Tax-Exempt Hospitals: Discussion Draft

This discussion draft is released by the Senate Committee on Finance – Minority as a staff document. The document reflects proposals for reform in the area of non-profit hospitals based on staff investigations and research as well as input from tax and health care attorneys and policy analysts. This document 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. This is not proposed legislation.

INTRODUCTION

As policymakers consider the issues presented in this draft, they may want to keep in mind these three comments:

> *For many nonprofit hospitals, we found the link between tax-exempt status and the provision of charitable activities for the poor or underserved is weak. Currently, the Internal Revenue Service (IRS) has no requirements relating hospitals' charitable activities for the poor to their tax-exempt status. If the Congress wishes to encourage nonprofit hospitals to provide charity care and other community services that benefit the poor, it should consider revising the criteria for tax exemption.*
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> July 10, 1991, Mr. Mark Nadel, Associate Director, National and Public Health Issues, General Accounting Office – testimony before the Committee on Ways and Means

> *Some tax-exempt health care providers may not differ markedly from for-profit providers in their operations, their attention to the benefit of the community, or their levels of charity care.*
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> March 30, 2005, Mark Everson, Commissioner of the IRS -- letter to the Senate Finance Committee

> *[C]urrent tax policy lacks specific criteria with respect to tax exemptions for charitable entities and detail on how that tax exemption is conferred. If these criteria are articulated in accordance with desired goals, standards could be established that would allow nonprofit hospitals to be held accountable for providing services and benefits to the public commensurate with their favored tax status.*
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> May 26, 2005, David W. Walker, Comptroller General of the United States – testimony before the Committee on Ways and Means

The Finance Committee minority staff has been investigating certain nonprofit hospitals and reviewing the standards currently applicable to nonprofit hospitals exempt under IRC § 501(c)(3). Although the staff investigation is ongoing and is particularly

interested in the results of the forthcoming IRS study and survey of tax-exempt hospitals, the staff has identified several areas of concern as it pertains to the tax-exempt status of nonprofit hospitals.[1] The staff is concerned that many nonprofit hospitals receive substantial federal income tax benefits and subsidies without providing commensurate benefits to society.[2] It is estimated that nonprofit hospitals receive between $12.6 billion and $20 billion a year in benefits from tax-exemption at the federal, state and local level.[3] A recent Congressional Budget Office (CBO) report found that nonprofit hospitals provided only slightly more uncompensated care than for-profit hospitals, based on a five state survey.[4]

In addition, it is important to note that CBO and other researchers have determined that there are significant differences between individual nonprofit hospitals in terms of the amount of uncompensated care or charity care each hospital provided. In general, according to CBO, nonprofit hospitals provide a mean of 4.7 percent uncompensated-care as a share of total hospital operating expenses. However, as a mean suggests, CBO reports there are quite a few nonprofit hospitals that provide significantly more than 4.7 percent in uncompensated-care and, unfortunately, many nonprofit hospitals providing less than 3 percent in uncompensated-care. Other researchers have found that a number of nonprofit hospitals do very little in providing charity care. In brief, some nonprofit hospitals are helping pull the wagon when it comes to charity care but far too many nonprofit hospitals are sitting in the wagon – receiving significant tax breaks but providing little to nothing in the way of charity care for those in need in our society.[5]

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[1] For the purposes of this discussion draft, the term "nonprofit hospitals" refers to hospitals that are exempt from Federal income tax under §501(c)(3).

[2] See testimony of Nancy Kane before the Senate Finance Committee, September 13, 2006 (Several studies have shown that the majority of tax-exempt hospitals do not provide charity care commensurate with the value of their tax exemptions).

[3] According to the Joint Committee on Taxation, in the year 2002 (the most recent year for which statistics are available), the value to nonprofit hospitals of the major tax exemptions they receive from federal, state and local governments was estimated to be $12.6 billion. *See* CBO Report, "Nonprofit Hospitals and the Provision of Community" Dec. 2006, p. 3. See also Kane, supra 2 (If the value of tax-exemption is roughly 5% of hospital expenditures [using the guideline used in Texas' community benefit law], then the value of tax exemption from all sources [federal, state and local] approaches $20 billion/year for private nonprofit hospitals).

[4] Congressional Budget Office Report, Nonprofit Hospitals and the Provision of Community Benefits, Dec. 2006. The issues raised in this paper are not new. For a historical perspective on this and many other issues discussed in this paper, policymakers should review "Nonprofit Hospitals: Better Standards Needed for Tax Exemption," General Accounting Office GAO? HRD-90-84 (May 1990); "Hospital Charity Care and Tax Exempt Status: Restoring the Commitment and Fairness" Hearing before the Select Committee on Aging, House of Representatives, 101st Congress, 2nd Session, June 28, 1990; and, "Free Ride: The Tax-exempt Economy" Chapter 3 "Charitable hospitals: Where's the charity?" by Gilbert Gaul and Neill Borowski, Andrews and McMeel (1993).

[5] See statement of David Walker, Comptroller General of the United States, "Nonprofit, For-Profit, and Government Hospitals: Uncompensated Care and Other Community Benefits," before the Committee on Ways and Means, May 26, 2005 (Further, within each group [of for-profit and nonprofit hospitals], the burden of uncompensated care costs was not evenly distributed among hospitals but instead was concentrated in a small number of hospitals. This meant that a small number of nonprofit hospitals accounted for substantially more of the uncompensated care burden than did others receiving the same tax

Specifically, the staff is concerned about: establishment of charity care policies and wide publication of those policies at nonprofit hospitals; amount of charity care and other community benefits provided by nonprofit hospitals; conversion of nonprofit hospital assets for use by for-profit entities; ensuring that an exempt purpose is furthered in joint ventures between a nonprofit hospital and a for-profit entity; transparency and accountability of nonprofit hospital governance and activities; and use of unfair billing and aggressive collection practices by nonprofit hospitals particularly with respect to low-income families. Finally, the staff believes that the present community benefit standard is extraordinarily vague and does not correlate with the federal tax benefits received by the hospital.

In this draft, the staff suggests various alternatives to be considered in drafting legislation to reform nonprofit hospital federal tax-exemption. The staff recommends the implementation of an exempt hospital structure which provides different requirements depending on whether the organization seeks to be classified as an IRC § 501(c)(3) or § 501(c)(4) exempt organization. While both §501(c)(3) and (c)(4) organizations are exempt from Federal income tax, § 501(c)(3) organizations receive the additional benefits of being able to issue tax-exempt bonds and receive contributions that are deductible under section 170. The requirements for § 501(c)(3) status should be more stringent than the requirements for § 501(c)(4) status to be commensurate with these additional tax benefits. Staff are unaware of any hospitals that are currently a 501(c)(4). The common practice is that a nonprofit hospital is classified as a 501(c)(3).

The staff proposal recommends setting specific standards for hospitals that seek exemption under § 501(c)(3), including: (i) establishing a charity care policy and wide publication of that policy; (ii) quantitative standards for charity care; (iii) requirements for joint ventures between nonprofit hospitals and for-profit entities; (iv) board composition and other governance requirements and executive compensation; (v) limiting charges billed to the uninsured; (vi) placing restrictions on conversions; (vii) curtailing unfair billing and collection practices; (viii) transparency and accountability requirements; and, (ix) sanctions for failure to comply with applicable requirements for a 501(c)(3) or 501(c)(4) hospital.

The staff proposal recommends setting standards for hospitals that seek exemption under 501(c)(4) including: (i) a quantitative amount of community benefits annually; (ii) limiting charges billed to the uninsured; (iii) governance reforms; (iv) restrictions on conversions; (v) curtailing unfair billing and collection practices; (vi) heightened transparency; and, (vii) sanctions for failure to comply with applicable requirements.

The proposals would apply in addition to existing legal requirements generally applicable to § 501(c)(3) and (c)(4) organizations, such as the private inurement prohibition, but would replace Rev. Rul. 69-545 and 83-157.

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preference). See also "It's All in the Numbers: A Beginner's Guide to Charity Care Analysis" by Leslie Bennett, Consumers Union (2005)(average percentage of charity care compared to total operating expenses for all hospitals from 1995 – 1999: 132 hospitals had zero charity care; 307 had 0.01% to 1.00%; 52 had 1.01% - 2.00%; 37 had 2.01% - 5.0%; and, 20 had 5.01% and above).

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.[6]

The staff believes that implementation of these proposed changes will bring real and meaningful health benefits to low-income families. Policymakers concerned about addressing the many health issues facing the nation should bear in mind that taxpayers currently provide billions of dollars in subsidies to nonprofit hospitals while at the same time many vulnerable and low-income families do not receive necessary free or discounted care. While certainly not a cure-all, policymakers have an opportunity to improve the health care for many low income families by ensuring that the tax benefits provided to nonprofit hospitals translate into health care for those in need and the community at large.

Congress should meet its responsibilities of being good stewards of the taxpayers' monies and ensure that in exchange for the billions of dollars given in tax breaks, nonprofit hospitals do in fact provide concrete benefits to the community, especially to the most vulnerable in our nation.

LAW CURRENTLY APPLICABLE TO NONPROFIT HOSPITALS

Hospitals that qualify as a tax-exempt organization under § 501(c)(3) are automatically classified as public charities, and not private foundations.[7] Prior to 1969, hospitals were eligible for § 501(c)(3) status by demonstrating charity care. Specifically, hospitals were required to be operated to the extent of their financial ability for those unable to pay for the services rendered. Under Rev. Rul. 56-185, tax-exempt hospitals: (i) were not allowed to refuse to accept or deny medical care or treatment to indigent patients in need of hospital care; (ii) could furnish services at reduced rates that are below cost; (iii) could set aside earnings for improvements and additions to hospital facilities; and (iv) could not restrict the use of its facilities to a particular group of physicians and surgeons or otherwise have net earnings inure (directly or indirectly) for the benefit of any private shareholder or individual.[8]

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[6] See "Voluntary Commitments: Have Hospitals That Signed a Confirmation of Commitment to the American Hospital Association's Billing and Collections Guidelines Really Changed Their Ways?" by Bill Lottero and Carol Pryor, The Access Project, May 2005 and Raymont Hartz, Executive Director Legal Aid Society of Eastern Virginia, Inc., Testimony before the Senate Finance Committee, September 13, 2006 (Every private hospital in Hampton Roads is non-profit. Each has a charity program, either for free-of-charge care and/or for discounted care for the un or under-insured patient. Unfortunately, the reality is that very few low income, uninsured patients are ever informed of the existence of these program. . . . This week I have spoken with Legal Aid programs around the country, and the problems I have described are not unique to Virginia. In almost all the states I spoke with, the same problems are present – charity care programs exist at the hospitals, but many eligible patients never learn of their existence).

[7] I.R.C. § 509(a) (referring to § 170(b)(1)(A)(iii)).

[8] Rev. Rul. 56-185.

In concert with passage of legislation creating Medicare and Medicaid, representatives of nonprofit hospitals began advocating for the Treasury to make changes to Rev. Rul. 56-185. One of the major claims made by nonprofit hospitals was that passage of Medicare and Medicaid legislation would eliminate or greatly reduce the demand for charity care – and therefore there needed to be flexibility in the requirements for nonprofit hospitals.

In response to the lobbying of nonprofit hospitals, IRS issued new guidance requiring that hospitals must meet a "community benefit" standard in order to be eligible for tax exemption under 501(c)(3). The community benefits standard is a facts and circumstances test without any clear lines. In Rev. Rul. 69-545, the IRS set forth certain factors that demonstrate a community benefit: (i) an emergency room open to all, including indigent patients; (ii) a board of directors drawn from the community; (iii) an open medical staff policy; (iv) treatment of patients who pay their bills through public programs, such as Medicaid and Medicare; (v) use of surplus funds to improve facilities, equipment, and patient care; and (vi) medical training, education, and research. In Rev. Rul. 83-157 the IRS stated that, although operation of an emergency room open to all regardless of ability to pay is a strong factor in demonstrating community benefit, the presence of other similar significant factors would warrant exempt status in the absence of such an emergency room due to a determination by a state/local health planning agency that emergency room service was unnecessary and duplicative.[9]

Current IRS guidance does not presently set forth quantitative standards for the amount of charity care or community benefits that must be provided, nor does it require the level of community benefits to be commensurate with the tax benefits received. Further, the present guidance by IRS establishing a community benefit standard does not even require that a hospital provide any charity care in order to be exempt as a public charity. The community benefit standard has been widely viewed as a failure administratively and, more importantly, in providing measurable benefits to low-income families.

It is important for policymakers (including those in the executive branch) to recognize that Rev. Rul. 69-545 was not put forward by the IRS in response to any changes in the tax laws. The new guidance in Rev. Rul. 69-545 was based on what turned out to be an inaccurate expectation of other legislation (namely that Medicaid and Medicare would eliminate or greatly reduce the need for charity care). Nothing prevents the executive branch from issuing new guidance that establishes (or reestablishes) charity care requirements for nonprofit hospitals.

[9] The staff believes the enactment of the Emergency Medical Treatment and Active Labor Act ("EMTALA"), which requires all Medicare provider hospitals to screen for and stabilize any emergency medical condition in all emergency room patients, diminishes the relevance of an open emergency room as a major factor in determining exempt status since the law is applicable to both for-profit and nonprofit hospitals. *See* 42 U.S.C. § 1395dd. Notably, EMTALA does not prohibit a hospital from seeking payment for the care provided in the emergency room after treatment has been provided.

STAFF PROPOSAL

This staff proposal is divided into four sets of recommendations:
(1) recommendations for special rules for hospitals exempt under § 501(c)(3);
(2) recommendations for special rules for hospitals exempt under 501(c)(4);
(3) recommendations applicable to hospitals exempt under 501(c)(3) and (c)(4); and;
(4) recommendations applicable to all hospitals (nonprofit, for-profit, and government hospitals).

I. Special Rules for Hospitals Exempt Under § 501(c)(3) and § 501(c)(4)

The staff suggests that Congress legislate special rules for hospitals seeking exemption under § 501(c)(3) and § 501(c)(4). Because the tax benefits for § 501(c)(3) organizations are greater than those for § 501(c)(4) organizations (*i.e.,* tax-exempt financing and § 170 deductible contributions), the requirements for exemption under § 501(c)(3) are more stringent than those for § 501(c)(4).

A. Standards Applicable to (c)(3) Hospitals:

No hospital will qualify for §501(c)(3) status unless they meet the following additional requirements:

1. A §501(c)(3) Hospital Must Develop a Charity Care Policy and Publicize It. Minimum Requirements for Charity Care

Consumer advocacy groups have found that many hospitals either do not offer charity care policies, or if they do, it is difficult for a patient to find out more about the procedures for obtaining such care. To remedy this problem, the staff recommends that each § 501(c)(3) hospital be required to develop a written charity care policy that sets forth eligibility requirements, procedures for obtaining free or discounted care, and where a patient can obtain more information.[10] Such policies must be made available: (1) on hospital websites, in emergency rooms, and in admissions offices, at all times; and (2) to members of the public, the IRS, and the Department of Health and Human Services (HHS) upon request. In addition, notice of the availability of charity care and where additional information may be obtained should be widely posted in areas that will ensure notice by patients. Charity care policies should be written in plain language and in a manner that is easily understandable by the general public. These policies should also be made available in multiple languages if the needs of the community require it.

[10] In the explanation of reforms of charitable credit counseling organizations included in the Pension Protection Act of 2006, the Joint Committee on Taxation noted that the provision of services and waiver of fees without regard to ability to pay and the establishment of a reasonable fee policy and independent board members are core issues to the matter of tax exemption . See General Explanation of Tax Legislation Enacted in the 109th Congress, Joint Committee on Taxation (January 17, 2007) p. 612 fn 858.

The staff recommends that the minimum eligibility threshold for all charity care policies shall be no less than 100% of the federal poverty level (FPL) and policymakers may want to consider a policy above 100%. That is, nonprofit hospitals should provide free of charge medically necessary in/out patient hospital services (not otherwise covered by Medicaid, etc.) to all individuals at or below the federal poverty level.[11]

2. A §501(c)(3) Hospital Must Provide Quantitative Amounts of Charity Care Annually

The staff believes that merely offering a charity care policy is not enough to justify exemption under Section 501(c)(3) – charity care must actually be provided. The staff considered various alternatives, including requiring a hospital to provide charity care to every person who satisfies the charity care policy, an annual minimum aggregate charity care amount, and a rolling average charity care amount over several years. The staff recommends that no hospital can maintain § 501(c)(3) status without dedicating a minimum of 5% of its annual patient operating expenses or revenues to charity care, whichever is greater, in accordance with its charity care policy.[12] The 5% test is based on staff review (discussed further below) and reflects the common practice of the IRS in auditing nonprofit hospitals prior to the 1969 regulatory changes.[13] Note: the 5% test must be met using the same measure/criterion for the numerator and the denominator – i.e., if the hospital uses operating expenses for the 5% test, the hospital must measure that against operating expenses overall. Staff believes a transition period to meeting the 5% test is warranted. Critical access hospitals would be exempt from this provision.[14]

For this purpose, charity care is 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 as discussed in Section A.1. above);[15]

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[11] The policy of charity care for those at 100% FPL is a common standard for nonprofit hospitals, with many nonprofit hospitals providing a higher standard. For example, the Iowa Health System has a policy of providing charity care for those up to 200% FPL.

[12] Policymakers may also wish to consider "net income" as the basis for measuring the amount of charity care required. For example, the Daughters of Charity had a policy that required hospitals to devote 25% of net income to care of the poor. However, staff has concerns about manipulation of this measurement.

[13] See Statement of John Colombo to the House Ways and Means Committee, Footnote 3(IRS auditing agents often denied or revoked exempt status if a hospital's charity care was less than 5% of gross revenues) May 27, 2005.

[14] Under federal law, a critical access hospital is located in a rural area and meets one of the following criteria: (i) be located over 35 miles away from another hospital; (ii) be located 15 miles from another hospital in mountainous terrain or areas with only secondary roads; or (iii) be state-certified as a necessary provider of health care services to residents in the area.

[15] See generally the definition of free care and charity care for the States of Maine and Rhode Island, See Code Me. R. 150:10-144-1.01(c) , Me. R. 150.10-144-10(c) and CRIR 14-090-007. For a discussion of state charity care laws see Rachael Kagan and Erinmauriah Conway, "State of the States' Charity 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.[16] Also included would be grants to other charities that provide free medical care to vulnerable populations through free clinics, community medical clinics, etc.

The value of care provided 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. Charity care would not include bad debt. Staff views it as inappropriate for a hospital to seek payment from a patient by sending a bill, and when payment is not received, to seek to recharacterize that debt as charity care. In addition, staff has found that the decision by some hospitals to include bad debt (which often consists of very high charges from the "chargemaster list" – see discussion below) provides a misleading and inflated accounting of a hospitals' charity care to policymakers and the public. The same issue of inflated and misleading accounting also applies when a hospital uses the "chargemaster" list to quantify charity care.

Staff recognizes that hospitals can face a significant burden or barrier with some patients in establishing whether the patient is eligible for charity care. However, hospitals that emphasize and make a priority of establishing patient eligibility for charity care have had good success in minimizing this problem. Staff believes that flexibility should be provided to hospitals to determine eligibility for charity care after medical services have been provided but before the patient is billed. Finally, staff believes that hospitals should be allowed some flexibility in deciding on the data necessary to determine eligibility for charity care -- as suggested by the Healthcare Financial Management Association (HFMA).[17]

Laws," Nicholas C. Petris Center on Health Care Markets and Consumer Welfare University of California, Berkeley, School of Public Health (September 2001).

[16] This expanded view of charity care and benefits a nonprofit hospital can/should provide is informed by the concept of "enhancing access" discussed in "Symposium: Health Care and Tax Exemption: The Push and Pull of Tax Exemption on the Organization and Delivery of Health Care Services: The Failure of Community Benefit," by John Colombo, 15 Health Matrix 29, 62 (Winter, 2005).

[17] See HFMA Principles and Practices Board Statement No. 15, "Valuation and Financial Statement Presentation of Charity Service and Bad Debts by Institutional Healthcare Providers," paragraphs 3.7 and 3.8, (December 5, 2006). In addition policymakers would benefit from a review of the entire Statement No. 15. The staff recommendations in this section are similar in many aspects to Statement No. 15 but differ in some parts, particularly in regards to determining for how long bad debt can still be converted to

The term "medically indigent" includes "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."[18] The staff recommends defining the term "underinsured" as 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 % FPL), out-of-pocket medical expenses amount to 5% or more of income; or 3) health plan deductibles equal or exceed 5% of income."[19]

The staff reviewed a 2005 GAO report regarding billing practices, which studied the average percent of patient operating expenses devoted to uncompensated care in the hospital systems in five states: (1) California – 3.2%; (2) Florida – 5.5%; Georgia – 6.9%; Indiana – 4.3; and Texas – 6.7%.[20] The average from these figures is 5.32% -- but policymakers should keep in mind that these figures include bad debt. Based on the results of this study and similar reviews, the CBO study discussed earlier, pre-1969 IRS practice and a review of different state and federal charity care requirements summarized below, the staff believes that a charity care requirement equivalent to at least 5% of patient operating expenses or revenues (whichever is greater) would be reasonable. The following are some of the charity care requirements (or proposed) under federal or state law studied by staff, which policymakers may want to review for comparison purposes:

- Hill-Burton Act: The provisions of this Act passed into law in 1946[21] mandate that, in order to receive funding for certain facility construction and modernization, hospitals must provide "uncompensated services" in an amount equal to the lesser of: 3% of the hospital's operating costs, or 10% of all Federal assistance provided to or on behalf of the hospital with certain adjustments.

- Illinois: During the 2006 legislative session, the Illinois Attorney General proposed a bill that would mandate hospitals to devote 8% of their annual operating costs to charity care.[22] Critical access hospitals were excluded from the provisions of the bill.

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charity care. Statement No. 15 views that it is desirable to determine eligibility for charity care at the time service is rendered but would continue to allow for bad debt to be considered charity care even after the patient has been billed (assuming that it was determined the patient was eligible and that the hospital had in place a good-faith effort and policy to determine eligibility at time of service and prior to billing).

[18] Term as defined by the Centers for Medicare and Medicaid Services (CMS), see http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/FAQ_Uninsured.pdf

[19] Insured But Not Protected: How Many Adults Are Underinsured?, Cathy Schoen, M.S., Michelle M. Doty, Ph.D., Sara R. Collins, Ph.D., and Alyssa L. Holmgren, *Health Affairs* Web Exclusive, June 14, 2005 W5-289–W5-302 (synopsis available at http://www.cmwf.org/publications/publications_show.htm?doc_id=280812)

[20] *See* "Nonprofit, For-profit, and Government Hospitals," Statement of David M. Walker, Comptroller General of the United States, GAO-05-743T, p. 11, Fig. 2.

[21] See 42 CFR § 124.503 for applicable provision.

[22] The Illinois bill did not include bad debt in the calculation, but Medicaid shortfalls would count toward the requirement. The bill exempted government hospitals and critical access hospitals (as defined in federal law) from the charity care requirement.

The bill was pulled because the Illinois Hospital Association argued that no Illinois nonprofit hospital would be able to meet the requirement.

- Texas: The Texas Health & Safety Code § 311.045 requires that a nonprofit hospital meet one of the following criteria: (1) provide charity care and government-sponsored indigent health care at a level that is reasonable in relation to the community needs, as determined through the community needs assessment, the available resources of the hospital or hospital system, and the tax-exempt benefits received by the hospital or hospital system; (2) provide charity care and government-sponsored indigent health care in an amount equal to at least 100% of the hospital's or hospital system's tax-exempt benefits, excluding federal income tax; or (3) provide charity care and community benefit in a combined amount of at least 5% of the hospital's or hospital system's net patient revenue, provided that charity care and government-sponsored indigent health care are provided in an amount equal to at least 4% of the net patient revenue.

- Rhode Island: Rhode Island's proposed regulations require that 1% of net patient revenue should be used to provide charity care and/or should be paid out to school based health centers or community health centers.[23] Any hospital that receives 50% or more of its payments from Medicaid would be exempt.

- Pennsylvania: The Institutions of Purely Public Charity Act requires that a hospital devote at least 3% of its total operating expenses toward charity care and it must provide financial assistance to at least 20% of its patients.

While policymakers might consider just requiring each 501(c)(3) hospital to provide charity care to every patient who meets certain minimum eligibility requirements (as discussed in Section A.1. above) and that the hospital also provide charges to the medically indigent based on the lower of: (i) the amount paid by the government (Medicare/Medicaid), or (ii) the actual hospital cost (discussed below), staff are concerned that such a policy would not change significantly the current situation in which many charity hospitals located in poorer urban areas provide a disproportionate amount of charity care while many charity hospitals, particularly those located in wealthier suburban and exurban hospitals, provide little in the way of charity care to assist low-income families.

3. Special Rules for Hospital Joint Ventures Between a For-Profit Entity and a § 501(c)(3) Hospital

The staff is concerned that joint ventures between for-profit entities and nonprofit hospitals are primarily for the most profitable patient care services and may divert surplus funds away from hospital services that are less profitable, including the provision of charity care. Some have commented that nonprofit hospitals are in an unequal bargaining position when negotiating a joint venture with certain for-profit entities; that is, in certain

[23] Rules and Regulations Pertaining to Charity Care in Health Care Facilities, R23-17-CHARITY, available at http://www.health.ri.gov/hsr/regulations/proposed/charitycare-proposed-march07.pdf.

instances, nonprofit hospitals enter into a joint venture to prevent the loss of services and/or expertise that are important or necessary to the hospital. On the other hand, hospitals may in some instances receive benefits from joint ventures such as access to new capital to upgrade facilities and medical equipment.

While the staff believes that § 501(c)(3) hospitals should be able to engage in joint ventures with for-profit entities, we recommend that special rules be adopted with respect to joint ventures involving patient care services between for-profit entities and § 501(c)(3) hospitals to help ensure that a charitable purpose is furthered by such a venture. For this purpose, a joint venture is any entity or arrangement taxed as a partnership for federal tax purposes.

To this end, the staff recommends that any patient care services joint venture involving a § 501(c)(3) hospital must have its own charity care policy. In the case of a whole hospital joint venture (*i.e.,* at least one or more § 501(c)(3) hospitals place all or substantially all of its assets into the joint venture), the joint venture must meet the charity care requirement applicable to § 501(c)(3) hospitals, and the joint venture's board must be controlled[24] by the nonprofit hospital. Where there is more than one nonprofit hospital involved in such a joint venture, board control shall be determined by looking at the aggregate control of all § 501(c)(3) hospitals in the joint venture.

In an ancillary joint venture (*i.e.,* a portion of the nonprofit's assets are placed in the joint venture), the § 501(c)(3) hospital must control the joint venture's charity care policy and there must be at least one voting member on the board who is from each § 501(c)(3) hospital involved in the joint venture. No decision may be made by the joint venture full board that affects charity care policy without approval by the nonprofit hospital. A joint venture's charity care policy must meet the charity care requirements described earlier in this draft. Given the joint venture's policy will be controlled by the nonprofit hospitals, the staff believes it is appropriate that all of the charity care provided at the joint venture level may be credited toward each nonprofit hospital involved in the joint venture based on such hospital's proportionate share, relative to the contributions made by any other non-profit hospital that is a part of the joint venture. The percentage of charity care attributable to each § 501(c)(3) hospital involved in the joint venture is equal to:

$$\frac{\text{501(c)(3)'s investment percentage}}{\text{501(c)(3) Total 501(c)(3) investment percentages}} \times \text{Total Charity Care}$$

Example 1: Two nonprofit hospitals contribute 10% each and a for-profit entity contributes the remaining 80% to a joint venture. Based on the above equation, each nonprofit hospital would be allowed to count 50% of the total charity care provided by the joint venture toward their minimum charity care requirement. The numerator for each nonprofit is 10, while the denominator is 20.

[24] Staff do not intend to change the current definition of "control," – See Rev. Rul. 98-15 and 2004-51 and generally, "Joint Ventures Involving Tax-Exempt Organizations," 3rd Edition, Michael Sanders, Section 4.2. Staff is seeking to ensure that the nonprofit has control of the charity care policy of either the whole hospital joint venture or ancillary joint venture.

Example 2: Two § 501(c)(3) hospitals, Hospitals A and B, contribute 20% and 10%, respectively, to a joint venture, while ForProfit Co. contributes 70%. Based on the equation, Hospital A would be allowed to count 2/3 and Hospital B would be allowed to count 1/3 of all the charity care provided by the joint venture toward their respective charity care requirements. The denominator is 30, while the numerator for Hospital A is 20 and the numerator for Hospital B is 10.

Example 3: Hospital A (a § 501(c)(3) hospital) contributes 30% and a for-profit entity contributes 70% to a joint venture. Hospital A would be allowed to count 100% of the charity care provided by the joint venture toward its charity care requirement because both the numerator and denominator of the equation is 30.

Note: a (c)(3) organization may not include as charity care any portion of a joint venture's charity care if the (c)(3) does not control the joint venture's charity care policy; or charity care that is provided by another separate entity taxed as a corporation. The staff also is considering whether a § 501(c)(3) hospital should be taxed on any non-medically necessary services (such as certain cosmetic surgery) performed by the joint venture as unrelated business income.

4. ***Community Needs Assessment and Additional Community Benefit Requirements***

Each nonprofit hospital has to conduct every three years a community needs assessment with a particular emphasis on vulnerable populations (i.e., populations with barriers to care: financial, transportation, disability, language, etc.). Policymakers should consider whether there should also be a minimum amount of other community benefits, such as education and outreach, training or research, health protection and health promotion for vulnerable populations. This community assessment should be performed in consultation with local advocates and representatives for vulnerable populations as well as state and local Department of Health officials. IRS should consult with the Department of Health and Human Services in providing guidance in this area.

B. Standards Applicable to (c)(4) Hospitals:

No hospital will qualify for § 501(c)(4) status unless they meet the following requirements (in addition to current law requirements for (c)(4)s):

1. A § 501(c)(4) Hospital Must Provide a Minimum Quantitative Amount of Community Benefits Annually

The staff recommends that no hospital can maintain § 501(c)(4) status without: (1) conducting a community needs assessment every three years with a particular emphasis on vulnerable populations; and (2) dedicating a minimum of 5% of its annual patient operating expenses or revenues to community benefits. Critical access hospitals must comply with the first provision, but would be exempt from the second provision. The following would be deemed *per se* community benefits: (1) charity care (as defined above); (2) an emergency room open to all, regardless of ability to pay; (3) burn units; (4)

trauma centers; (5) health profession education and training programs; (6) health research; and (7) activities conducted in response to issues raised by a community needs assessment. The IRS would be permitted to develop additional *per se* community benefits. The staff believes that the Catholic Health Association definition of community benefit categories should serve as a template for defining community benefit.[25] Any activity that falls outside of the *per se* community benefit standard would be subject to written approval by the IRS.

C. Standards Applicable To Both § 501(c)(3) and § 501 (c)(4) Hospitals:

The staff recommends that the following standards be applicable to all § 501(c)(3) and § 501(c)(4) hospitals. These standards are in addition to the present-law provisions applicable to § 501(c)(3) and § 501(c)(4) organizations, including, but not limited to, the prohibitions on private inurement and impermissible private benefit.

1. *Charges to the medically indigent who are uninsured or under-insured shall not exceed the lower of: (i) the amount paid by the government, or (ii) the actual hospital cost.*

All hospitals develop a list of charges for the medical services that they provide, often referred to as a "chargemaster." These charges reflect an amount above the actual cost of providing the service.[26] Private insurers negotiate rates lower than those listed in the chargemaster. Medicare and Medicaid set their own reimbursement levels irrespective of an individual hospital's chargemaster; these rates are generally lower than the rates listed in most hospital chargemasters, and at times are lower than the actual cost of service provided by the hospital. Both for-profit and nonprofit hospitals (as well as other medical providers) have engaged in "cost-shifting," *i.e.,* they shift many of their costs resulting from the significant discounts to third-party payers (private insurers, Medicaid, and Medicare) to self-payers (uninsured and underinsured). In some cases, hospitals charge self-payers 2-3 times what they accept as payment from private insurers.[27] Where a person is uninsured, a hospital generally charges a patient the amount listed in the hospital's chargemaster, unless the patient has negotiated a reduced rate. Notably, most patients are not aware that they can negotiate a reduced rate.

The staff believes that the medically indigent should not be charged rates higher than those charged to persons who are covered by the government or the actual cost of

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[25] Available at: http://www.chausa.org/NR/rdonlyres/68057062-B902-420D-BB04-C5B1597E64BB/0/CBCategories_Hospitals.pdf.

[26] Dobson, A. et. al., "A Study of Hospital Charge Practices," The Lewin Group (Dec. 2005) at 1, available at http://www.medpac.gov/publications/contractor_reports/Dec05_Charge_setting.pdf. (Study prepared for the MedPAC).

[27] See Gerald F. Anderson, "From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing" 26 Health Affairs 780 (May/June 2007)(In 2004, the rates charged to many uninsured and other "self-pay" patients for hospital services were often 2.5 times what most health insurers actually paid and more than three times the hospital's Medicare-allowable costs. The gaps between rates charged to self-pay patients and those charged to other payers are much wider than they were in the mid-1980s, and they make it increasingly more difficult for some patients, especially the uninsured, to pay their hospital bills).

service. Accordingly, the staff recommends that, as a condition of federal tax-exemption, a § 501(c)(3) or § 501(c)(4) hospital may not charge a medically indigent patient who is uninsured or under-insured a rate that exceeds the lower of: (i) the lowest rate that would be paid by Medicare/Medicaid or (ii) the actual cost to the hospital for such service. The staff recommends that at a minimum this charge policy should be for patients with incomes of 100 – 200 percent of FPL for a (c)(3) hospital (recall that (c)(3) hospitals are already required to provide free care for families below 100 percent FPL) and that (c)(4) hospitals will have a minimum charge policy for patients from 0 – 200 FPL. Policy makers should consider raising that to 300 percent for non-critical access hospitals. To the extent that such rates fall below the actual cost of service, the hospital can count the shortfall toward their charity care or community benefit standards. In addition, as mentioned earlier in the discussion of quantitative amounts of charity care, any discount in charges below the rate (referenced above) can be included for purposes of charity care or community benefit. Staff is considering the issues raised by the fact that the underinsured may already have a negotiated rate with the hospital.

2. Governance

All § 501(c)(3) or § 501(c)(4) hospitals must have a board of directors that represents the broad interests of the community. Accordingly, the staff recommends adopting provisions similar to that in § 501(q)(1)(D), such that: (1) the hospital is governed by a board of directors that is controlled by members who represent the broad interests of the public, such as public officials, persons having special knowledge or expertise in community health care, community leaders and especially advocates or representatives of those benefiting (or potentially benefiting) from charity care and discounted care for the medically indigent; and (2) not more than 25% of the voting power of the board of directors is vested in persons who are employed by the hospital or who will benefit financially, directly or indirectly, from the organization's activities (other than through the receipt of reasonable directors' fees). Additionally, physicians and management should not comprise more than 25% of the board of directors or any of its committees, except for those committees responsible for quality care, credentialing, determining medical staff privileges and the like.

All § 501(c)(3) or § 501(c)(4) hospitals must have detailed conflict of interest policies that describe the scope of covered persons and arrangements (including all officers and directors), the procedures for addressing an actual or potential conflict of interest, the consequences of policy violation, and at least annual review of the policy and the potential conflicts reviewed thereunder. Each conflict of interest policy should address arrangements in which the nonprofit hospital partners with a for-profit entity through a joint venture, conversion, partnership, or otherwise.

The staff agrees with the recommendations of HFMA Principles and Practices Board Statement No. 15 (Appendix A), that the board should be responsible for the following policies: setting 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 determinations 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. Finally, the board should review the Form 990 and schedules as well as review and approve the community needs assessment.

3. Special Rules for Conversions from Nonprofit to For-Profit

When a charitable organization owns assets, those assets are required to be perpetually dedicated to charitable purposes. In recent years, a large number of nonprofit hospitals have converted all or a significant portion of their assets to for-profit entities, often with minimal public oversight of the conversion process. The staff is concerned about this growing trend and recommends imposing a termination tax on the conversion of assets in accordance with a proposal submitted by the Joint Committee on Taxation.[28] The purpose of this proposal is not to collect any tax but to affect behavior and ensure that charitable assets remain for the benefit of the public.

Given the provisions for a 501(c)(4) hospital in this draft, conversion rules will have to be created for a 501(c)(3) nonprofit hospital to become a 501(c)(4). Staff is also concerned about the impact of conversion from a 501(c)(3) to a 501(c)(4) at the state level.

4. Sanctions for Failure to Meet Requirements

The staff recommends imposing the following sanctions where a tax-exempt hospital fails to meet the § 501(c)(3) or § 501(c)(4) requirements:

a. Intermediate sanctions:

i. The staff recommends that an excise tax be imposed upon any § 501(c)(3) or § 501(c)(4) hospital that fails to meet the quantitative requirements applicable to each such entity. A tax-exempt hospital that fails to meet its annual charity care requirement or community benefit requirement will be subject to excise taxes in an amount at least equal to twice the hospital's shortfall. In an effort to account for fluctuations in patient needs, the staff suggests that the legislation give the IRS some flexibility in determining compliance and directs that Treasury issue regulations in this matter. Staff suggests that the IRS look at the average over a three-year period to determine whether a hospital has met its charity care or community benefit requirements. With respect to a § 501(c)(3) hospital's failure to meet its charity care requirement, the IRS should have the authority to reduce the excise tax to no less than the amount of the hospital's shortfall if the hospital demonstrates that it has met its requirements over a period of years (*e.g.,* 4 out of 5 years) and that the shortfall was due to lack of demand by medically indigent persons for services.

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[28] *Options to Improve Tax Compliance and Reform Tax Expenditures*, Joint Committee on Taxation, at 230-246 (Jan. 2005), available at http://www.house.gov/jct/s-2-05.pdf. Note: The JCT proposal and the staffs concerns are not limited to nonprofit hospitals in the area of conversions.

ii. The staff recommends that the initial contract exception and the rebuttable presumption of reasonableness for § 4958 excess benefit transactions be eliminated with respect to joint ventures between for-profit entities and tax-exempt hospitals. In addition, the staff recommends expanding the definition of disqualified person as it pertains to joint ventures between tax-exempt hospitals and for-profit entities to include any person that participates in such joint venture where: (a) such person receives an excess financial benefit; or (b) the exempt hospital receives a disproportionate financial detriment. Additionally, any exempt hospital's manager who knowingly participates or authorizes an excess benefit transaction should be subject to an excise tax in an amount equal to 25% of the excess benefit.

iii. The staff notes repeated concerns by Congress and the public about excessive benefits being provided to executives of charities. The staff recommends that policymakers consider disallowing payments for country club fees, spousal travel, private airplanes (unless for provision of medical services), loans to executives (as is already prohibited for private foundations) and placing significant restrictions on first-class travel. Finally, the initial contract exception for employment contracts should be eliminated.[29]

b. Revocation of Exempt Status

The IRS would retain authority to revoke exempt status where a § 501(c)(3) or § 501(c)(4) hospital fails to meet any applicable requirements. Repeated violations of the charity care requirement also could result in ineligibility to raise additional tax exempt bonds, to raise tax deductible charitable contributions and a recapture of tax benefits relating to such subsidies.

c. Impact on Medicare provider status

The IRS should inform HHS when it revokes a hospital's exempt status or when, in its determination, an exempt hospital has repeatedly or substantially failed to meet its requirements over a period of time. HHS shall take such information into account when determining whether that hospital should continue to qualify as a Medicare provider. The staff believes that policymakers should consider whether there should be outright revocation of Medicare provider status upon revocation of tax-exempt status. Staff believes such a decision should be weighed carefully given possible detrimental effects on the provision of health care in a community and especially among the medically

[29] See Government Accountability Office, June 30, 2006 letter to Chairman William Thomas, Committee on Ways and Means, "Nonprofit Hospital Systems: Survey on Executive Compensation Policies and Practices" (45 of the 65 hospital systems reported that they provide for memberships in recreational or social clubs as a perquisite to the CEO; 13 of the 64 hospitals systems reported that they provide for personal travel expenses for the spouse of the CEO; 28 [of 65] systems reported that they pay for the CEO to attend sports events; 48 [of 65] systems reported that they pay for the CEO to attend meetings, retreats, or other off-site activities involving trips to resort locations or private, exclusive clubs; 17[of 65] systems reported that they pay for the CEO to attend theatre performances). For a general discussion of problems in executive compensation and perks see also statement of Minnesota Attorney General Mike Hatch before the Senate Finance Committee, April 5, 2005.

indigent within such community. However, staff notes that current law provides for Medicare provider status to be revoked under certain circumstances.

II. Recommendations Applicable to Tax-Exempt and Government Hospitals

The staff recommends that the following standards be applicable to all nonprofit ((c)(3) and (c)(4)) and government hospitals:

A. Specific Transparency and Reporting Requirements

The staff recommends that all nonprofit and government hospitals annually report to the IRS and to the public on the following: (1) composition of board of directors; (2) total patient operating expenses and revenues for the year; (3) with respect to charity care, total amount of care provided, number of people receiving such care, and number of people who applied to receive such care; (4) with respect to community benefits, the total amount of community benefits provided disaggregated by type of community benefit provided and the total number of persons who benefited; (5) amounts reimbursed by private and governmental insurers; (6) amounts paid to the hospital from special indigent funds, such as charitable care pools; and (7) with respect to joint ventures, purpose of the joint venture, copy of any charity care or community benefits policy of the joint venture, number of persons benefiting under such policies, and a description of the composition of the board. This information can be reported on a special form for hospitals (*i.e.,* Form 990-H, as proposed recently by the IRS last June for public comment) (Note: government hospitals would not be required to complete other portions of the Form 990). The staff believes this information will promote transparency, help ensure compliance with the laws, inform local communities, and provide information that would assist with future legislation or regulations. Finally, similar to current SEC requirements, the hospital must make publicly available the comparables survey on which it relied to establish the salaries of executives. Staff recognizes the reporting burden placed on hospitals and seeks to limit that burden by encouraging greater common reporting (same elements and terms, acceptance of other filed documents, etc.) to state and federal agencies.

B. Hospitals Cannot Engage In Unfair Billing and Collection Practices

The staff recommends developing certain practices that would be applicable to the collection of medical debt, whether by a collection agency or the internal hospital collections department.

The Federal Debt Collection Practices Act ("FDCPA") is 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 regularly collect debts; the law does not apply to a hospital's internal billing or debt collection department. The FDCPA controls how and when a debt collector may contact a patient-debtor and what the debt collector can say to such patient-debtor. It also gives patients the right to dispute the debt and force debt collectors to leave them alone. Nothing in the law prohibits a hospital from instituting a legal action against a patient-debtor.

Unlike most consumer debt, medical debt is often incurred because of necessity, and often because of a medical emergency. Despite the uncontrollable nature under which most medical debt arises, patients and consumer advocacy groups have reported that hospitals have engaged in aggressive collection practices against those who are unable to pay medical debt, including those who are low-income uninsured and underinsured. Such practices include the institution of legal actions to, among other things: garnish wages; seize bank accounts; place a lien and/or foreclose on patient-debtors' homes; and force patient-debtors into bankruptcy.

The staff recommends that the provisions of the FDCPA be expanded to apply to internal hospital billing and collection practices.

Because of the unexpected and emergent situations under which most medical debt is incurred, the staff is considering whether to ban and/or restrict the use of certain aggressive collection practices against an uninsured/underinsured medically indigent patient for the medical debt incurred by such person and his/her dependents. The staff seeks comment on which aggressive collection practices should be banned and/or restricted as it relates to vulnerable populations.[30]

III. Specific Requests for Comments

The staff requests comments on all suggestions contained in this discussion draft. In particular, the staff is interested in comments regarding (a) the definition of hospitals for this purpose; (b) the application of any standards in the context of a hospital system involving multiple hospitals; (c) the propriety of any transition rules from present law to a new exemption regime particularly in regards to the 5% quantitative test; (d) the circumstances under which revocation of exemption would be appropriate; (e) whether Medicare and/or Medicaid disproportionate share payments (DSH) should be netted out for purposes of determining whether hospitals have met the 5% test (note: Medicare and Medicaid programs make payments to hospitals called DSH to compensate hospitals that serve large proportions of low-income individuals); (f) consideration of encouraging/requiring (c)(3) hospitals to provide particular community benefits, especially targeted at vulnerable populations; (g) consideration of rewarding nonprofit hospitals that provide quantitative charity care amounts significantly above 5% (what threshold and what rewards); (h) whether Medicare graduate medical education payments should be netted out for purposes of determining whether hospitals have met the 5% test; (i) should hospitals above a certain level of operating revenue be required to comply with the financial management and audit requirements in the Sarbanes-Oxley legislation; (j) implication of these proposals for access to tax-exempt financing; and, (k) should certain subsidized health services be included for purposes of meeting the quantitative test for 501(c)(3)'s such as burn units, trauma centers – and if so, how should this be defined, quantified and limited.

[30] If policymakers decide to provide for a broader allowance for converting bad debt into charity care, consideration should be given to prohibiting hospitals from assigning a patient's debt to an external debt collection agency or an attorney who regularly collects debt without the hospital first conducting screening of the patient for Medicaid eligibility and charity care eligibility.