

# Do Nonprofit Hospitals Provide Community Benefit? A Critique of the Standards for Proving Deservedness of Federal Tax Exemptions

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### I. INTRODUCTION

According to Senator Charles Grassley,<sup>1</sup> we are at a “critical crossroads for non-profit hospitals.”<sup>2</sup> Many qualified nonprofit hospitals have received great financial benefits from tax exemption.<sup>3</sup> For example, in 2002, qualified nonprofit hospitals reportedly saved \$2.5 billion in income taxes and \$1.8 billion through the use of tax-exempt bonds.<sup>4</sup> Whether they deserve these exemptions is questionable. A 1990 report by the Government Accountability Office (GAO) showed that “57 percent of the nonprofit hospitals provided less charitable care than the value of the tax exemption they received.”<sup>5</sup> This conflicts with the rationale for tax exemptions: that the benefits

1. Charles Grassley is a Republican Senator from Iowa and former chairman of the Senate Finance Committee. Senator Chuck Grassley of Iowa, *More About Grassley*, <http://www.grassley.senate.gov/about/More-About-Grassley.cfm> (last visited Oct. 16, 2008). Senator Grassley remains on the Senate Finance Committee as a ranking member, *id.*, and has been a ringleader in evaluating and prompting the reform of standards for Internal Revenue Code (I.R.C.) § 501(c)(3) tax-exempt hospitals. *See* Press Release, U.S. Senate Comm. on Fin., *Grassley Asks Non-profit Hospitals to Account for Activities Related to Their Tax-exempt Status* (May 25, 2005) [hereinafter *Press Release*, May 2005], available at <http://finance.senate.gov/press/Gpress/2005/prg052505.pdf> (evidencing Grassley’s leadership in the area of nonprofit compliance).

2. Press Release, U.S. Senate Comm. on Fin., *Grassley Announces Roundtable on Staff Discussion Draft on Non-profit Hospitals* (Oct. 24, 2007), available at <http://www.senate.gov/~finance/press/Gpress/2007/prg102407a.pdf>.

3. “Not-for-profit” is the “technically proper [word] usage” in the tax setting. THOMAS K. HYATT & BRUCE R. HOPKINS, *THE LAW OF TAX-EXEMPT HEALTHCARE ORGANIZATIONS* 4 n.3 (2d ed. 2001). However, this Note will refer to such hospitals as “nonprofit.” Nonprofit hospitals that meet the requirements for tax exemption under the I.R.C. § 501(c)(3) are also referred to as § 501(c)(3) hospitals. Not all nonprofit hospitals are tax-exempt. *Id.* at 5; BRUCE R. HOPKINS, *650 ESSENTIAL NONPROFIT LAW QUESTIONS ANSWERED* 41 (2005). In addition to being exempt from federal income taxes, § 501(c)(3) hospitals “can also obtain tax-exempt-bond financing and receive charitable contributions that are tax deductible to the donor.” CONG. BUDGET OFFICE, *109TH CONG., NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS* 4 (2006) [hereinafter *2006 CBO REPORT*], available at <http://www.cbo.gov/ftpdocs/76xx/doc7695/12-06-Nonprofit.pdf>.

4. 2006 CBO REPORT, *supra* note 3, at 5. Another report suggests that hospitals exempt over \$500 billion in annual gross receipts. John M. Quirk, *Turning Back the Clock on the Health Care Organization Standard for Federal Tax Exemption*, 43 WILLAMETTE L. REV. 69, 72 (2007).

5. HYATT & HOPKINS, *supra* note 3, at 535 (citing GOV’T ACCOUNTABILITY OFFICE, *NONPROFIT HOSPITALS: BETTER STANDARDS NEEDED FOR TAX EXEMPTION* (1990)). Effective July 7, 2004, the General Accounting Office changed its name to the Government Accountability Office. GAO Human Capital Reform Act of 2004, 31 U.S.C. § 702 (2006); *see also* U.S. Government Accountability Office, *Our Name*, <http://www.gao.gov/about/namechange.html> (last visited Feb. 18, 2009) (discussing name change). This Note

nonprofit hospitals provide to society outweigh the benefits that the government would receive from taxing the organizations.<sup>6</sup> Despite congressional proposals in 1991 for stricter standards,<sup>7</sup> the community benefit standard remains in effect.<sup>8</sup> The debate over deservedness has recently reignited, and nonprofit hospitals have been under great scrutiny for the tax exemptions they receive.<sup>9</sup> A study by the Congressional Budget Office (CBO) found that nonprofit hospitals still provide only a mean of 4.7% uncompensated care as a share of total hospital operating expenses.<sup>10</sup> A small number of hospitals, where the majority of charity care is concentrated, significantly influence this average.<sup>11</sup> This suggests that a substantial number of nonprofit hospitals are not *earning*—but are still *receiving*—the same tax exemptions. Since nonprofit hospitals are important to the community,<sup>12</sup> and because it is unfair to allow undeserved tax exemptions, this issue demands serious attention from Congress, the Internal Revenue Service (IRS), and hospital directors.

Part II describes the history of tax exemption for § 501(c)(3) hospitals, from the historical “charity care” tax exemption standard to the current “community benefit” standard. Part II also discusses the criticisms of the current standard and the action the government has taken to improve it. Namely, Part II addresses the discussion draft released by staff members of the Senate Finance Committee (the Committee staff) in July 2007 with proposals for improving the community benefit standard. Part II also discusses the IRS’s redesign of Form 990, the tax form that § 501(c)(3) hospitals must file with the IRS each year.<sup>13</sup>

Part III examines the Committee staff’s proposals and subsequent reactions by

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will refer to all reports authored by the GAO as being authored by the Government Accountability Office, regardless of whether the report was authored before or after its name change.

6. Jack Burns, Note, *Are Nonprofit Hospitals Really Charitable?: Taking the Question to the State and Local Level*, 29 J. CORP. L. 665, 676 (2004).

7. In 1991, two prominent Representatives proposed legislation with stricter standards for hospitals to maintain their tax-exempt status—H.R. 790: The Roybal Bill and H.R. 1374: The Donnelly Bill. See HYATT & HOPKINS, *supra* note 3, at 536–37 (describing The Roybal Bill and The Donnelly Bill). While the bills sparked debate in the House Committee on Ways and Means about the tax-exempt status of nonprofit hospitals, neither bill received enough support for Congress to enact them into law. *Id.*

8. See Quirk, *supra* note 4, at 73 (stating that “the IRS continues to insist that Revenue Ruling 69-545 is the governing law for health care organization tax exemption”).

9. See, e.g., Burns, *supra* note 6, at 672–73 (recognizing that nonprofit hospitals provide less charity care and closely resemble for-profit hospitals); John D. Colombo, *Federal and State Tax Exemption Policy, Medical Debt and Health Care for the Poor*, 51 ST. LOUIS U. L.J. 433 (2007) (same); Press Release, May 2005, *supra* note 1 (evidencing Senator Grassley’s inquiries into the tax exemptions that nonprofit hospitals receive).

10. STAFF OF S. COMM. ON FIN.—MINORITY, 110TH CONG. TAX-EXEMPT HOSPITALS: DISCUSSION DRAFT 2 (Comm. Print 2007) [hereinafter DISCUSSION DRAFT], available at <http://www.senate.gov/~finance/press/Gpress/2007/prg071907a.pdf>; 2006 CBO REPORT, *supra* note 3, at 2.

11. DISCUSSION DRAFT, *supra* note 10, at 2 n.5.

12. Burns, *supra* note 6, at 679 (stating that “local communities see a direct correlation between their increasing health care costs and the diminishing amount of charity care coming from the local, nonprofit hospitals”); see also HYATT & HOPKINS, *supra* note 3, at 8 (“For the United States and other democratic nations, the community of nonprofit organizations is a necessary ingredient of a civil society. Through these organizations, citizens can resolve societal problems and enhance the government.”).

13. See HOPKINS, *supra* note 3, at 66–70 (discussing annual information returns and which organizations have to file them); HYATT & HOPKINS, *supra* note 3, at 695 (stating that the annual return form for hospitals is usually Form 990).

interested persons, including hospitals and scholars. It also examines the changes and reactions to the redesigned Form 990. Part IV suggests that Congress should enact legislation to replace the community benefit standard. This legislation should largely reflect the Committee staff's proposals, with changes and additions discussed in Part IV. Part IV also recommends that Congress refine and enforce the redesigned Form 990.

## II. BACKGROUND

### *A. History of the Standards for Nonprofit Hospitals*

Since 1894, organizations that operate exclusively for one of the purposes described in I.R.C. § 501(c)(3) have been exempt from federal income taxes.<sup>14</sup> In 1976, the U.S. Supreme Court explained that “[n]onprofit hospitals have never received these benefits [from tax-exemption] as a favored general category, but an individual nonprofit hospital has been able to claim them if it could qualify as a corporation ‘organized and operated exclusively for . . . charitable . . . purposes’ within the meaning of § 501(c)(3) of the Code.”<sup>15</sup> A hospital's tax-exempt status is determined on a case-by-case basis, so each hospital must individually prove that it qualifies as a charitable organization.<sup>16</sup> Since the IRS has the authority to enforce the Internal Revenue Code,<sup>17</sup> the IRS determines whether a nonprofit hospital qualifies as a charitable organization under § 501(c)(3).<sup>18</sup> In interpreting § 501(c)(3), the IRS places specific limitations on which organizations are eligible for this benefit. In addition to the standards described throughout this Part, the organization must be formed exclusively for a charitable purpose, its assets must be dedicated to this purpose, and a substantial amount of its activities must further this

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14. I.R.C. § 501(c)(3) (2006); *see also* Nina J. Crimm, *Do Fiduciary Duties Contained in Federal Tax Laws Effectively Promote National Health Care Policies and Practices?*, 15 HEALTH MATRIX 125, 135 n.38 (2005) (describing the history of I.R.C. § 501(c)(3)). To understand tax exemption, it is useful to have a basic understanding of federal income taxation and its purpose:

Under the law of federal income taxation in the United States, every element of gross income received by a person—individual, corporation, trust, estate, or other entity—is subject to tax unless there is a statutory provision that exempts from tax either that person or that element of income . . . . [T]ax features such as exemptions and deductions are usually narrowly construed, although there is authority for the proposition that provisions according tax exemption for charitable organizations are to be liberally construed.

HYATT & HOPKINS, *supra* note 3, at 655 (quotations and citations omitted).

15. *Simon v. E. Ky. Welfare Rights Org.*, 426 U.S. 26, 29 (1976) (citing I.R.C. § 501(c)(3)).

16. HYATT & HOPKINS, *supra* note 3, at 169–70 (citing *Simon*, 426 U.S. at 29).

17. *See* I.R.C. § 7801(b)(2) (2006) (“The Chief Counsel shall be the chief law officer for the Internal Revenue Service and shall perform such duties as may be prescribed by the Secretary of the Treasury.”); *see also* IRS, *The Agency, Its Mission and Statutory Authority*, <http://www.irs.gov/irs/article/0,,id=98141,00.html> (last visited Oct. 16, 2008) (“The IRS is organized to carry out the responsibilities of the [S]ecretary of the Treasury under section 7801 of the Internal Revenue Code.”).

18. *See* IRS, *Exemption Requirements*, <http://www.irs.gov/charities/charitable/article/0,,id=96099,00.html> (last visited Oct. 16, 2008) (explaining the minimum requirements for organizations to qualify for tax exemptions under § 501(c)(3)). Since Congress defines the eligibility of exemptions, it indirectly grants tax exemption. HYATT & HOPKINS, *supra* note 3, at 655; *see also* HOPKINS, *supra* note 3, at 41 (describing how an organization becomes tax exempt). In this context, the IRS's role is to recognize tax exemption in appropriate situations and enforce the I.R.C. HYATT & HOPKINS, *supra* note 3, at 655.

purpose.<sup>19</sup>

### *1. The Charity Care Standard*

Throughout its history, the IRS has used different standards to determine whether a hospital is “charitable” under § 501(c)(3). In 1956, the IRS issued Revenue Ruling 56-185, which implemented “charity care” and “financial ability” standards for determining whether hospitals deserved tax exemptions.<sup>20</sup> The charity care standard of Revenue Ruling 56-185 generally required the following:

(1) the hospital must be organized as a nonprofit charitable organization, the purpose of which is to operate a hospital [that] cares for the sick; (2) the hospital must be operated so that services are provided, to the extent of its financial ability, to those who are not able to pay and not exclusively to those who are able and expected to pay; (3) the use of the hospital’s facilities must not be limited to a particular group of surgeons and physicians . . . to the exclusion of all other qualified doctors; and (4) the hospital’s net earnings must not inure directly or indirectly to the benefit of any private shareholder or individual.<sup>21</sup>

The charity care standard is a reflection of the long-lasting belief that helping the poor should be the determining factor in deciding whether an entity is a charity.<sup>22</sup> The standard is also consistent with the fact that early nonprofit hospitals served indigent persons and thus operated as a type of charity.<sup>23</sup> However, by 1969 the IRS found that changing times necessitated a reformed standard.<sup>24</sup>

### *2. The Community Benefit Standard*

In 1969, the IRS issued Revenue Ruling 69-545,<sup>25</sup> which replaced the charity care standard with a “community benefit” standard.<sup>26</sup> Two main factors influencing the shift were the changing patient base of nonprofit hospitals and the effect of Medicare and Medicaid.<sup>27</sup> Nonprofit hospitals started serving more than just indigent persons,<sup>28</sup> and the

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19. HYATT & HOPKINS, *supra* note 3, at 655.

20. *See, e.g.*, HYATT & HOPKINS, *supra* note 3, at 532 (summarizing the requirements of the charity care standard of Rev. Rul. 56-185); Quirk, *supra* note 4, at 73 (citing Rev. Rul. 56-185, 1956-1 C.B. 202).

21. HYATT & HOPKINS, *supra* note 3, at 532 (citing Rev. Rul. 56-185).

22. *Id.* at 530.

23. Burns, *supra* note 6, at 667 (discussing the history of nonprofit hospitals).

24. *See infra* Part II.A.2 (discussing the community benefit standard that updated the charity care standard); *see also* HYATT & HOPKINS, *supra* note 3, at 170 (stating that it was because of changes in society that “in 1969, the IRS modified its 1956 position by recognizing that the promotion of health is inherently a charitable purpose and is not obviated by the fact that the cost of services is borne by patients or third-party payors”).

25. Rev. Rul. 69-545, 1969-2 C.B. 117.

26. *See, e.g.*, HYATT & HOPKINS, *supra* note 3, at 130 (describing the shift to the community benefit standard); Burns, *supra* note 6, at 668 (same); Quirk, *supra* note 4, at 74 (same).

27. *See, e.g.*, Burns, *supra* note 6, at 669 (describing the effect of Medicare and Medicaid on the standard for tax exemptions); Quirk, *supra* note 4, at 74 (same).

28. HYATT & HOPKINS, *supra* note 3, at 170; Burns, *supra* note 6, at 668.

paying patients generated most of their revenue.<sup>29</sup> Expectations of nonprofit hospitals also changed when the government started paying for health care services for the poor and elderly through Medicare and Medicaid.<sup>30</sup> As a result, the IRS broadened the definition of “charitable” to “include[] over a dozen ways to achieve that status,” including “the ‘promotion of health.’”<sup>31</sup>

The IRS intended the community benefit standard to be a more flexible standard.<sup>32</sup> Accordingly, the IRS eliminated the requirement that nonprofit hospitals must provide health care at a free or reduced cost.<sup>33</sup> The IRS also provided factors that courts should consider when determining whether a hospital is charitable for tax purposes.<sup>34</sup> These factors include:

- (1) whether a board of trustees control[s] the hospital and, if so, whether civic leaders compose the board;
- (2) whether the hospital has an open medical staff and extends privileges to all qualified physicians in the area;
- (3) whether the hospital operates an active and accessible emergency room,<sup>35</sup> regardless of patients’ ability to pay;
- (4) whether the hospital provides medical care to all persons able to pay; and
- (5) whether surplus funds, when used, improve the quality of patient care.<sup>36</sup>

Courts recognize that these are merely factors for consideration; absence of one or more factors does not prevent a hospital from obtaining § 501(c)(3) tax-exempt status.<sup>37</sup> Despite the IRS’s push for more charity care, the community benefit standard remains the standard for determining tax-exempt status.<sup>38</sup>

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29. See Burns, *supra* note 6, at 668 (stating that “a significant source of [nonprofit hospitals’] revenue came from paying patients”).

30. See, e.g., HYATT & HOPKINS, *supra* note 3, at 170 (stating that “reimbursement programs under Medicare and Medicaid have reduced the number of patients who lack an ability to ‘pay’ for health services”); Burns, *supra* note 6, at 669 (recognizing that “Medicare and Medicaid also played a role in the changing definition of ‘charitable’”); Quirk, *supra* note 4, at 73 (stating that “[t]he movement toward a new standard for exemption began in the 1960s due to hospital objections that the [charity care standard] was no longer relevant following the advent of the new Medicare and Medicaid legislation”).

31. HYATT & HOPKINS, *supra* note 3, at 130.

32. *Id.* at 132.

33. *Id.* at 171.

34. Burns, *supra* note 6, at 668–69; Rev. Rul. 69-545, 1969-2 C.B. 117; HYATT & HOPKINS, *supra* note 3, at 33–34 (describing the community benefit standard).

35. In 1983, the IRS issued Revenue Ruling 83-157, which eliminated the emergency room requirement for nonprofit hospitals that already have an emergency room in their community. Rev. Rul. 83-157, 1983-2 C.B. 94.

36. Burns, *supra* note 6, at 668–69; *accord* Rev. Rul. 69-545, 1969-2 C.B. 117.

37. See *St. David’s Health Care Sys. v. United States*, 349 F.3d 232, 236 (5th Cir. 2003) (stating that “[a] hospital need not demonstrate all of these factors in order to qualify for § 501(c)(3) tax-exempt status” (citing Rev. Rul. 69-545, 1969-2 C.B. 117; *Geisinger Health Plan v. Comm’r*, 985 F.2d 1210, 1219 (3d Cir. 1993))).

38. See JANET E. GITTERMAN & MARVIN FRIEDLANDER, IRS HEALTH CARE PROVIDER REFERENCE GUIDE, EXEMPT ORGANIZATIONS CONTINUING PROFESSIONAL EDUCATION (CPE) TECHNICAL INSTRUCTION PROGRAM FOR FISCAL YEAR 2 (2004), available at <http://www.irs.gov/pub/irs-tege/eotopic04.pdf> (explaining that to qualify for tax exemption, “the organization must meet the community benefit standard”); see also *St. David’s Health Care Sys.*, 349 F.3d at 232; HYATT & HOPKINS, *supra* note 3, at 41–42 (discussing two circuit cases decided in 2003 that upheld the community benefit standard (citing *IHC Health Plans, Inc. v. Comm’r*, 325 F.3d 1188 (10th Cir. 2003))). But see Quirk, *supra* note 4, at 75–76 (discussing the IRS’s position in the 1978 Tax Court case, *Sound Health Ass’n v. Comm’r*, 71 T.C. 158 (1978), suggesting that receiving tax-exempt

### 3. Criticisms of the Community Benefit Standard

Scholars and policymakers alike believe the community benefit standard is flawed. According to the CBO, “[a]lthough nonprofit hospitals must provide community benefits in order to receive tax exemptions, there is little consensus on what constitutes a community benefit or how to measure such benefits.”<sup>39</sup> In addition to believing that the community benefit standard is unworkable, people also criticize the standard for not requiring free health care for the poor<sup>40</sup> and for lacking accountability.<sup>41</sup> Scholars have suggested that “[u]nder the current community benefit standard, it is entirely possible for a nonprofit hospital to provide less charity care than a for-profit counterpart and still be tax exempt.”<sup>42</sup>

The judicial system has also weighed in on the community benefit standard.<sup>43</sup> Federal courts generally show support for the community benefit standard,<sup>44</sup> though their application of the standard has been somewhat inconsistent. In *St. David’s Health Care System v. United States*,<sup>45</sup> the Fifth Circuit held that “the community benefit standard was the appropriate benchmark for analysis,” though the decision turned on the fact that the hospital did not meet the § 501(c)(3) guidelines.<sup>46</sup> In *IHC Health Plans, Inc., v.*

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status requires “more than simply provid[ing] for free health care to a large portion of the community”).

39. 2006 CBO REPORT, *supra* note 3, at 1; *see also* GOV’T ACCOUNTABILITY OFFICE, NONPROFIT HOSPITALS: VARIATIONS IN STANDARDS AND GUIDANCE LIMITS COMPARISON OF HOW HOSPITALS MEET COMMUNITY BENEFIT REQUIREMENTS 40 (2008), *available at* <http://www.gao.gov/new.items/d08880.pdf>. In a 2008 report, the GAO observed:

States vary considerably in the extent to which they have community benefit requirements, the nature of the requirements, and instructions on how to measure the components of community benefit. At present, determination and measurement of activities as community benefit for federal purposes are still largely matters of individual hospital discretion.

GOV’T ACCOUNTABILITY OFFICE, *supra*, at 40.

40. Burns, *supra* note 6, at 677.

41. *See* Colombo, *supra* note 9, at 447. Colombo alleges the community benefit standard “provides essentially zero accountability in operational behavior” since hospitals can qualify for tax exemptions even though they behave like for-profit hospitals. *Id.* at 447–48.

42. Burns, *supra* note 6, at 678; *see also* Colombo, *supra* note 9, at 433 (stating that “tax-exempt nonprofit hospitals provide little more in the way of uncompensated care for the uninsured poor than for-profit hospitals do, except to call it by a different name (for-profit hospitals refer to it as bad debt; nonprofits refer to it as charity care)”).

43. *E.g.*, *St. David’s Health Care Sys.*, 349 F.3d at 232; *IHC Health Plans, Inc.*, 325 F.3d at 1188; *Geisinger Health Plan v. Comm’r*, 985 F.2d 1210 (3d Cir. 1993); *Hosp. Utilization Project v. Commonwealth*, 487 A.2d 1306 (Pa. 1985); *Utah County v. Intermountain Health Care*, 709 P.2d 265 (Utah 1985); *Med. Ctr. Hosp. of Vt., Inc. v. City of Burlington*, 566 A.2d 1352 (Vt. 1989).

44. *See* THOMAS K. HYATT & BRUCE R. HOPKINS, *THE LAW OF TAX-EXEMPT HEALTHCARE ORGANIZATIONS* 41–42 (2d ed., Supp. 2007) [hereinafter HYATT & HOPKINS, Supp. 2007] (noting that the Third Circuit and Fifth Circuit upheld the community benefit standard in two high profile cases). *But see* Quirk, *supra* note 4, at 75–76 (describing a Third Circuit decision that upheld the community benefit standard but used a more general application of it (citing *Geisinger Health Plan*, 985 F.2d 1210)).

45. *St. David’s Health Care Sys.*, 349 F.3d at 232.

46. HYATT & HOPKINS, Supp. 2007, *supra* note 44, at 42 (citing *St. David’s Health Care Sys.*, 349 F.3d 232). In *St. David’s Health Care System*, the court found that after a nonprofit hospital partnered with a for-profit company, it was questionable whether a substantial amount of its activities furthered the for-profit interests of the organization. *St. David’s Health Care Sys.*, 349 F.3d at 239–44.

*Commissioner*,<sup>47</sup> the Third Circuit held that “while the concept of ‘community benefit’ is somewhat amorphous, . . . it provides a workable standard for determining tax exemption under section 501(c)(3).”<sup>48</sup> The court then applied a “benefit-plus” standard.<sup>49</sup> Essentially, the court found that promoting health is not determinative of tax exemption under § 501(c)(3); determining whether an organization should be tax exempt “turns ‘not on the nature of the activity, but on the *purpose* accomplished thereby.”<sup>50</sup> Thus, according to the Third Circuit, a nonprofit hospital must be available to all community members, provide community benefits in addition to its services, and show that the additional benefit is the primary purpose for the organization’s existence.<sup>51</sup> This test is stricter than the test that the Third Circuit laid out in *Geisinger Health Plan v. Commissioner*,<sup>52</sup> a case in which the court denied tax exemption to a health care organization that served 70,000 community members because those who benefited were “subscribers” to the organization and not “the community at large.”<sup>53</sup>

Some state courts have also applied seemingly stricter standards, requiring a more in-depth analysis to determine whether a hospital is charitable.<sup>54</sup> The Utah Supreme Court held that a “nonprofit hospital is not a charitable entity for state property tax exemption purposes, because it operates no differently from a for-profit hospital.”<sup>55</sup> In reaching its decision, the court recognized that nonprofit hospitals are being “financed principally out of payments from patients.”<sup>56</sup> Therefore, these hospitals have migrated toward the categories of “business” and “professionals.”<sup>57</sup> In contrast, the Vermont Supreme Court approached the issue of whether a hospital is charitable in a manner more closely reflecting the IRS’s interpretation.<sup>58</sup> The Vermont court “extended tax-exempt status to nonprofit hospitals because it saw the social value of care for the sick as being great enough to justify tax exemption.”<sup>59</sup>

In the IRS’s 2004 Exempt Organizations Continuing Professional Education text, the IRS seemingly contradicted its position from the 2003 lawsuits.<sup>60</sup> In this publication,

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47. *IHC Health Plans, Inc.*, 325 F.3d at 1188.

48. *Id.* at 1197.

49. *Id.*

50. *Id.* at 1197–98 (quoting *Bethel Conservative Mennonite Church v. C.I.R.*, 746 F.2d 388, 391 (7th Cir. 1984)).

51. *Id.* at 1198.

52. *Geisinger Health Plan v. Comm’r*, 985 F.2d 1210 (3d Cir. 1993).

53. *Quirk*, *supra* note 4, at 75–77 (citing *Geisinger Health Plan*, 985 F.2d at 1219).

54. *Burns*, *supra* note 6, at 674–75 (describing the six-point test that the Utah Supreme Court utilized to determine whether a hospital is “charitable” and the five-point test that the Pennsylvania courts have utilized to determine whether a hospital is “charitable” (citing *Utah County v. Intermountain Health Care*, 709 P.2d 265 (Utah 1985); *Hosp. Utilization Project v. Pennsylvania*, 487 A.2d 1306 (Pa. 1985))). States have authority to set their own standards for tax exemptions, though state laws providing tax exemption for nonprofit organizations are frequently very similar to the federal law providing tax exemptions for nonprofit organizations. *HOPKINS*, *supra* note 3, at 41.

55. *HYATT & HOPKINS*, *supra* note 3, at 171 (citing *Utah County*, 709 P.2d 265).

56. *Id.*

57. *Id.*

58. *Burns*, *supra* note 6, at 675–76 (citing *Med. Ctr. Hosp. of Vt., Inc. v. City of Burlington*, 566 A.2d 1352 (Vt. 1989)).

59. *Id.* at 676.

60. *See Quirk*, *supra* note 4, at 83 (discussing the IRS’s position in its 2004 Exempt Organizations Continuing Professional Education text).

the IRS confirmed that community benefit continued to be the standard, asserting “a formal policy to provide charity care is still relevant,” but that the additional factors listed in Revenue Ruling 69-545<sup>61</sup> “modified [the] financial ability standard.”<sup>62</sup> This position is contrary to the IRS’s position in *St. David’s Healthcare System*, in which the IRS argued in favor of applying the financial ability standard.<sup>63</sup>

#### 4. Criticisms of Nonprofit Hospitals

Many critics have highly scrutinized nonprofit hospitals because of their belief that such hospitals do not provide enough charity care or community benefit to justify the tax benefits they receive.<sup>64</sup> Critics suggest that nonprofit hospitals too closely resemble for-profit hospitals and that these hospitals write off bad debt as charity care<sup>65</sup> while receiving an estimated \$12.6 to \$20 billion in tax exemptions each year at the federal, state, and local levels.<sup>66</sup> A 2006 study by the CBO showed that nonprofit hospitals provide a mean of 4.7% of uncompensated care as a share of their operating expenses.<sup>67</sup> This is not significantly higher than for-profit hospitals, which provided a mean of 4.2% of uncompensated care as a share of their operating expenses in 2006.<sup>68</sup> Analysts have noted that some nonprofit hospitals have decreased their amount of charity care in exchange for greater efficiency.<sup>69</sup> However, scholars also suggest that this push for efficiency is, at least in part, the result of pressure from the federal government.<sup>70</sup>

#### B. Recent Action by the Senate Finance Committee

Growing concern over nonprofit hospitals’ deservedness of the tax exemptions and the ambiguities in the community benefit standard led Senator Charles Grassley, former Senate Finance Committee Chairman, to initiate further investigation into nonprofit hospitals.<sup>71</sup> In May 2005, Senator Grassley sent letters to ten large nonprofit health care

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61. See discussion *supra* Part II.A.2 for factors included in Revenue Ruling 69-545.

62. Quirk, *supra* note 4, at 84.

63. See *id.* at 84 (describing the IRS’s position in *St. David’s Healthcare System*).

64. Colombo, *supra* note 9, at 433 (stating that “[a]nother substantial body of empirical evidence indicates that . . . many tax-exempt hospitals do not provide charity care in an amount equivalent to the value of their tax exemptions”).

65. See, e.g., Burns, *supra* note 6, at 666, 672–73 (discussing the complaints that nonprofit hospitals provide less charity care and community benefit than for-profit hospitals and that nonprofit hospitals write off bad debt as charity care); Colombo, *supra* note 9, at 433 (stating that a “substantial body of empirical evidence indicates that tax-exempt nonprofit hospitals provide little more in the way of uncompensated care for the uninsured poor than for-profit hospitals do, except to call it by a different name (for-profits refer to it as bad debt; nonprofits refer to it as charity care”).

66. DISCUSSION DRAFT, *supra* note 10, at 2. On October 30, 2007, Senator Charles Grassley commented that nonprofit hospitals receive \$50 billion in tax breaks each year. Press Release, U.S. Senate Comm. on Fin., Remarks of Sen. Charles Grassley, Roundtable on Non-profit Hospitals (Oct. 30, 2007), available at <http://finance.senate.gov/press/Gpress/2007/prg103007.pdf>.

67. 2006 CBO REPORT, *supra* note 3, at 2.

68. *Id.*

69. Burns, *supra* note 6, at 679.

70. *Id.* at 678 (“The amount of money the federal government expends through Medicare and Medicaid programs predisposes the federal government to favor an efficient, business-like hospital. Unfortunately, this drives the nonprofit hospitals to imitate the for-profit hospitals.”).

71. Quirk, *supra* note 4, at 72; Senator Charles Grassley, Chairman, U.S. Senate Comm. on Fin., Remarks

providers inquiring about their charity care policies, compensation policies, and types of community benefit.<sup>72</sup> The hospitals' responses indicated there was a lack of "common policy among hospitals" regarding "such critical areas as charity care."<sup>73</sup> Grassley found that nonprofit hospitals were "provid[ing] less care to the poor than their for-profit counterparts, . . . charg[ing] poor, uninsured patients more for the same services than they charge insured patients, . . . [and] giv[ing] their executives gold-plated compensation packages and generous perks."<sup>74</sup> Grassley also found that the lack of "uniform standards or definitions for charity care and community benefit," coupled with the fact that nonprofit hospitals are not required to report information about their charity care or community benefit activities to the IRS, makes it nearly impossible to measure just how much charity care and community benefit each nonprofit hospital provides.<sup>75</sup>

In September 2006, Senator Grassley instructed the Committee staff to prepare a discussion draft with proposals to tackle the problems saturating the world of nonprofit hospitals.<sup>76</sup> This group released the discussion draft in July 2007.<sup>77</sup> The Committee staff considered findings in recent studies by the CBO and GAO, among other information, when preparing its proposals.<sup>78</sup> In short, the Committee staff proposed that § 501(c)(3) hospitals should have to do the following to maintain their tax-exempt status: (1) establish a charity care standard and widely publicize the same; (2) meet minimum quantitative standards of charity care; (3) govern all joint ventures with non-§ 501(c)(3) hospitals according to these § 501(c)(3) standards; (4) regularly conduct a community needs assessment; (5) follow a specified formula for determining charges for uninsured or underinsured patients; (6) meet detailed specifications for the make-up of the board of

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at 2005 Independent Sector Annual Conference, CEO Summit 4 (Oct. 24, 2005) [hereinafter Grassley, Independent Sector Conference], available at <http://finance.senate.gov/press/Gpress/2005/prg102405b.pdf>. He was not alone, as May 2005 was the beginning of heavy debate in both the Senate Finance Committee and the House Ways and Means Committee regarding the tax-exempt status of nonprofit hospitals. Quirk, *supra* note 4, at 85. The year 2005 was not the beginning of Senator Grassley's review of nonprofit organizations. He began looking into general nonprofit compliance in June 2004. Press Release, U.S. Senate Comm. on Fin., Grassley Works to Protect Charities from Misuse, Exploitation (June 22, 2004), available at <http://www.senate.gov/~finance/press/Gpress/2004/prg062204a.pdf>. Grassley focused on hospitals, however, beginning in 2005. See Press Release, May 2005, *supra* note 1 (showing the Senate's increased interest in the activity of nonprofit hospitals).

72. Press Release, May 2005, *supra* note 1.

73. Grassley, Independent Sector Conference, *supra* note 71, at 4. Senator Grassley commented that "[i]t was rare to get the same answer from even two hospitals" on questions, including those regarding measuring charity care and community benefit. Press Release, U.S. Senate Comm. on Fin., Non-profit Hospital Responses to Finance Committee (Sept. 12, 2006) [hereinafter Grassley, Non-profit Hospital Responses], available at <http://www.senate.gov/~finance/press/Gpress/2005/prg091206.pdf>.

74. Grassley, Non-profit Hospital Responses, *supra* note 73, at 1.

75. *Id.*

76. Press Release, U.S. Senate Comm. on Fin., EMBARGOED staff discussion draft (not proposed legislation) of Non-profit Hospital Reforms 1 (July 18, 2007), available at <http://finance.senate.gov/press/Gpress/2007/prg071907.pdf>.

77. *Id.*

78. See DISCUSSION DRAFT, *supra* note 10, at 2 (referencing studies by the CBO and GAO). Note that this is not proposed legislation; it is "a work in progress and is meant to encourage and foster additional discussion as the Finance Committee continues to consider possible legislative reform in this area." *Id.* Additionally, note that the Committee staff prepared this discussion draft prior to the release of the IRS Questionnaire results, discussed *infra* Part II.C.2.

directors; and (7) file annual reports in specified areas.<sup>79</sup>

### *1. The Committee Staff's Proposals*

The Committee staff provided proposals for ensuring that nonprofit hospitals are deserving of the tax exemptions they receive. First, the Committee staff proposed that Congress should require all § 501(c)(3) hospitals to develop a charity care policy. The Committee staff explained that hospitals should write this policy so that the general public can easily understand it, and it should “[set] forth eligibility requirements, procedures for obtaining free or discounted care, and where a patient can obtain more information.”<sup>80</sup> Additionally, Congress should require the hospitals to make the policies available online at all times, in emergency rooms, and in admissions offices.<sup>81</sup> Congress should also require the hospitals to make the policy available upon request to members of the public, the IRS, and the Department of Health and Human Services.<sup>82</sup> Congress should require the hospital to provide this policy in the foreign languages necessary to meet the needs of the community.<sup>83</sup> The Committee staff even recommended that 100% of individuals at or below the Federal Poverty Level (FPL) should receive free medically necessary hospital services.<sup>84</sup>

Second, the Committee staff proposed that nonprofit hospitals should meet an annual minimum aggregate charity care amount and a rolling average charity care amount measured over the course of several years.<sup>85</sup> The Committee staff proposed that a hospital should dedicate a minimum of five percent of either its operating expenses or revenues—whichever is greater—to charity care.<sup>86</sup> Additionally, the Committee staff proposed that the value of charity care “will be based on a rate that equals the lower of: (i) the lowest rate that would be paid by Medicare/Medicaid or (ii) the actual unreimbursed cost to the hospital for such service.”<sup>87</sup>

Third, the Committee staff recognized that nonprofit hospitals may be “in an unequal bargaining position when negotiating a joint venture with certain for-profit entities,” and that some nonprofit organizations divert funds from nonprofit hospitals to

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79. DISCUSSION DRAFT, *supra* note 10, at 16–17.

80. *Id.* at 6.

81. *Id.*

82. *Id.*

83. The Committee staff did not determine specific foreign languages in which hospitals should provide their charity care policies; it only suggested “[t]hese policies should also be made available in multiple languages if the needs of the community require it.” *Id.*

84. DISCUSSION DRAFT, *supra* note 10, at 7. FPL refers to guidelines issued annually by the Department of Health and Human Services as “a simplification of the poverty thresholds for use for administrative purposes.” U.S. Dep’t of Health & Human Servs., 2007 Federal Poverty Guidelines, <http://aspe.hhs.gov/poverty/07poverty.shtml> (last visited Oct. 15, 2008). According to the Department of Health & Human Services, “poverty guidelines are sometimes loosely referred to as the ‘federal poverty level’ . . . but that phrase is ambiguous and should be avoided, especially in situations (e.g. legislative or administrative) where precision is important.” *Id.* Because the Committee staff uses the phrase “Federal Poverty Level” in its discussion draft, that phrase is used throughout this Note to refer to the poverty guidelines. See *id.* for the 2007 poverty guidelines.

85. DISCUSSION DRAFT, *supra* note 10, at 7.

86. *Id.* The Committee staff chose five percent as the standard based upon staff review audits. *Id.*

87. *Id.* at 8.

for-profit entities.<sup>88</sup> Therefore, the Committee staff proposed the following regulations to govern such situations. To start, “the joint venture must meet the charity care requirement applicable to § 501(c)(3) hospitals,” and the nonprofit hospital must control the joint venture’s board.<sup>89</sup> When a nonprofit hospital places its assets in a joint venture, the nonprofit hospital’s charity care policy must also control the joint venture’s charity care policy.<sup>90</sup> If multiple nonprofits are involved in a joint venture, at least one member on the board of directors must represent each nonprofit hospital involved in the joint venture.<sup>91</sup>

Fourth, the Committee staff proposed requiring nonprofit hospitals to identify vulnerable populations in their communities by completing a community needs assessment every three years.<sup>92</sup> Fifth, the Committee staff specified how to determine charges for hospital patients. According to the Committee staff, charges to medically indigent<sup>93</sup> or underinsured<sup>94</sup> patients must be the lower of the amount paid by the government or the actual hospital cost.<sup>95</sup> While this rule would ideally apply equally to everyone, the Committee staff recommended that, at a minimum, it would apply to those patients who are at the FPL.<sup>96</sup>

Sixth, the Committee staff proposed regulations in corporate governance. Specifically, the Committee proposed that the board of directors consist of “members who represent the broad interests of the public,” including “advocates or representatives of those benefiting . . . from charity care and discounted care for the medically indigent.”<sup>97</sup> Additionally, “not more than 25% of the voting power of the board of directors [should be] vested in persons who are employed by the hospital or who will benefit financially” from the hospital’s activities, and “physicians and management should not comprise more than 25% [of the board’s voting power].”<sup>98</sup> Hospitals should implement a detailed conflict of interest policy, and the board should be responsible for overseeing the charity care policy.<sup>99</sup>

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88. *Id.* at 10–11.

89. DISCUSSION DRAFT, *supra* note 10, at 11.

90. See *id.* for a discussion of the formula to determine how much of the joint venture’s charity care can count toward the nonprofit hospital’s annual charity care requirement.

91. *Id.* at 11.

92. *Id.* at 12.

93. The Committee staff defined “medically indigent” as “patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and that their medical expense, in relationship to their income, would make them indigent if they were forced to pay full charges for their medical expenses.” *Id.* at 9.

94. The Committee staff proposed the following definition for “underinsured”:

[A] patient who has insurance all year but has inadequate financial protection, as indicated by one of three conditions: 1) annual out-of-pocket medical expenses amount to 10% or more of income; 2) among low-income adults (incomes under 200% [of the FPL]), out-of-pocket medical expenses amount[ing] to 5% or more of income; or 3) health plan deductibles equal [to] or exceed[ing] 5% of income.

DISCUSSION DRAFT, *supra* note 10, at 9 (quotation omitted).

95. *Id.* at 13.

96. *Id.* at 14.

97. *Id.*

98. *Id.*

99. DISCUSSION DRAFT, *supra* note 10, at 14–15. Specifically, the Committee staff proposed that the board of directors should be responsible for the following:

Seventh, the Committee staff addressed sanctions for hospitals that fail to comply with § 501(c)(3) requirements.<sup>100</sup> Specifically, the Committee staff proposed an excise tax on any organization that fails to meet the quantitative requirements.<sup>101</sup> In the case of nonprofit hospitals, the Committee staff suggested that the excise tax be at least double the amount that the hospital fell short in meeting the annual charity care and community benefit requirements.<sup>102</sup> However, the Committee staff suggested that to determine whether the hospital met the requirements, the IRS should look at the average charity care or community benefits over a three-year period.<sup>103</sup> The IRS should also have authority, according to the Committee staff, to reduce the excise tax to the amount of the shortfall, if the hospital can show both that it typically meets the requirement and that a lack of demand caused the shortfall.<sup>104</sup>

Finally, the Committee staff proposed reporting requirements.<sup>105</sup> According to its proposal, nonprofit hospitals would have to make an annual report to the IRS and to the public disclosing compensation of the board of directors, operating expenses and revenues, total amount of charity care provided, how many people received charity care, how many people applied for charity care, the total amount of community benefits provided and how many people benefited, amounts reimbursed by private and governmental insurers, amounts paid to the hospital from special indigent funds, and specific information regarding joint ventures.<sup>106</sup> The Committee staff intended such reporting to “promote transparency, help ensure compliance with the laws, inform local communities, and provide information that would assist future legislation or regulations.”<sup>107</sup>

## *2. Reactions to the Prospect of New Legislation*

On October 24, 2007, Senator Grassley stated that he “[had not] made any decisions about whether legislation is necessary to address the issues we’ve seen regarding non-

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[S]etting the criteria for charity care; discounts for low-income or uninsured patients who have the ability to pay a small portion of their bill; eligibility determination when there is insufficient information provided by the patient to fully evaluate all the criteria, and the ability to pay cannot be reliably determined; the extent of verification necessary for eligibility determinations; the time frame within which patients are eligible for charity care; and other related issues. [The board should also] review the Form 990 and schedules as well as review and approve the community needs assessment.

*Id.*

100. *Id.* at 14–15, 17. The Committee staff recommended that the Federal Debt Collection Practices Act, “a federal law that protects those with medical debt from certain unfair or abusive debt collection practices conducted by debt collection agencies and attorneys who collect debts . . . be expanded to apply to internal hospital billing and collection practices.” *Id.* at 17–18.

101. *Id.* at 15.

102. DISCUSSION DRAFT, *supra* note 10, at 15.

103. *Id.*

104. *Id.*

105. The Committee staff also made recommendations relating to other areas, such as requirements for converting from a § 501(c)(3) to § 501(c)(4) hospital and practices for the collection of medical debt, but these topics are outside the scope of this Note. *See id.* at 6–18 (discussing all of the Committee staff’s proposals).

106. *Id.* at 17.

107. DISCUSSION DRAFT, *supra* note 10, at 17.

profit hospitals.”<sup>108</sup> However, scholars have speculated that the actions of the Senate Finance Committee will lead to a new standard for determining tax-exempt status.<sup>109</sup> On October 30, 2007, Senator Grassley held a roundtable discussion with “representatives from the government, hospitals, hospital associations, public charities that advocate on behalf of the poor, and academics” to “discuss issues in the implementation of proposals of the staff discussion draft, as well as questions raised in the staff discussion draft.”<sup>110</sup> Not surprisingly, individuals potentially affected by this change have reacted to the prospect of new legislation with mixed reviews.<sup>111</sup>

### *C. Recent Action by the Internal Revenue Service*

#### *1. Reporting Requirements for Tax-Exempt Hospitals*

Once the IRS recognizes a nonprofit organization as being tax-exempt, the nonprofit organization is required to file Form 990, an annual information return.<sup>112</sup> Form 990, a public document, is “the primary tax compliance tool for tax-exempt organizations.”<sup>113</sup> Most states also rely on Form 990 as a method of overseeing § 501(c)(3) organizations.<sup>114</sup> Thus, Form 990 “is the key transparency tool relied on by the public, state regulators, the media, researchers, and policy makers to obtain information about the tax exempt sector and individual organizations.”<sup>115</sup>

Form 990 originally contained mostly financial information.<sup>116</sup> Over time, however,

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108. Press Release, U.S. Senate Comm. on Fin., Grassley Announces Roundtable on Staff Discussion Draft on Non-profit Hospitals (Oct. 24, 2007) [hereinafter Press Release, Oct. 2007], available at <http://www.senate.gov/~finance/press/Gpress/2007/prg102407a.pdf>.

109. See Quirk, *supra* note 4, at 89 (suggesting that the end result of the Senate Finance Committee’s investigations will be clarity in the “level of ‘charity care’ [] required” and “Revenue-Ruling 69-545’s ‘Community Benefit Standard’ [will be put] to rest”).

110. Press Release, Oct. 2007, *supra* note 108. For a list of the 18 participants in the roundtable discussion, see Press Release, U.S. Senate Comm. on Fin., Participant List for October 30, 2007, Non-profit Hospital Roundtable (Oct. 26, 2007) [hereinafter Roundtable Participants], available at <http://www.senate.gov/~finance/press/Gpress/2007/prg102607.pdf>. See Part III.A for the participants’ perspectives on the Committee staff’s proposals.

111. See discussion *infra* Part III.A (describing certain individuals’ reactions to a potential change in the legislation).

112. See HYATT & HOPKINS, *supra* note 3, at 695 (stating that the annual return form for hospitals is usually Form 990); HOPKINS, *supra* note 3, at 66–70 (discussing annual information returns and which organizations have to file them). It is important to appreciate the distinction between the annual information return and other tax returns. Hopkins makes this distinction clear:

The document involved is not an *annual report* (such as may be required under state law), and it is not a *tax return*. . . . The document that must be filed is an *information return*, which means, among other things, it is a return that contains much more than financial information and it must be made available to the public.

*Id.* at 67.

113. IRS, TAX-EXEMPT & GOV’T ENTITIES DIV., BACKGROUND PAPER: REDESIGNED DRAFT FORM 990, at 1 (2007) [hereinafter BACKGROUND PAPER], available at [http://www.irs.gov/pub/irs-tege/form\\_990\\_cover\\_sheet.pdf](http://www.irs.gov/pub/irs-tege/form_990_cover_sheet.pdf).

114. *Id.*

115. *Id.*

116. HYATT & HOPKINS, *supra* note 3, at 696.

the IRS amended the form to include revenues,<sup>117</sup> expenses, a description of program service accomplishments, and a list of trustees, directors, and officers, along with their compensation.<sup>118</sup> In addition to the basic information required on Form 990, the IRS also required tax-exempt hospitals to report additional information regarding “taxable subsidiaries, changes made in organizing or governing documents, receipt of unrelated income, . . . relationships with other organizations, political expenditures, receipt of nondeductible gifts, and requests to see an annual information return or application for recognition of tax exemption.”<sup>119</sup>

Finally, in addition to filing the annual return, the IRS required tax-exempt hospitals to file a Schedule A form.<sup>120</sup> On this form, the hospital disclosed the compensation of the highest paid employees and submitted information regarding interactions and relationships with other organizations.<sup>121</sup> The IRS also required hospitals to make these annual information forms available for public inspection, without charge, for three years.<sup>122</sup>

In addition to overseeing the annual information forms, the IRS has authority to audit tax-exempt organizations.<sup>123</sup> Just as the IRS has special reporting requirements for nonprofit hospitals, it also has audit guidelines specific to health care organizations, including tax-exempt hospitals.<sup>124</sup> In recent years, auditing “tax-exempt hospitals and other healthcare entities [has been] a matter of special priority [for the IRS].”<sup>125</sup> However, according to one report, from 1996–2006 the IRS audited only 375 of the 7000 nonprofit hospitals and health care organizations.<sup>126</sup> Additionally, “IRS audits of nonprofit hospitals from 2001 to 2006 did not examine community benefit.”<sup>127</sup>

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117. Form 990 requires disclosure of where the revenue originated (i.e., fundraising, grants, Medicare/Medicaid payments), and whether the revenue is related to the exempt function of the organization. IRS, OMB NO. 1545-0047, FORM 990, RETURN OF ORGANIZATION EXEMPT FROM INCOME TAX (2008) [hereinafter FORM 990], available at <http://www.irs.gov/pub/irs-tege/f990rcore.pdf>; see also HOPKINS, *supra* note 3, at 74–80 (describing the information tax-exempt organizations must disclose on Form 990). Exempt function revenue “is revenue derived from related business activities.” HOPKINS, *supra* note 3, at 76.

118. HYATT & HOPKINS, *supra* note 3, at 696–97. Form 990-EZ is a simplified form available to organizations with “gross receipts that are less than \$100,000 and total assets that are less than \$250,000 . . .” *Id.* at 699. Even if a nonprofit hospital files Form 990-EZ, it must still file a Schedule A. *Id.*

119. *Id.* at 697–98 (footnotes omitted).

120. *Id.* at 699.

121. HYATT & HOPKINS, *supra* note 3, at 699.

122. *Id.* at 702–03.

123. *Id.* at 712.

124. *Id.* at 715. “The guidelines emphasize nearly all aspects of qualification for tax-exempt status by hospitals, with emphasis on private inurement and private benefit situations, and also focus on joint venture arrangements and unrelated business income circumstances.” *Id.* (footnotes omitted). For information regarding the audit guidelines, see HYATT & HOPKINS, *supra* note 3, at 715–25. See also *Exempt Organizations Examination Guidelines Handbook, IRS Hospital Audit Guidelines*, reprinted in HYATT & HOPKINS, *supra* note 3, at 761–71.

125. HYATT & HOPKINS, *supra* note 3, at 715.

126. Sarah Zuckerman, *Nonprofit Hospitals: Operating for the Benefit for the Community*, 54 EXEMPT ORG. TAX REV. 39, 40 (2006).

127. Press Release, U.S. Senate Comm. on Fin., GAO Report on Non-profit Hospitals (Oct. 14, 2008), available at <http://finance.senate.gov/press/Gpress/2008/prg101408.pdf>.

## 2. *The IRS's "Hospital Compliance Project"*

In May 2006, the IRS sent questionnaires to 544 tax-exempt hospitals as a part of its "Hospital Compliance Project" (the Project).<sup>128</sup> The 81-item questionnaire asked hospitals about revenues, annual patient visits, patients' insurance coverage, denial of medical services, governance, medical staff privileges, medical research conducted, professional training paid for, uncompensated care, billing and collection practices, and community programs offered.<sup>129</sup> Four hundred eighty-seven hospitals responded, though not every hospital answered every question.<sup>130</sup> While the data from these questionnaires is still under review, the IRS indicated its initial review revealed that "respondents report similar information in different ways, . . . [and that] there is variation in the level of expenditures hospitals report in furtherance of community benefit, . . . [including] considerable variation in how hospitals report uncompensated care."<sup>131</sup> The IRS also reported that "[a]lthough 97% of hospitals . . . had a written uncompensated care policy, there was no uniform definition of what constitutes 'uncompensated care' among the respondents."<sup>132</sup>

## 3. *The IRS's Recent Amendments to Form 990*

Even though an IRS spokesperson testified in 1991 that "[t]he 'nonprofit hospital environment . . . demands considerable interpretative and enforcement resources,'"<sup>133</sup> the IRS has not redesigned Form 990 since 1979.<sup>134</sup> However, the IRS found that "the

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128. See IRS, EXECUTIVE SUMMARY, HOSPITAL COMPLIANCE PROJECT INTERIM REPORT (2007) [hereinafter EXECUTIVE SUMMARY], available at <http://www.senate.gov/~finance/press/Gpress/2007/prg071907e.pdf> (discussing the Hospital Compliance Project); see also IRS, HOSPITAL COMPLIANCE PROJECT, INTERIM REPORT 1, 5 (2007) [hereinafter INTERIM REPORT], available at <http://www.senate.gov/~finance/press/Gpress/2007/prg071907f.pdf> (summarizing the Project and its data); Press Release, IRS, IRS Releases Interim Report on Tax-Exempt Hospitals and Community Benefit Project (July 19, 2007) [hereinafter Press Release, July 2007], available at <http://www.senate.gov/~finance/press/Gpress/2007/prg071907d.pdf> (stating that "[t]he Internal Revenue Service released an interim report summarizing responses from almost 500 tax-exempt hospitals to a May 2006 questionnaire").

129. IRS, OMB No. 1545-2015, FORM 13790, COMPLIANCE CHECK QUESTIONNAIRE TAX-EXEMPT HOSPITALS (2006); see also INTERIM REPORT, *supra* note 128 (summarizing the Project and corresponding data). According to the IRS, "[t]he Hospital Compliance Project was initiated in 2006 by the Internal Revenue Service . . . to study nonprofit hospitals and community benefit, as well as to determine how hospitals establish and report executive compensation." INTERIM REPORT, *supra* note 128, at 1.

130. EXECUTIVE SUMMARY, *supra* note 128, at 1.

131. *Id.* The IRS continues to look for "more meaningful comparisons across the respondents," obtain additional research to assist in its analysis of community benefits, and "[t]est the reported community benefit amounts and types." *Id.* at 5.

132. *Id.* at 3.

133. HYATT & HOPKINS, *supra* note 3, at 36. A spokesperson for the IRS gave this testimony at a 1991 hearing before the House Committee on Ways and Means regarding the tax-exempt status of nonprofit hospitals. *Id.* at 34-36.

134. IRS, Highlights of Redesigned Form 990, [http://www.irs.gov/pub/irs-tege/highlightsform990redesign\\_061307.pdf](http://www.irs.gov/pub/irs-tege/highlightsform990redesign_061307.pdf) (last visited Oct. 16, 2008) [hereinafter Highlights]. The IRS has revised Form 990 to comply with changing tax laws, but due to the expense of reprogramming the IRS's computer systems, these revisions consisted of adding necessary lines in illogical places rather than redesigning the form. Phone Forum, IRS, Draft Redesign Form 990 (July 18-19, 2007) [hereinafter IRS, Phone Forum], available at [http://www.irs.gov/pub/irs-tege/990redesignphoneforumscript7\\_2007.pdf](http://www.irs.gov/pub/irs-tege/990redesignphoneforumscript7_2007.pdf).

current form neither adequately describes the filing organization nor provides a basis for comparing an organization with its peers.”<sup>135</sup> Thus, the IRS’s “Project Team,” the group of people who reviewed the questionnaire responses from the Project, also assisted in developing proposed changes to Form 990 and its corresponding schedules.<sup>136</sup> The Project Team followed three principles when redesigning the form: (1) enhancing transparency; (2) promoting compliance; and (3) minimizing the burden on filing organizations.<sup>137</sup> As explained by Kevin Brown, Acting Commissioner of the IRS, “[t]he new [Form] 990 aims to give both the IRS and the public an improved window into the way tax-exempt organizations go about their vital mission.”<sup>138</sup>

The most significant changes to Form 990 include: (1) adding a summary page that provides “a snapshot of the organization’s key financial, compensation, governance, and operational information”;<sup>139</sup> (2) “requiring governance information, including the composition of the board” and financial practices;<sup>140</sup> and (3) revising and adding “[s]chedules that will focus reporting on certain areas of interest to the public and the IRS.”<sup>141</sup> Schedules are organization-specific, so whether an organization has to complete each schedule depends on the type of organization it is and the activities it is involved in.<sup>142</sup> Under the redesigned Form 990, all tax-exempt hospitals have to complete Schedule A (specific to § 501(c)(3) organizations),<sup>143</sup> Schedule D (completed by all organizations that file Form 990),<sup>144</sup> and Schedule H (specific to hospitals and health care organizations).<sup>145</sup> Nonprofit organizations have the option of filing Schedule O, which allows organizations “to supplement information reported elsewhere.”<sup>146</sup> The IRS may require tax-exempt hospitals to complete other schedules as well, depending on the

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135. BACKGROUND PAPER, *supra* note 113, at 2.

136. EXECUTIVE SUMMARY, *supra* note 128, at 4.

137. BACKGROUND PAPER, *supra* note 113, at 2. The IRS has defined each principle: “[e]nhancing transparency means providing the IRS and its stakeholders with a realistic picture of the organization and its operations”; “[p]romoting compliance means the form must accurately reflect the organization’s use of assets”; and “[m]inimizing the burden on filing organizations means asking questions in a manner that makes it relatively easy to fill out the form.” *Id.*

138. Press Release, IRS, IRS Releases Discussion Draft of Redesigned Form 990 for Tax-Exempt Organizations (June 14, 2007), available at <http://www.irs.gov/newsroom/article/0,,id=171329,00.html>.

139. Highlights, *supra* note 134.

140. *Id.*

141. *Id.*

142. *Id.*

143. See IRS, OMB NO. 1545-0047, SCHEDULE A FOR FORM 990, SUPPLEMENTARY INFORMATION FOR ORGANIZATIONS EXEMPT UNDER SECTION 501(c)(3) (2008), available at <http://www.irs.gov/pub/irs-tege/f990rscha.pdf> (stating that Schedule A must be completed by § 501(c)(3) organizations); see also IRS, Phone Forum, *supra* note 134 (discussing Schedule A).

144. See IRS, Phone Forum, *supra* note 134 (discussing Schedule D). To find out which nonprofit organizations must report on Schedule D, see IRS, OMB No. 1545-0048, SCHEDULE D FOR FORM 990, SUPPLEMENTAL FINANCIAL STATEMENTS (2008), available at <http://www.irs.gov/pub/irs-tege/f990rschd.pdf>.

145. See IRS, OMB No. 1545-0047, SCHEDULE H FOR FORM 990, HOSPITALS (2008) [hereinafter SCHEDULE H], available at <http://www.irs.gov/pub/irs-tege/f990rschh.pdf> (stating that this form must be completed by organizations that answer “Yes” to the question on Form 990 that asks whether the organization operated one or more hospitals); see also IRS, Phone Forum, *supra* note 134 (discussing Schedule H).

146. IRS, BACKGROUND PAPER: FORM 990 REDESIGN FOR TAX YEAR 2008, at 1, available at [http://www.irs.gov/pub/irs-tege/background\\_paper\\_form\\_990\\_redesign.pdf](http://www.irs.gov/pub/irs-tege/background_paper_form_990_redesign.pdf).

organization and its business relationships.<sup>147</sup> The IRS suggested that the redesigned Form 990 promotes tax compliance by focusing questions on problematic areas and asking for an array of identifying information.<sup>148</sup> The form also enhances transparency by asking additional questions and improving the manner of presenting the information,<sup>149</sup> and its logical structure minimizes the reporting burdens.<sup>150</sup>

### III. ANALYSIS

The Committee staff accurately described the current community benefit standard as a “failure administratively and, more importantly, in providing measurable benefits to low-income families.”<sup>151</sup> An ineffective standard causes a broad spectrum of problems. Lois Lerner, director of the IRS’s Exempt Organizations division, stated that the lack of a uniform understanding of uncompensated care and community benefit makes it difficult to evaluate whether nonprofit hospitals are in compliance with the law.<sup>152</sup> Since nonprofit hospitals receive at least \$12.6 to \$20 billion in tax breaks each year,<sup>153</sup> clarity is of the utmost importance. This Part analyzes both the Senate Finance Committee’s and the IRS’s recent actions to fix this ineffective standard.

#### *A. Analyzing the Senate Finance Committee’s Actions*

While the Senate Finance Committee is not ignorant of the ineffectiveness of the community benefit standard, it has also not taken enough action to correct it. On July 19, 2007, the Senate Finance Committee released a discussion draft that described the Committee staff’s proposals for reform in the area of tax exemptions for nonprofit hospitals.<sup>154</sup> A closer look at the Committee staff’s proposals illustrates the potentially positive impact of these proposals on this area of law, as well as areas in which the proposals still need improvement.

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147. BACKGROUND PAPER, *supra* note 113, at 2.

148. *Id.* at 4.

149. *Id.*

150. *Id.* at 4–5. Upon the IRS’s invitation, many people and entities offered feedback on the proposed Form 990. See IRS, Comments on Draft Redesigned Form 990, <http://www.irs.gov/charities/article/0,,id=173106,00.html> (last visited Mar. 7, 2008) [hereinafter Form 990 Comments] (providing web links to all feedback received). This feedback ranged from suggestions regarding the format to suggestions regarding content of the form. See, e.g., Letter from Naomi Horsager, Chair 990 Task Force, American Inst. of Certified Pub. Accountants, to Theresa Pattara, IRS Project Manager (Sept. 13, 2007), available at [http://www.irs.gov/pub/irs-tege/redesignedform990comments\\_aicpa.pdf](http://www.irs.gov/pub/irs-tege/redesignedform990comments_aicpa.pdf) (providing recommendations on both format and content); Letter from Susan B. Taylor, Dir. of Tax, Legacy Health Systems, to IRS (Sept. 13, 2007), available at [http://www.irs.gov/pub/irs-tege/990redesigncomments\\_healthcare\\_1.pdf](http://www.irs.gov/pub/irs-tege/990redesigncomments_healthcare_1.pdf) (same). These comments were not all specific to nonprofit hospitals, and thus have limited applicability here. See, e.g., Form 990 Comments, *supra* (providing links to recommendations on Schedule F and Schedule K, which do not apply to nonprofit hospitals).

151. DISCUSSION DRAFT, *supra* note 10, at 5.

152. Press Release, July 2007, *supra* note 128 (stating that “[t]he lack of consistency or uniformity in classifying and reporting uncompensated care and various types of community benefit often makes it difficult to assess whether a hospital is in compliance with current law”).

153. DISCUSSION DRAFT, *supra* note 10, at 2.

154. *Id.*; see also *supra* Part II.B.1 (discussing the Committee staff’s proposals).

*I. Quantitative Measure of Community Benefit*

Requiring quantitative measures of community benefits is one of the Committee staff's recommendations for ensuring that nonprofit hospitals provide a sufficient amount of community benefit to justify their tax exemptions. This proposal includes requiring nonprofit hospitals to conduct a community needs assessment every three years.<sup>155</sup> The Committee staff also proposed that Congress require nonprofit hospitals to dedicate a minimum of five percent annually of either its operating expenses or revenues—whichever is greater—to charity care.<sup>156</sup> This quantitative measurement helps ensure that the value of the community benefits that nonprofit hospitals provide closely relates to the value of the tax exemptions they receive.

Health care organizations and scholars provided completely mixed reviews about the proposed quantitative standard. At least one health care organization finds the present community benefit standard to be effective and concludes that “a fixed percentage is not in the best interest of the communities we serve.”<sup>157</sup> At the roundtable on the Committee staff's proposals, the Catholic Health Association (CHA), comprised of more than 2000 Catholic health care sponsors, systems, hospitals, facilities, and related organizations, expressed concern that the Committee staff's standard would impede flexibility of hospitals to target the local needs of the community.<sup>158</sup>

Some scholars are concerned that the Committee staff's five percent proposal is too strict.<sup>159</sup> At the roundtable discussion, Professor Nancy Kane expressed concern that a five percent standard will force some nonprofit hospitals to either convert to for-profit hospitals or close their doors.<sup>160</sup> This, she suggested, will “adversely affect . . . access [to health care].”<sup>161</sup> Professor Kane urged the Senate Finance Committee to reinstate the pre-1969 standard, which required charity care only “to the extent of [the hospital's] financial ability.”<sup>162</sup>

Conversely, organizations such as the Community Catalyst expressed concern that the five percent proposal is too low a standard for some hospitals.<sup>163</sup> Frank McLoughlin, staff attorney with the Community Catalyst's Hospital Accountability Project, urged that the Committee staff's five percent proposal not be a de facto ceiling and that any

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155. DISCUSSION DRAFT, *supra* note 10, at 12 (describing the Committee staff's proposal of a community needs assessment).

156. *Id.* at 7.

157. Michael F. Rodgers, Senior Vice President of Advocacy and Public Policy, Catholic Health Ass'n, Statement by the Catholic Health Association to the Senate Finance Committee Roundtable on Tax Exempt Hospitals (Oct. 30, 2007), available at <http://finance.senate.gov/press/Gpress/2007/prg102607k.pdf>.

158. *Id.*

159. See Nancy Kane, Professor of Mgmt., Harvard Sch. of Pub. Health, Written Comments for the Roundtable on the Senate Finance Committee Minority Staff Discussion Draft on Tax-Exempt Hospitals (Oct. 30, 2007), available at <http://finance.senate.gov/press/Gpress/2007/prg102607h.pdf> (urging the Senate to adopt pre-1969 standards).

160. *Id.*

161. *Id.*

162. *Id.*

163. Frank McLoughlin, Staff Attorney, Cmty. Catalyst's Hosp. Accountability Project, Statement of Community Catalyst at the Roundtable on the Senate Finance Committee Minority Staff Discussion Draft on Tax-Exempt Hospitals (Oct. 30, 2007), available at <http://finance.senate.gov/press/Gpress/2007/prg102607j.pdf>.

legislation should allow states to raise the standard as necessary.<sup>164</sup> Similarly, other health care organizations agreed that nonprofit hospitals should be required to meet a quantifiable standard, but were admittedly unsure of what that standard should be.<sup>165</sup>

The CHA expresses a minority belief seemingly ignorant of the statistics regarding nonprofit hospitals' abuse of their tax-exempt status. Professor Kane's concern also seems contradictory to the purpose of imposing strict standards on nonprofit hospitals—ensuring that nonprofit hospitals provide an amount of community benefit and charity care that justifies their tax exemptions. However, policy analyst Keith Hearle may be on the right track when suggesting that Congress not set the quantitative standard until the IRS receives and analyzes data from the revised Form 990,<sup>166</sup> thus establishing a fact base to guide an appropriate standard.

## 2. Defining "Charity Care"

The Committee staff's proposals defined "charity care" and proposed a formula to determine how to calculate charges for uninsured or underinsured patients.<sup>167</sup> Unlike multiple definitions of charity care currently used by hospitals, the staff's definition does not specify whether hospitals report charity care based on costs or charges.<sup>168</sup> The

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164. *Id.*

165. See Matt Fishman, Vice President for Cmty. Health, Partners HealthCare, Statement at the Roundtable on the Senate Finance Committee Minority Staff Discussion Draft on Tax-Exempt Hospitals (Oct. 30, 2007), available at <http://finance.senate.gov/press/Gpress/2007/prg102607f.pdf> (stating that "it's important to acknowledge that circumstances may vary significantly among the states and among hospitals. A one-size fits all numerical standard may not be the best measure of success"); see also The Access Project, Statement at the Roundtable on the Senate Finance Committee Minority Staff Discussion Draft on Tax-Exempt Hospitals (Oct. 30, 2007), available at <http://finance.senate.gov/press/Gpress/2007/prg102607m.pdf> ("While we are not certain of the exact percentage that should be required, we agree that it is essential that a quantifiable standard be set.").

166. Keith Hearle, President, Verite Healthcare Consulting, Statement at the Roundtable on the Senate Finance Committee Minority Staff Discussion Draft on Tax-Exempt Hospitals (Oct. 30, 2007), available at <http://finance.senate.gov/press/Gpress/2007/prg102607g.pdf>. Hearle has been very involved in developing and updating community benefit accounting frameworks for major hospital organizations, such as the CHA and Healthcare Financial Management Association. *Id.*

167. DISCUSSION DRAFT, *supra* note 10, at 7–8. The Committee staff recommended that for the purpose of determining whether hospitals meet quantitative standards of charity care, "charity care" should be defined as:

- (a) medically necessary in/out patient hospital services provided without expectation of payment from or on behalf of the individual receiving the hospital services (example, those at FPL 100% or below who receive free care . . . );
- (b) the amount of revenue, less any payments received for patient care, which is expected to be written off as a result of a designation (prior to billing) that the patient is unable to pay for the medically necessary hospital services. This would include discounts to low-income uninsured individuals (FPL 100% to 300%) as well as free or discounted care to the underinsured or medically indigent (FPL 100% to 300%). Discounts (and foregone revenue) would be valued based on the reduction of price from the value of care stated below; and,
- (c) providing medical care through free clinics and community medical clinics as well as other means of providing free medical care to vulnerable populations such as school-based programs. Also included would be grants to other charities that provide free medical care to vulnerable populations through free clinics, community medical clinics, etc.

*Id.*

168. Compare *id.* at 7–8 (defining "charity care"), with HYATT & HOPKINS, Supp. 2007, *supra* note 44, at

roundtable discussion also unveiled differing views on this definition. While the Discussion Draft states “[c]harity care would not include bad debt,” the Hospital & Healthsystem Association of Pennsylvania argued “bad debt is a community benefit” and therefore the government should include bad debt in its determination of whether a hospital is tax exempt.<sup>169</sup> The Hospital & Healthsystem Association of Pennsylvania, however, holds a minority belief. In its December 2006 report, the CBO agreed that “charity care is a better measure [than bad debt] of the community benefits provided by a hospital.”<sup>170</sup> Spokespersons for both the Community Catalyst and Family USA also emphasized at the roundtable discussion that the Senate Finance Committee should not consider bad debt as a part of charity care.<sup>171</sup>

The Committee staff’s effort to define charity care is an improvement over previous legislation. However, the Committee staff qualified that its definition applies when hospitals are measuring quantitative amounts of charity care under the proposed five percent standard.<sup>172</sup> This qualification limits the effectiveness of the definition because defining critical terms, such as “charity care,” will be most effective if the definition applies uniformly in all circumstances.

### *3. Accountability and Transparency*

In addition to ensuring that nonprofit hospitals provide community benefit, the Committee staff’s proposals encourage accountability by requiring transparency.<sup>173</sup> For example, the Discussion Draft includes annual reporting requirements regarding compensation of the organization’s board, operating expense and income, charity care, community benefits, insurance reimbursements, and joint venture policies.<sup>174</sup> Both Professor Kane and the Community Catalyst support the improved transparency, but request more specific reporting standards.<sup>175</sup> While these critics are correct that standards should be specific, in this context tax forms are an appropriate place for such specificity because (1) they eliminate redundancy between potential legislation and already-existing reporting requirements, and (2) government officials can amend tax forms more easily than legislation—an important consideration during a time when the government struggles to find appropriate reporting standards for nonprofit hospitals. In fact, the IRS implemented specific standards into its redesigned Form 990 and corresponding schedules.<sup>176</sup>

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134–40 (providing the definitions of “charity care” used by five major organizations involved with nonprofit hospitals).

169. Letter from Carolyn F. Scanlan, President & Chief Executive Officer, The Hosp. & Healthsystem Ass’n of Pa., to Charles Grassley, U.S. Senator (Sept. 7, 2007), *available at* <http://finance.senate.gov/press/Gpress/2007/prg102607b.pdf>.

170. 2006 CBO REPORT, *supra* note 3, at 2.

171. Cheryl Fish-Parcham, Deputy Dir. of Health Policy, Families USA, Statement at the Roundtable on the Senate Finance Committee Minority Staff Discussion Draft on Tax-Exempt Hospitals (Oct. 30, 2007), *available at* <http://finance.senate.gov/press/Gpress/2007/prg102607e.pdf>; McLoughlin, *supra* note 163, at 1–3.

172. DISCUSSION DRAFT, *supra* note 10, at 7.

173. *See id.* at 6–18 (describing the Committee staff’s proposal).

174. *Id.* at 17.

175. Kane, *supra* note 159, at 1–3; McLoughlin, *supra* note 163, at 3 (suggesting that “[t]here must be clear and uniform standards for valuing and reporting the services provided by hospitals”).

176. FORM 990, *supra* note 117.

#### 4. Sanctions

The Committee staff's proposal provides specific, measurable standards that help achieve consistency in the application and enforceability of the standards. It also provides sanctions for nonprofit hospitals that fail to meet the § 501(c)(3) requirements.<sup>177</sup> These sanctions include an excise tax, "in an amount at least equal to twice the hospital's shortfall," for not meeting the quantitative requirements.<sup>178</sup> The government may waive this excise tax if the hospital has met the requirement over a determined period of years and "the shortfall was due to lack of demand by medically indigent persons for services."<sup>179</sup> These sanctions are similar to the Tax Exempt Hospitals Responsibility Act of 2006,<sup>180</sup> a bill introduced on December 8, 2006, by Representative Bill Thomas, then Chairman of the House Ways and Means Committee.<sup>181</sup>

Sanctions, if enforced, are an appropriate way to ensure greater compliance. Penalizing a hospital by two times the amount of its shortfall eliminates the financial advantage the hospital received for its noncompliance. This excise tax takes into account individual situations and looks for repeat offenders. The additional excise tax is a substantial deterrent that will decrease abuse of tax exemptions.

#### B. Analyzing the IRS's Actions

Recent changes made by the IRS—particularly those relating to redesigning Form 990—are steps to ensure that nonprofit hospitals truly deserve their tax exemptions. The IRS based its redesign of Form 990 on three guiding principles: enhancing transparency, promoting compliance, and minimizing the burden on filing organizations.<sup>182</sup> These guiding principles are apparent in the new Form 990.

First, Form 990 provides greater transparency of nonprofit hospitals. The summary in Part I of the form, and the more logical design of the remainder of the form, makes it easier for the general public to look at the redesigned Form 990 and get a general impression of the reporting organization.<sup>183</sup> Since the redesigned Form 990 requires § 501(c)(3) organizations to itemize all expenses, the general public can more easily decipher how a nonprofit hospital is spending its money. Additionally, such transparency makes it easier for the IRS to evaluate compliance. For example, Schedule H asks for very specific information regarding a hospital's charity care.<sup>184</sup> This provides better information to the IRS to determine whether the hospital meets § 501(c)(3) requirements. Finally, the IRS made a conscious effort to balance the purpose of reporting and the

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177. DISCUSSION DRAFT, *supra* note 10, at 15.

178. *Id.*

179. *Id.*

180. Tax Exempt Hospitals Responsibility Act of 2006, H.R. 6420, 109th Cong. (2d Sess. 2006). The Tax Exempt Hospitals Responsibility Act of 2006, had it passed, would have imposed an excise tax on nonprofit hospitals for "fail[ing] to provide specified medically necessary care," "overcharging for specified medically necessary care," or "fail[ing] to disclose charitable medical care information and negotiated charges." *Id.* Essentially, "specified medically necessary care" is care that is available from nonprofit hospitals. *Id.*

181. HYATT & HOPKINS, Supp. 2007, *supra* note 44, at 133.

182. Highlights, *supra* note 134.

183. FORM 990, *supra* note 117.

184. SCHEDULE H, *supra* note 145.

resulting burden on filing organizations.<sup>185</sup> This is important so that the resources of nonprofit hospitals can continue to focus on providing care to patients and services to the community while also ensuring the organization deserves its tax exemptions.

The IRS and the Committee staff did not work together on their recent proposals, but they placed similar emphases on both the standards Congress should require nonprofit hospitals to meet to receive tax exemptions, and the information a hospital must show to meet these standards.<sup>186</sup> For example, Form 990 requires disclosure regarding governance, revenues, expenses, and compensation—all of which would provide the information necessary to measure at least three of the Committee staff's proposed standards.<sup>187</sup> Schedule H requires disclosure of the cost of charity care, Medicare and Medicaid reimbursements, billing and collection information, joint ventures, and community benefits the hospital provided, which relate to the remaining standards proposed by the Committee staff.<sup>188</sup> Additionally, Schedule H asks for information about specific troubling areas, such as the organization's charity care policy, bad debt and debt collection policies, and how the organization assesses and provides community benefit.<sup>189</sup> These questions seem particularly important in repairing the poor image hospitals have recently acquired for abusing such vague reporting requirements.

Despite the IRS's progress in establishing reporting requirements for § 501(c)(3) organizations, it has fallen behind in conducting audits. In 1992, the IRS developed audit guidelines specific to nonprofit health care organizations,<sup>190</sup> but according to a 2006 report, from 1996 to 2006 the IRS audited only 375 of the 7000 nonprofit hospitals and health care organizations.<sup>191</sup> It does not anticipate conducting more audits as a result of its 2006 Project.<sup>192</sup> Thus, the IRS is missing opportunities to ensure compliance with the standards for tax exemption.

#### IV. RECOMMENDATION

Just as changing times led the IRS to issue Revenue Ruling 69-545, changing times again necessitate updated requirements for tax exemption. While the IRS recently conducted its own studies and amended the tax forms nonprofit hospitals must file,<sup>193</sup> this alone will not fix all of the problems with the current standard.<sup>194</sup> Members of the Senate Finance Committee recognize that not all nonprofit hospitals have policed themselves, nor will they, in this area.<sup>195</sup> Therefore, Congress should enact legislation as

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185. See IRS, FORM REDESIGN FOR TAX YEAR 2008: FORM 990 (CORE FORM)—HIGHLIGHTS (2007) [hereinafter HIGHLIGHTS FOR 2008], available at [http://www.irs.gov/pub/irs-tege/highlights\\_core\\_form.pdf](http://www.irs.gov/pub/irs-tege/highlights_core_form.pdf) (discussing "Expected Impact on Burden" at the end of each amended part of Form 990).

186. Compare DISCUSSION DRAFT, *supra* note 10 (describing the Committee staff's proposals), with FORM 990, *supra* note 117 (providing evidence of the IRS's proposals).

187. FORM 990, *supra* note 117.

188. Compare DISCUSSION DRAFT, *supra* note 10 (describing the Committee staff's proposals), with SCHEDULE H, *supra* note 145 (showing the reporting requirements on Schedule H).

189. SCHEDULE H, *supra* note 145.

190. HYATT & HOPKINS, *supra* note 3, at 715.

191. Zuckerman, *supra* note 126, at 40.

192. HYATT & HOPKINS, Supp. 2007, *supra* note 44, at 42.

193. See discussion *supra* Part II.C (discussing the IRS's recent actions).

194. See discussion *supra* Part III.B (analyzing the IRS's recent actions).

195. See DISCUSSION DRAFT, *supra* note 10, at 4. In this report, Committee staff members stated:

described in this Part.

*A. Congress Should Enact Legislation to Replace Revenue Ruling 69-545*

Legislation will provide greater assurance that nonprofit hospitals earn their tax exemptions. Given the Senate's control over legislation in the area of tax exemptions for nonprofit organizations, and the in-depth research initiated by Senator Charles Grassley and the Senate Finance Committee, Congress seems like a logical group to take the next step in correcting the problems with, and ambiguities in, the current standards. Therefore, Congress should enact legislation to replace Revenue Ruling 69-545.

Legislation to improve the current community benefit standard should require that: (1) nonprofit hospitals provide a sufficient amount of community benefits to justify their tax exemptions; (2) the government hold nonprofit hospitals accountable for their actions; (3) the new regulations be both enforceable and enforced; and (4) nonprofit hospitals comply with the new regulations. The Committee staff's proposals in its July 2007 discussion draft are consistent with all four of these considerations. Therefore, with few changes, legislation that mirrors the Committee staff's proposals will improve upon the community benefit standard, increase the benefits that nonprofit hospitals provide to their communities, and salvage the tarnished image of nonprofit hospitals.

Congress should fully adopt into new legislation the Committee staff's following proposals: (1) nonprofit hospitals must develop a charity care policy and highly publicize the same; (2) joint ventures with non-§ 501(c)(3) hospitals must be governed according to § 501(c)(3) standards; (3) § 501(c)(3) hospitals must conduct community needs assessments every three years; (4) § 501(c)(3) hospitals must determine charges for uninsured or underinsured patients based on the Committee staff's proposed formula; and (5) the board of directors of § 501(c)(3) hospitals must comply with the Committee staff's detailed specifications. Congress should also adopt a minimum quantitative standard of charity care, additional reporting requirements for § 501(c)(3) hospitals, and new sanctions on § 501(c)(3) hospitals that fail to meet reporting requirements. While the latter three were also included in the Committee staff's recommendations, Congress should adopt these provisions with the amendments recommended in Part IV.A.6 through Part IV.A.8.

*1. Charity Care Policy*

As suggested by the Committee staff, "each § 501(c)(3) hospital [should] be required to develop a written charity care policy that sets forth eligibility requirements, procedures for obtaining free or discounted care, and [information as to] where a patient can obtain more information."<sup>196</sup> Written policies help ensure uniform application of the

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It is important that policymakers be cautious in relying on reforms in this area through voluntary efforts by nonprofit hospitals instead of through regulatory or statutory changes. While some nonprofit hospitals do a good job of providing charity care to those in need, there are far too many nonprofit hospitals that say the right words but too often fail to do the right thing when it comes to providing for low-income families.

*Id.*

196. *Id.* at 6.

policy by employees and, ultimately, compliance by the organization. Additionally, the charity care policy should include a minimum eligibility threshold of 100% of the FPL, because nonprofit hospitals should strive to serve this socioeconomic class.<sup>197</sup> To be effective, these policies need to be written in plain language and be available in multiple languages.<sup>198</sup>

Having strict requirements for publicizing charity care policies will encourage accountability. Therefore, Congress should adopt the Committee staff's proposal that charity care policies need to be available on hospital websites, in emergency rooms, admissions offices, and upon request.<sup>199</sup> Publicizing charity care policies is also important because patients who are unaware that they qualify for care under a charity care policy may suffer from bad credit scores and garnished wages when they are stuck with medical bills that they cannot pay.<sup>200</sup> Better publication of charity care policies will help inform patients of their eligibility and ensure that a hospital complies with its charity care policy rather than keep it hidden from eligible patients.

### 2. Joint Ventures

Congress should adopt the Committee staff's proposal to govern all joint ventures with non-§ 501(c)(3) hospitals according to § 501(c)(3) standards. Additionally, Congress should adopt the Committee staff's proposals that (1) when a joint venture involves a § 501(c)(3) hospital, the joint venture must have its own charity care policy; (2) when substantially all of the nonprofit's assets are placed in the joint venture, the nonprofit hospital must control the joint venture's board; and (3) when only a portion of the nonprofit's assets are placed in the joint venture, the nonprofit hospital must control the joint venture's charity care policy and have at least one voting member on the board.<sup>201</sup> As recognized by the Committee staff, "joint ventures between for-profit entities and nonprofit hospitals . . . may divert surplus funds away from [charity care]," and some nonprofit hospitals do not have equal bargaining power when negotiating a joint venture with for-profit entities.<sup>202</sup> Thus, adopting the Committee staff's proposal ensures tax-exempt purposes are maintained in joint ventures, and that the joint ventures still deserve § 501(c)(3) tax exemptions.

### 3. Community Needs Assessments

Congress should adopt the Committee staff's proposal to require regular community

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197. *See id.* at 7 (suggesting a minimum eligibility threshold).

198. To be effective, the charity care policy needs to be available in the languages prevalent in the community where the hospital is located. So, for example, if a nonprofit hospital is located in a community that has both English-speaking and French-speaking residents, then the nonprofit hospital should make its charity care policy available in both English and French.

199. DISCUSSION DRAFT, *supra* note 10, at 6 (describing the Committee staff's proposal regarding charity care policies).

200. *See* Bill Sizemore & Nancy Young, *Do Nonprofit Hospitals Offer a Helping Hand or Heavy Hand?*, VIRGINIAN-PILOT, Sept. 16, 2007, available at <http://hamptonroads.com/2007/09/do-nonprofit-hospitals-offer-helping-hand-or-heavy-hand> (telling the stories of multiple indigent persons who did not benefit from a hospital's charity care policy simply because they were unaware of it).

201. DISCUSSION DRAFT, *supra* note 10, at 10–11.

202. *Id.* at 10.

needs assessments.<sup>203</sup> Because “the nonprofit hospital environment is extremely complicated and fast-changing,”<sup>204</sup> this requirement ensures nonprofit hospitals are truly serving the needs of the community, thereby providing community benefit. Three years is an appropriate time frame for hospitals to conduct such assessments initially, though Congress must revisit the issue after this standard is implemented to ensure a three-year time frame remains adequate.

#### 4. *Calculating Charges*

Congress should adopt a specified formula for determining charges for uninsured or underinsured patients. Thus, hospitals should charge medically indigent uninsured or underinsured patients the lower of “the amount paid by the government,” or “the actual hospital cost.”<sup>205</sup> As the Committee staff recommended, this policy should apply to patients with incomes 100%–200% of the FPL since nonprofit hospitals should strive to serve this socioeconomic class.<sup>206</sup>

#### 5. *Board of Directors*

Congress should adopt the Committee staff’s requirement for detailed specifications regarding the make-up of the board of directors. Thus, the board of directors must be “controlled by members who represent the broad interest of the public,” and “not more than 25% of the voting power of the board of directors [should be] vested in persons who are employed by the hospital or who will benefit financially, directly or indirectly, from the organization’s activities.”<sup>207</sup> As with joint ventures, this standard helps ensure furtherance of the nonprofit hospital’s true purpose. Hospitals must also have and abide by a detailed conflict of interest policy to help ensure their boards do not violate fiduciary duties.

#### 6. *Quantitative Standards*

Congress should adopt the Committee staff’s proposal for a minimum quantitative standard of charity care. Having a strict charity care standard encourages accountability and provides a measurable standard for enforcement.<sup>208</sup> Prior to setting this standard, however, Congress needs to gather more data to determine an appropriate minimum requirement. An unattainable standard will harm the ability of some hospitals to continue operating as nonprofits, whereas too loose of a standard will not accomplish the purpose of new legislation. Because one must evaluate multiple nonprofit hospitals over multiple years to determine an appropriate standard, Congress should impose the five percent minimum requirement suggested by the Committee staff, but wait at least three years to impose sanctions on hospitals that do not meet the standard. This grace period would give

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203. *See id.* at 12 (describing the Committee staff’s proposed community assessment requirement).

204. HYATT & HOPKINS, *supra* note 3, at 36 (quotation and citation omitted).

205. DISCUSSION DRAFT, *supra* note 10, at 13.

206. *Id.* Recall that nonprofit hospitals must already provide free care for families below the FPL 100%. *Id.*

207. *Id.* at 14.

208. *See Colombo, supra* note 9, at 433 (stating that “[a] strict charity care standard for exemption would greatly improve the accountability of nonprofit hospitals”).

hospitals time to adjust their operations to meet the standards, and it would allow Congress time to evaluate data reported on the revised Form 990 to determine whether five percent is an appropriate minimum requirement.

Congress should adopt the Committee staff's proposal to measure the annual minimum aggregate charity care amount as a rolling average over several years. Hospitals should determine that aggregate amount as a percentage of a hospital's annual patient operating expenses or revenues, whichever is greater.<sup>209</sup> This would help to ensure that one "down year" for nonprofit hospitals does not have disproportionate adverse effects on the ability of the hospital to maintain its tax-exempt status.

However, Congress should base the value of care on a "combination of both negotiated insurance reimbursement rates and actual cost," as recommended by Iowa Health System.<sup>210</sup> This standard is more appropriate than the Committee staff's recommendation because it accounts for the fact that a hospital would not be reimbursed for the full expense of care provided even if Medicare or Medicaid covered the patient or service, yet it also recognizes the actual cost to the hospital for providing that service.<sup>211</sup> Balancing these factors is a fair measure that acknowledges the hospital's charity care without inflating the value of the care provided.

### *7. Reporting Requirements*

Congress should adopt most of the reporting requirements proposed by the Committee staff. As Senators Max Baucus and Charles Grassley recognized, "transparency and openness are pillars in encouraging our nation's charities to be responsive to the needs of the community and to act in accordance with the principles and goals for which they were established."<sup>212</sup> The reporting requirements proposed by the Committee staff would provide this transparency.

Some of the proposed requirements, however, would also impose too great a burden on nonprofit hospitals. For example, a hospital cannot accurately measure the number of persons who benefited under its community benefit policy. Therefore, Congress should not adopt this requirement. The IRS should oversee these reporting requirements, as they significantly overlap with the reporting requirements of redesigned Form 990.

### *8. Sanctions*

To encourage compliance with proposed regulations, Congress should adopt the proposed excise tax for § 501(c)(3) hospitals that fail to meet the quantitative charity care and community benefit requirements. However, the remaining sanctions under the

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209. DISCUSSION DRAFT, *supra* note 10, at 7.

210. Letter from Sabra Rosener, Dir. of Gov't Relations, Iowa Health Sys., to Dean Zerbe, Senior Counsel and Tax Counsel, Senate Fin. Comm. and David Young, Chief of Staff, Senator Charles Grassley, Senate Fin. Comm. (Aug. 24, 2007), available at <http://finance.senate.gov/press/Gpress/2007/prg1026071.pdf>.

211. *See id.* (describing government reimbursement rates in comparison to actual cost incurred by the hospital).

212. Letter from Max Baucus, Senator, and Charles E. Grassley, Senator, to Henry Paulson, Secretary, Treasury Dept. (May 29, 2007), in Press Release, Senate Comm. on Fin., Grassley, Baucus Work to Build Confidence in Nonprofits Through Greater Transparency (May 29, 2007), available at <http://finance.senate.gov/press/Gpress/2007/prg052907a.pdf>.

Committee staff's proposal need to be tougher. While the IRS should have discretion to revoke § 501(c)(3) status from hospitals not meeting the requirements, it should also be required to impose some level of sanction. Thus, the IRS should have the discretion to determine the level of sanction, but not the discretion whether to impose a sanction or not.

The IRS should have discretion over whether a hospital's failure to meet any requirement is significant enough to immediately revoke its § 501(c)(3) status, or whether a fine would be more appropriate. The IRS, however, must impose a fine if it does not revoke the hospital's § 501(c)(3) status. The fine should be in an amount large enough to deter the hospital from repeating its bad act, yet small enough to not affect the hospital's § 501(c)(3) status. Regardless, it is important for the IRS to impose sanctions for all violations to ensure nonprofit hospitals earn their tax exemptions.

### *B. Congress Should Define All Critical Terminology*

It is difficult for anyone to enforce a standard with ambiguous terminology, and it is impossible to do so consistently. Therefore, Congress should define all critical terminology. For example, neither the Senate nor the IRS has adequately defined the term "community benefit"—a crucial term in this area of law. Thus, Congress should define an activity that provides community benefit as one that "[e]xplicitly address[es] a documented need or health status [p]roblem, such as (A) [i]mproving access to health services for vulnerable people . . . [;] (B) [e]nhancing population (public or community) health; [or (C)] [a]dvanc[ing] knowledge (through educating health professionals or supporting research that benefits the public)."<sup>213</sup> This definition is flexible enough that hospitals can remain tax-exempt for meeting the needs of their communities, yet measurable since it requires hospitals to document such needs. This documentation is also consistent with the Committee staff's proposals.

In addition to not defining "community benefit," neither Congress nor the IRS has adopted a consistent definition of "charity care." Both should adopt the Discussion Draft's proposed definition of charity care uniformly for all purposes. Additionally, neither Congress nor the IRS should include bad debt in the definition of charity care. Far too many factors, including those under the hospital's control,<sup>214</sup> prevent bad debt from being an accurate measure of charity care. Finally, because the above definitions are of such importance, they should be visible and familiar to § 501(c)(3) organizations rather than buried in fine print.

### *C. The IRS Should Refine and Enforce Redesigned Form 990*

While the redesigned Form 990 could have substantial positive effects on

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213. Hearle, *supra* note 166, at 4 (emphasis omitted). Situations that do not qualify as community benefit include, for example, programs with a marketing focus, programs that are available only for hospital staff, or activities that are a part of the "normal 'cost of doing business'" or "associated with the current standard of care." *Id.*

214. See Sizemore & Young, *supra* note 200 (telling the stories of multiple indigent persons who did not benefit from a hospital's charity care policy simply because they were unaware of it); see also DISCUSSION DRAFT, *supra* note 10, at 8 (suggesting that bad debt is often the product of "very high charges from the 'chargemaster list'").

transparency and compliance, a few more changes by the IRS will improve its oversight of nonprofit hospitals. First, the IRS should provide more definitions in Form 990, and these definitions should be consistent with the definitions used by Congress. Defining all critical terminology benefits all parties. It reduces a hospital's uncertainty as to what is required of it, thereby improving compliance. It also reduces uncertainty for those enforcing the standards, thereby easing enforcement and assuring uniform application of the standards. Thus, the IRS should adopt the definitions proposed in Part IV.B. It should make these definitions visible on its website under "Charities & Non-Profits,"<sup>215</sup> and on Schedule H for Form 990.

Second, the IRS should amend Form 990 to facilitate oversight of the reporting requirements proposed in Part IV.A.7. While Form 990 already provides oversight for many of the reporting requirements, the IRS should amend it to increase reporting regarding charity care and joint ventures. Currently, Schedule H requires a nonprofit hospital to answer questions regarding its charity care policy and incurred expenses.<sup>216</sup> The hospital has discretion over whether to report how many people it served through charity care.<sup>217</sup> However, Schedule H should require hospitals to report the total amount of charity care provided, measured both in a dollar amount and by the number of people served. It should also require the hospitals to report the number of people who applied for charity care. This additional reporting will both increase the transparency of the hospital and help measure the value the hospital contributes to the community.

While the legislation proposed in Part IV.A emphasizes transparency in joint ventures between § 501(c)(3) organizations and non-§ 501(c)(3) organizations, Form 990 does not require the same level of transparency. Thus, the IRS should amend Schedule H<sup>218</sup> to require joint ventures involving § 501(c)(3) hospitals to report a copy of charity care and community benefits policies of the joint venture. This will help ensure that for-profit goals of the joint venture do not supersede the charity care and community benefit requirements of the nonprofit hospital.

The IRS has given considerable attention to the burden that additional reporting places on nonprofit hospitals.<sup>219</sup> Adding the reporting requirements proposed to Schedule H is likely to create a greater burden on nonprofit hospitals. However, reporting this information will make nonprofit hospitals more accountable and more transparent. Accountability and transparency are necessary to achieve the overall goal of ensuring nonprofit hospitals are worthy of the tax benefits they receive. Thus, the benefits will outweigh the costs.

Despite the benefits of transparency, compliance, and accountability, additional reporting requirements should not unduly harm a hospital's ability to provide services as a nonprofit organization. Therefore, the IRS should bear some burden associated with the

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215. IRS, Tax Information for Charities & Other Non-Profits, <http://www.irs.gov/charities/index.html> (last visited Oct. 16, 2008).

216. FORM 990, *supra* note 117.

217. *Id.*

218. All nonprofit organizations engaged in joint ventures must fill out Schedule R. IRS, TAX EXEMPT & GOV'T ENTITIES DIV., DRAFT FORM 990 REDESIGN—SCHEDULE R (2007), *available at* [http://www.irs.gov/pub/irs-tege/draftform990redesign\\_schr\\_instr.pdf](http://www.irs.gov/pub/irs-tege/draftform990redesign_schr_instr.pdf).

219. See HIGHLIGHTS FOR 2008, *supra* note 185 (discussing the "Expected Impact on Burden" at the end of each amended part of Form 990).

stricter reporting requirements of Form 990 and ensure that nonprofit hospitals have the ability to comply with the new reporting requirements. Accordingly, the IRS should provide training and resources to nonprofit hospitals that educates them on both the new reporting requirements and cost effective ways of meeting these reporting requirements. This collaboration will achieve more positive results.

Finally, despite its limited resources, the IRS should increase the number of audits it performs on tax-exempt hospitals. Standards are less effective if they are not enforced. Increasing audits will help ensure compliance by nonprofits. This additional oversight is especially important right now, during a period of criticism and change in the nonprofit world.

#### V. CONCLUSION

The community benefit standard has been an ineffective measure of the deservedness of nonprofit hospitals to receive tax exemptions. For at least 17 years, many nonprofit hospitals have received tax exemptions greater than the value of the community benefit they provided.<sup>220</sup> The Senate Finance Committee's staff, keenly aware of the ineffectiveness of the community benefit standard, has proposed reforms in this area.<sup>221</sup> The IRS, also aware of the need for improvement in the reporting requirements of § 501(c)(3) hospitals, recently redesigned Form 990 for the first time in nearly 30 years.<sup>222</sup> These actions do not go far enough. Congress needs to enact legislation, substantially based on the Committee staff's proposals, that will ensure § 501(c)(3) hospitals are deserving of their tax exemptions. This legislation needs to define all critical terminology, as recommended in Part IV.B. The IRS needs to strictly enforce this legislation and impose sanctions on all hospitals that violate the standards. Additionally, the IRS needs to refine and strictly enforce its redesigned Form 990. Together, these recommended actions will promote transparency, accountability, and—most importantly—deservedness of tax exemptions.

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220. See HYATT & HOPKINS, *supra* note 3, at 535 (noting that in 1990, "57 percent of the nonprofit hospitals provided less charitable care than the value of the tax exemption they received" (citing GOV'T ACCOUNTABILITY OFFICE, NONPROFIT HOSPITALS: BETTER STANDARDS NEEDED FOR TAX EXEMPTION (1990))).

221. See DISCUSSION DRAFT, *supra* note 10 (describing the Committee's proposals).

222. See Highlights, *supra* note 134 (stating that the IRS has not redesigned Form 990 since 1979); see also discussion *supra* Part II.C.3 (describing the IRS's recent amendments to Form 990).