options-Financing Comprehensive Healthcare Reform: Proposed Health System Savings and Revenue Options (hereinafter, Proposed Financing Options) at <http://finance.senate.gov/sitepages/leg/LEG%202009/051809%20Health%20Care%20Description%20of%20Policy%20Options.pdf>.

2 See "Senate Finance Panel Leaders Offer Medicare, Tax Changes to Fund Reform," BNA's Healthcare Daily Report, May 19, 2009.

3 See Rev. Rul. 69-545, 1969-2 C.B. 117; see also *Eastern Kentucky Welfare Rights Org. v. Simon*, 506 F.2d 1278 (D.C. Cir. 1974), *vacated on other grounds* 426 U.S. 26 (1975).

fact that the Standard was introduced by means of an administrative agency ruling as opposed to legislative action has been a major basis of Congressional criticism over the years. The Standard articulates a multi-factor test to determine whether a hospital operates to benefit the community. Relevant factors include:

- i. Whether the governing board of the hospital is composed of a majority of independent members who are representative of the community (as opposed to practicing physicians and other persons with financial interests in the hospital);
- ii. Whether medical staff privileges in the hospital are available to all qualified physicians in the area, consistent with the size and nature of the hospital facilities;
- iii. Whether the hospital maintains a full-time emergency room open to all patients regardless of their ability to pay for emergency services;
- iv. Whether the hospital admits as patients those persons able to pay for medical care, either directly by themselves or through third-party payment programs such as private health insurance or governmental plans such as Medicare or Medicaid; and
- v. Whether the hospital's excess funds are invested in patient care and facility improvement and medical training, education, and research.

In applying the Community Benefit Standard, the IRS historically has also considered other factors such as community outreach/health education programs, but has viewed the most significant factors as those relating to emergency room availability and non-discrimination against Medicare and Medicaid beneficiaries.⁴ These are not the only factors considered by the IRS and, of course, hospitals must also meet the general requirements for income tax exemption under IRC Section 501(c)(3), including the prohibitions against private inurement, payment of excess compensation, and impermissible private benefit.

A comprehensive discussion of the history and development of the Community Benefit Standard is beyond the scope of this Executive Summary.

⁴ See Internal Revenue Service Corporate Education, *Introduction to the Healthcare Industry*, Training 3303-102 (1-95), TADS 83846E at p. 64.

The correctness of the Community Benefit Standard has long been a subject of Congressional interest and was the focus of House Ways and Means Committee hearings in 2005-2006. The specific interest of the Senate Finance Committee also comes as no surprise. Health lawyers are very familiar with the concerns of Sen. Charles Grassley (R-IA), ranking Minority Member of the Committee, who has long been a critic of the Standard. Indeed, in recent public comments Grassley repeated his often-heard perspective that the operations of many tax-exempt hospitals are difficult to distinguish from those of taxable hospitals.⁵ In particular, he questioned whether tax-exempt status would remain appropriate if healthcare reform causes the number of uninsured to significantly decrease.⁶ Theresa Pattara, minority tax legislative counsel to the Finance Committee, also recently predicted that the Finance Committee will release some form of legislative alternative to the Community Benefit Standard.⁷

The IRS also has been considering the need for additional guidance on the qualifications a hospital must satisfy in order to exist as a tax-exempt organization—including a possible "bright line facts and circumstances" approach.⁸ From the IRS' perspective, this could incorporate such criteria as: (1) the nature of a hospital's decision-making process and structure; (2) the amount of accountability a hospital has to the community it serves; and (3) the nature of the activities and services that the hospital provides.⁹ In the same vein, (former) TE/GE Commissioner Steven Miller acknowledged in a January speech some of the fault lines in the Community Benefit Standard and recognized "the need to consider whether refinements to the [S]tandard are warranted."¹⁰ Commissioner

5 See, e.g., Meg Shreve, "Senate Panel Considers Effect of Healthcare Reform on Tax-Exempt Hospitals," 2009 EAT 90-4, May 13, 2009.

6 *Id.*

7 See Simon Brown, "Finance Committee May Release Revised Nonprofit Hospital Proposal, Says Staffer," 2009 EAT 87-15, May 8, 2009.

8 See Simon Brown, "IRS Considering Bright-Line Standards for Hospital Tax Exemption," 2009 EAT 87-5, May 8, 2009.

9 *Id.*

10 Steven T. Miller, Commissioner, Tax Exempt and Government Entities, Internal Revenue Service, "Community Benefit and Nonprofit Hospitals"; Remarks before the Office of the Attorney General of Texas, "Charitable Hospitals: Modern Trends, Obligations and Challenges," January 12, 2009, Austin, TX. See transcript at www.irs.gov/pub/irs-tege/miller_speech_011209.pdf.

Miller offered no opinion on whether the proposal should come from Congress or the IRS.

Thus, the options for change announced by the Committee are not a "bolt from the blue," but a continuation of proposals that to date have not been enacted. Nevertheless, it is important for health lawyers to be aware of the components of the Committee's proposed change in tax-exemption standards, even though they are described only in broad-brush terms at this time. The proposal as currently articulated states that it is the codification of organizational and operational requirements for determining whether a hospital is a charitable organization for purposes of IRC Section 501(c)(3). In other words, the proposal would add requirements to the IRC specifically for tax-exempt hospitals. For example, the proposal would require, in part, that Section 501(c)(3) hospitals:

- Regularly conduct a community needs analysis;
- Provide a minimum annual level of charitable patient care;
- Not refuse service based upon a patient's inability to pay; and
- Follow certain procedures before instituting collection actions against patients.

Those hospitals deemed critical to the communities that they serve or that have an independent basis for federal tax-exempt status (for example, educational or scientific research organizations) would not be subject to the proposed minimum charity-care requirements. The proposal also indicates that there would be requirements relating to reporting and operational transparency.

The proposal's principal enforcement mechanism would be the imposition of intermediate sanctions penalty excise taxes. The goal of such taxes would be to incentivize compliance with the operational requirements of the proposal (e.g., when a hospital fails to satisfy the required level of patient care). Like other forms of intermediate sanctions excise taxes under the IRC, the proposed taxes are intended as an alternative to the extraordinary step of revocation of tax-exempt status.

The proposal is, at this point, extremely brief. No details or definitions have been provided; for example, we do not know what charitable patient care is or what would be the minimum level required. We also do not know the specific rates of the applicable penalty taxes.

In some respects, this new proposal is a more moderate version of the controversial Senate Finance Committee staff discussion draft released in 2007. That draft was released to substantial criticism, and its suggestions were never introduced as legislation. The staff discussion draft would have served, in part, to significantly limit the number of hospitals capable of qualifying under IRC Section 501(c)(3). A principal feature of the staff discussion draft was the requirement that a tax-exempt hospital provide a minimum amount of charity care annually. Specifically, the staff discussion draft indicated that a hospital could not maintain exempt status under IRC Section 501(c)(3) unless it dedicated at least 5% of the greater of its annual patient operating expenses or revenues to charity care. The staff discussion draft also proposed the following requirements for Section 501(c)(3) status: a widely distributed charity-care policy; community-benefit-related restrictions on joint ventures with for-profit entities; restrictions on conversion to for-profit status; requirements for board composition, corporate governance, and executive perquisites; restrictions on billing and collection practices; a periodic analysis of community needs; increased transparency and accountability standards; and sanctions for noncompliance.¹¹ The last four items now have re-appeared in the options released by the Senate Finance Committee.

Despite the lack of detail in the recently released proposal, the Committee now is proceeding with further consideration of this and the other financing options presented in its May 18 proposal. Reports are that some of the issues were discussed in more detail at a closed, invitation-only meeting of the Committee

¹¹ For hospitals that did not satisfy the new Section 501(c)(3) standards but could meet a less restrictive set of standards (including a charity care requirement), Section 501(c)(4) tax-exempt status would be available under the staff discussion draft.

held on May 20.¹² The plan apparently is to have a healthcare reform bill "marked up" by sometime in June.¹³

The main significance of the Committee's action is that it likely signals the beginning of a new round of legislative debate concerning the future of the Community Benefit Standard. Health lawyers are familiar with the historical criticism of the Standard and may rightly be somewhat skeptical about the prospects for legislative action. However, two factors are present that suggest that this new round of debate may produce some substantive change to the Standard. One is the President's emphasis on effecting healthcare reform in the near term (and the concomitant need to finance the cost of such reform). A second factor is that, as noted above, IRS officials have suggested the possibility of revising the Standard to incorporate a "bright line facts and circumstances" test for hospital tax exemption.

Those two factors alone do not ensure that neither Congress nor the IRS will replace the Community Benefit Standard. However, a great deal is potentially at stake. The benefits of tax-exempt status are significant, and the financial risks associated with loss of such status are severe. Accordingly, health lawyers may wish to make their clients aware of this new development. Boards and executive leadership of tax-exempt hospitals would be well advised to monitor this debate as it may be carried forward throughout Congressional deliberation on healthcare reform. Boards and executive leadership should also reinforce from the top the hospital's commitment to community benefit and recognize the pressures that may exist in these financially uncertain times to step up collection efforts from patients who cannot pay. Health lawyers may also wish to encourage their clients to strengthen and better document their community benefit activities so that the Schedule H on their Forms 990 accurately depict the full array of their charity care, community benefit, and other community-benefiting activities.

¹² Shreve, *supra*.

¹³ *Id.*

**AHLA's Tax and Finance Practice Group will continue to keep its members apprised of further developments on these matters.*

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