Return of ‘Charity Care’: The Evolving Debate Over Nonprofit Hospitals’ Tax-Exempt Status

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The Evolving Debate over Nonprofit Hospitals’ Tax-Exempt Status

By Nicholas A. Mirkay, Associate Professor of Law

With nonprofit hospitals receiving an estimated $12.6 to $20 billion a year in federal, state and local benefits on account of their tax-exempt status, the commensurate public benefit from that status is once again the focus of federal and state tax authorities and lawmakers. Although nonprofit hospitals must provide “community benefit” in order to maintain their federal income tax exemption, ample disagreement exists on what constitutes, and how to measure, community benefit. A recent Congressional Budget Office (CBO) report compared the community benefit conferred by nonprofit and for-profit hospitals, evaluating primarily “uncompensated care,” health care services to Medicaid/Medicare patients, and unprofitable specialized services (e.g., burn victims’ intensive care, emergency room care). The report defines uncompensated care as “the sum of charity care (services for which a hospital does not expect payment) and bad debt (services for which a hospital expects but does not collect payment).” The comparison, based on a five-state survey, produced mixed results. The CBO determined that nonprofit hospitals provide, on average, more uncompensated care than their for-profit counterparts. However, that provision of uncompensated care varied extensively among individual hospitals.

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tals, with distributions by non-
profit and for-profit hospitals largely overlapping.6

In July 2007, the Internal Reve-
uenue Service (IRS) released an Interim Report with respect to
its Hospital Compliance Project, enumerating the results of sur-
veys sent to more than 500 non-
profit hospitals concerning their community benefit programs and executive compensation practices.7 Uncompensated care comprised the largest reported expenditure and most frequently reported type of community benefit.8 The report stated that approximately 22 percent of the responding nonprofit hospitals spend less than one percent of their total revenue on uncompensated care; 23 percent spend between one and three percent.9 Although 97 percent of responding nonprofit hospitals have a written charity care policy, no uniform definition of what constitutes uncompensated care emerged from the responses. Specifically, divergence existed in the survey results as to whether bad debt expenses and Medicare shortfalls are included in a hospital’s uncompensated care calculation.10 Accordingly, a fundamental question remains unresolved – how much uncompensated care or ‘charity care’ should nonprofit hospitals provide to justify their tax exemptions?

A late October 2007 roundtable on tax-exempt hospitals spon-
sored by the Senate Finance Committee addressed this char-
ity care question. In advance of that roundtable, the Com-
mittee’s Minority Staff (Staff) released a discussion draft. In
acknowledging the varying de-
gree of charity care being pro-
vided, the Staff concluded that
some hospitals are “helping to
pull the wagon . . . but far too
many . . . are sitting in the
wagon.”11 Accordingly, the Staff
proposed “alternatives to be
considered in drafting legislation
to reform nonprofit hospital
federal tax-exemption.”12 One
proposed reform would bifur-
cate nonprofit hospitals into two
tax-exempt classes: (1) those
meeting the section 501(c)(3)
charity requirements, and (2)
those meeting the section 501(c)
(4) social welfare require-
ments.13 While hospitals will be
exempt from federal income tax
under either classification, only
those exempt under section 501
(c)(3) will be eligible to receive
tax-deductible contributions
under section 170 and issue tax-
exempt bonds.

Among other prerequisites,14
one of the proposed require-
ments to maintain exemption
under section 501(c)(3) is a
quantitative charity care standard. Under that standard, a
hospital must dedicate a min-
imum of five percent of its an-
nual patient revenues or operat-
ing expenses to charity care, whichever is greater, in accor-
dance with a written and
widely-disseminated charity care
policy.15 This test reflects the
common IRS audit practice
prior to the 1969 conversion to
the community benefit stan-
dard.16 Charity care is defined
as “medically necessary in/out
patient hospital services pro-
vided without expectation of
payment from or on behalf of
the individual receiving the hos-
pital services.”17 It also includes
revenue write-offs as a result of
a pre-billing designation of pa-
tients unable to pay for med-
ically necessary hospital services
and medical care provided
through free and community
medical clinics.18 Under the
Staff’s proposal, medical care
would be valued at a rate that
equals the lower of the (1) low-
est rate paid by Medicare/
Medicaid, or (2) actual unreim-
bursed cost to the hospital for
the service provided. Bad debt
would not be included in any
charity care calculation because
it would be “inappropriate” to
tax-deductible contributions
under section 170 and issue tax-
exempt bonds.

In addition to conducting a
community needs assessment
every three years with an em-
phasis on vulnerable popula-
tions,19 a nonprofit hospital ex-
empt under section 501(c)(3)
would also be subject to ad-
ternal rules and restrictions on
its joint ventures with for-profit
health care providers. The Staff

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recommended that any joint venture conferring patient care must have its own charity care policy. As to whole-hospital joint ventures (the nonprofit hospital transfers all or substantially all of its assets into the venture), the venture is subject to the same charity care standard as hospitals and the tax-exempt hospital must “control” the venture’s board. Not all legal experts on the nonprofit sector support a charity care test as the fundamental standard for section 501(c)(3) exemption. Professor John Colombo, a participant in the roundtable discussion, suggested an alternative “enhancing access” test, which would grant exemption only to nonprofit hospitals that establish that they either provide substantial services to the general population that are otherwise unavailable from for-profit competitors or . . . provide services to populations underserved by for-profit competitors. In support of his proposal, empirical research indicates that qualitative differences exist between for-profit and nonprofit hospitals as to the services provided.

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In addition, for-profit hospitals tend to respond more readily to changes in financial incentives, such as home health care when it was profitable, and exit more quickly when the profitability decreases. Therefore, the conclusion drawn from the research is that these distinctive features, rather than charity care alone, justify the continued tax exemption of nonprofit hospitals.

Although this recent focus on nonprofit hospitals’ tax exemption is not novel, it is also not likely to evaporate quickly. A House bill has already been introduced that would institute a minimum charity care requirement and similar Senate-initiated legislation has been threatened. The detail and tone of the Staff’s discussion draft, as well as the IRS’s compliance initiatives, arguably reveal a concerted objective to institute some bright-line standard for nonprofit hospitals’ tax exemption. The primary question that remains is whether this reform will continue to be governmentally driven or whether it will emerge from the nonprofit hospital sector itself.
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1 Unless otherwise indicated, the term “nonprofit hospitals” refers to hospitals exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code of 1986, as amended.


3 See Rev. Rul. 69-545, 1969-2 C.B. 94. Factors that demonstrate a “community benefit” include: (i) An emergency room that is "open to all persons" (i.e., no one requiring emergency care is denied treatment); (ii) hospital care provided to all persons in the community able to pay the cost thereof either directly or through third party reimbursement (including both private health insurance or public programs such as Medicare); (iii) an open medical staff, with members of its active staff having the privilege of leasing available space in its medical building; (iv) control of the hospital rests with a community board of trustees comprised of independent civic leaders; and (v) any surplus in operations used to improve the quality of patient care, expand its facilities, and advance medical training, education, and research. See also Rev. Rul. 83-157, 1983-2 C.B. 94.


5 Id. at 1-2. Limitations on available data prevented the CBO from separately quantifying charity care and bad debt.

6 Id.


8 I.R.S. HOSPITAL COMPLIANCE PROJECT INTERIM REPORT 1 (July 19, 2007) (hereinafter INTERIM REPORT), available at http://www.irs.gov/pub/irs-tege/ eo_interim_hospital_report_072_007.pdf. After uncompensated care, the next largest components of community benefit expenditures were medical education and training (23% of aggregate expenditures), medical research (15%), and community programs (6%). Id. at 48.

9 Id. at 24.

10 Id. at 26-28. Forty-four percent of responding hospitals included bad debt expense and 20 percent included Medicare shortfalls in their calculations of uncompensated care. Although uncompensated care comprised the largest reported expenditure, other community benefit costs included medical education and training, research, and community outreach and education. Id.

11 DISCUSSION DRAFT, supra note 2, at 2.

12 Id. at 3.

13 Id.

14 Other standards required for section 501(c)(3) exemption are: (i) written and widely disseminated charity care policy; (ii) special rules for joint ventures with for-profit entities; (iii) board composition and governance reforms; (iv) limitations on charges billed to uninsured; (v) restrictions on unfair billing and collection practices; (vi) transparency requirements; and (vii) sanctions for noncompliance Id. at 3. Similar requirements are imposed on section 501(c)(4) exemption. Id. at 3.

15 Id. at 7. In formulating this standard, the Staff reviewed charity care requirements or proposals of Illinois, Texas, Rhode Island, and Pennsylvania, as well as other federal laws. Id. at 9-10.

16 Id.; see Rev. Rul. 56-185, 1956-1 C.B. 202, which required hospitals to demonstrate charity care for eligibility under section 501(c)(3). Specifically, “hospitals were required to operate to the extent of their financial ability for those unable to pay for services rendered.” Id. at 4.

17 DISCUSSION DRAFT, supra note 2, at 7.

18 Id. at 8. Charity care would also include grants to other tax-exempt health care providers that administer free health care services to “vulnerable populations” through clinics. Id.

19 Id.

20 Id. at 7.

21 Id. at 12. “Vulnerable populations” are defined as ones “with barriers to care: financial, transportation, disability, language, etc.” Id.


23 DISCUSSION DRAFT, supra note 2, at 11.

24 Id. at 15-16.


27 Id.

28 Id. generally.

29 Diane Freda, Thomas Introduces Hospital Bill to Require Minimum Charity Care, DAILY TAX REP. (Dec. 12, 2006) at G-7; Diane Freda, At Roundtable, Hospitals, Patient Advocates, Split on Mandatory Charity Care, Standards, DAILY TAX REP. (Nov. 1, 2007) at G-4 (Senate Finance Committee ranking Republican Charles Grassley “told the roundtable that those who are trying to water down the standard for community benefit . . . could actually tip him over to reform legislation. . . .”).