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Douglas M. Mancino

THE IMPACT OF FEDERAL TAX EXEMPTION STANDARDS ON HEALTH CARE POLICY AND DELIVERY

Douglas M. Mancino[†]

One of the accepted legal definitions of "charitable" for purposes of § 501(c)(3) of the Internal Revenue Code is the promotion of health for the benefit of the community. One of the best and perhaps the most widely accepted formulation of the charitable purpose of promotion of health is found in Revenue Ruling 69-545:[1]

> The promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole, even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community.[2]

This is the standard of exemption that applies to hospitals, health maintenance organizations, medical groups, home health agencies, and a wide range of other types of health care organizations that desire to qualify for exemption from federal income taxation under § 501(a) of the Code as organizations described in § 501(c)(3) of the Code.[3] In addition, this standard of exemption has been applied by the courts as well as the Internal Revenue Service (IRS) to a wide range of other types of activities including activities undertaken through partnerships and limited liability companies that have been formed by tax-exempt health care organizations and proprietary firms or individuals.

Revenue Ruling 69-545 has withstood legal challenges and continues to reflect the legal standard applicable for determining the tax-exempt status of health care organizations, and the promotion of

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[†] Partner, McDermott Will & Emery LLP (Los Angeles Office); author of TAXATION OF HOSPITALS AND HEALTH CARE ORGANIZATIONS (2000); co-author of TAXATION OF EXEMPT ORGANIZATIONS (2002).

[1] Rev. Rul. 69-545, 1969-2 C.B. 117.

[2] *Id.*

[3] I.R.C. §§ 501(a), (c)(3) (2000).

health rationale continues to serve as a meaningful and relevant standard for granting exemption. However, in recent years, Revenue Ruling 69-545 and the legal conclusions to be drawn from its two fact situations have spawned considerable discussion about what it takes to satisfy the promotion of health for the benefit of the community standard so as to obtain "charitable" exemption under § 501(c)(3).[4] Much of this discussion is centered on the question of whether, and if so, to what extent, an organization claiming exemption because it promotes health for the benefit of the community must provide free or below cost services to the poor or medically underserved. In addition, the IRS has made it clear through its published positions as well as in its litigating positions that it is uncomfortable with the potential scope of the promotion of health for the benefit of the community rationale in the absence of an express commitment to provide free or below-cost services to the indigent.[5]

This article reviews the development of the standards of exemption applicable to nonprofit hospitals that have, in turn, been applied to other types of health care organizations such as health maintenance organizations (HMOs). It then discusses how the seemingly straightforward principles set forth in Revenue Ruling 69-545 have been interpreted by the IRS and the courts in a manner that directly or indirectly has impacted the shaping of health care policy and the methods of delivery of health care.

I. THE CHANGING HEALTH ENVIRONMENT

Revenue Ruling 69-545 was published in 1969, more than thirty-five years ago, when the health care delivery and financing systems in the United States were much simpler and considerably different from today.

In the first place, patient care provided in the nation's nonprofit hospitals in 1969 was predominantly provided on an inpatient basis. The health care delivery system would not see the dramatic shift from inpatient to outpatient modes of delivering health care until the late 1970s and early 1980s when, for example, the number of surgical procedures that could be performed in an outpatient or ambulatory care environment dramatically increased as the types of technology and other aspects of outpatient surgery, such as anesthesia, changed. In 1969, patient care was considerably less technology-driven than it

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[4] *See infra* pp. 14-15.

[5] *See, e.g.*, Internal Revenue Service, Field Service Advice, FSA 200110030 at 2, 4 (Feb. 5, 2001) (explaining how the organization must narrow its activities to adhere to the operational test under 26 U.S.C. 501(c)(3)).

is today. Although noninvasive diagnostic imaging procedures such as computerized tomography scanning and magnetic resonance imaging are taken for granted today, in 2005, those technologies did not exist in 1969 and would not exist until a decade or more later.

Similarly, in 1969, the notion of competition among nonprofit hospitals was a relatively foreign concept. In the first place, capital access was considerably more limited than it is today, and the limited access to capital provided a significant barrier to entry to new competitors in most marketplaces. Second, health planning laws that were enacted on a national basis in the early 1970s provided further restraints on the development of robust competition in all marketplaces throughout the United States. As a consequence, facility expansion and technical advances within the health care industry were effectively rationed.

The late 1960s was also a time period when nonprofit organizations were the dominant providers of acute care hospital services, long-term care and what we refer to today as "managed care." In fact, most proprietary hospitals were owned by individual physicians or entrepreneurs. Medicare had been enacted only in 1965, and its incentives that drove the consolidation of proprietary hospitals into investor-owned public companies, such as cost-based reimbursement and a return on equity for proprietary hospitals, were only being recognized and exploited toward the late 1960s.

Today, at the beginning of the new millennium, things are, to say the least, quite different. The continued shift from acute care emphasis to outpatient, ambulatory care continues unabated. Each year, increasing numbers of surgical and other procedures are being shifted from the inpatient setting to the outpatient setting, and even discharges from complex inpatient procedures and surgeries such as open heart surgery are swifter. In addition, the single corporation, single hospital mode of doing business has all but disappeared. Multihospital systems predominate and they operate through complex corporate structures. Moreover, those large hospital systems typically will integrate multiple levels of care within the same system, such as by establishing skilled nursing facilities.

The pace of technological change continued to accelerate. We have already witnessed several generations of change in the various technologies that now support our health care delivery system and virtually every hospital, managed care organization and other type of health care delivery or financing system is dependent upon sophisticated information systems. Furthermore, the widespread availability of health care information that is relatively consumer friendly through the Internet and other sources has made the health care consumer considerably more well informed than consumers were in 1969. This

greater wealth of knowledge, along with greater financial responsibility, has caused many consumers to become more involved in the determination of the type and quality of care they seek.

Cost-based reimbursement for hospital services is all but gone and hospitals as well as other health care providers now are compensated for their services pursuant to fee schedules and deep discounts predominate in many marketplaces. Medicare and private payors historically compensated hospitals on the basis of their costs of providing care, including depreciation and interest expense. Since the enactment of the Prospective Payment System in 1983, payment methodologies have increasingly used fee schedules, and discounting by private payors now predominates.

Competition in the health care marketplace today is fierce. Market factors, such as access to capital, now dictate who can enter most markets and who will survive, rather than regulation. Traditional full-service players are now competing with niche players. Publicly-traded firms such as MedCath now openly compete to develop and operate specialized heart hospitals with many well-established institutions such as The Cleveland Clinic Foundation. Physicians, traditional loyalists to the hospitals on whose staffs they had privileges in the past, are now competitors with those very same hospitals for services such as ambulatory surgery and nuclear medicine.

Finally, nonprofit organizations have lost their dominant positions in long-term care and managed care. In 2005, when this article is being published, both the long-term care and managed care industries will be dominated by investor-owned companies whose stock is traded on national stock exchanges rather than by the freestanding nonprofit organizations that had historically owned and operated the nation's long term-care facilities and its health maintenance organizations.

Against this backdrop, the IRS through its rulings positions and its litigating positions has, subtly, been reversing the legal advances it had pioneered with the publication of Revenue Ruling 69-545 and begun regressing towards the relief of poverty theory of exemption that it formally promulgated in Revenue Ruling 56-185.[6] Similarly, litigation has seldom been a good place for the development of sound health care policy, but that is precisely what has occurred in decisions such as *IHC Health Plans, Inc. v. Commissioner,*[7] *Redlands Surgical Services v. Commissioner*[8] and *St. David's Health Care System v.*

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[6] Rev. Rul. 56-185, 1956-1 C.B. 202, 203 (stating the grounds for a hospital's exemption under § 501(c)(3) of the Code).

[7] 325 F.3d 1188 (10th Cir. 2003).

[8] 113 T.C. 47, 93-94 (1999), *aff'd per curiam*, 242 F.3d 904 (9th Cir. 2001).

United States.[9] In *IHC Health Plans, Inc. v. Commissioner*, the Court of Appeals for the Tenth Circuit all but eliminated the ability of non-staff model and non-dedicated group model HMOs to obtain tax-exempt status under § 501(c)(3) of the Code. *Redlands Surgical Services v. Commissioner* and *St. David's Health Care System v. United States* have superimposed a new "control" test on joint ventures between nonprofit health care providers and individuals or proprietary firms. Thus, the thesis of this article is how the development of federal tax exemption standards has shaped health care policy and methods of delivery.

II. TAX-EXEMPT STATUS OF NONPROFIT HOSPITALS

Since the enactment of the first federal tax laws, nonprofit hospitals have been entitled to tax exemption if they were organized and operated exclusively for charitable or other exempt purposes. Despite this heritage, the criteria for determining whether a nonprofit hospital is entitled to obtain or maintain its tax-exempt status were not formalized until the publication in 1956 of Revenue Ruling 56-185.

In 1969, Revenue Ruling 69-545 was published, modifying Revenue Ruling 56-185.[10] Subsequently, Revenue Ruling 83-157 further modified the exemption criteria set forth in Revenue Ruling 69-545.[11]

Revenue Ruling 56-185 set forth the affirmative organizational and operational requirements a hospital had to meet in order to qualify for or remain eligible for tax exemption under § 501(c)(3). First, Revenue Ruling 56-185 established an organizational test for hospitals, even though none was expressly required at that time by statute or regulation.[12] Reflecting the approach taken by the courts, Revenue Ruling 56-185 expressly prohibited the payment of dividends and generally reiterated the view of the courts that the organizational test could be satisfied by the actions of for profit corporations rather than only by legally enforceable limits on the payments of dividends or the transfers of stock for value.[13] In fact, Revenue Ruling 56-185 said:

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[9] 349 F.3d 232, 233 (5th Cir. 2003), *vacating and remanding* 90 A.F.T.R.2d (RIA) 6878 (W.D. Tex. 2002).

[10] Rev. Rul. 69-545, 1969-2 C.B. 117.

[11] Rev. Rul. 83-157, 1983-2 C.B. 94.

[12] Rev. Rul. 56-185, 1956-1 C.B. 202, 203 ("It must be organized as a nonprofit charitable organization for the purpose of operating a hospital for the care of the sick.").

[13] *Id.*

> [e]xemption will not be defeated . . . merely because the shareholders or members might possibly at some future date share in the assets upon dissolution in the absence of a case of mala fides where there appears to be a plan on the part of the shareholder or individual to acquire assets on the dissolution of the corporation.[14]

Second, Revenue Ruling 56-185 required that to obtain or maintain its tax-exempt status, a nonprofit hospital "must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay."[15] The focus of Revenue Ruling 56-185 on the relief of poverty theory of exemption was consistent with the then applicable definition of "charitable" contained in the pre-1959 Treasury Regulations.[16]

Revenue Ruling 56-185 also prescribed the other criteria that IRS would use to determine the eligibility of nonprofit hospitals for tax-exempt status. These criteria included medical staff composition, calculation of the level or free or below cost care provided, the hospital's charity record, and the propriety of charging for services rendered.[17]

In 1959 the § 501(c)(3) regulations were amended comprehensively. They now provide that:

> [t]he term "charitable" is used in section 501(c)(3) in its generally accepted legal sense and is, therefore, not to be construed as limited by the separate enumeration in section 501(c)(3) of other tax-exempt purposes which may fall within the broad outlines of "charity" as developed by judicial decisions.[18]

The 1959 revised regulations, which incorporated the long-established common law concepts of what constitutes a charitable

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[14] *Id.* at 203-04.

[15] *Id.* at 203.

[16] Treas. Reg. § 39.101(6)-1 (1954) ("Corporations organized and operated exclusively for charitable purposes comprise, in general, organizations for the relief of the poor. The fact that a corporation established for the relief of indigent persons may receive voluntary contributions from the persons intended to be relieved will not necessarily deprive it of exemption.").

[17] Rev. Rul. 56-185, 1956-1 C.B. 202, 202-03.

[18] Treas. Reg. § 1.501(c)(3)-1(d)(2) (1959), *as amended by* T.D. 6391, 1959-2 C.B. 139.

purpose, paved the way for the publication of Revenue Ruling 69-545.[19]

Revenue Ruling 69-545 modified the standards of exemption for nonprofit hospitals as originally set forth in Revenue Ruling 56-185. Revenue Ruling 69-545 concluded that the promotion of health is a charitable purpose deemed beneficial to the community as a whole, even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community.[20] The ruling qualified its general statement, however, by adding that the class benefited by the hospital may not be so small that its relief fails to be of any benefit to the community.[21]

The acceptance of the promotion-of-health rationale for the exemption of nonprofit hospitals by the IRS was a late but welcome recognition of the fact that hospitals in the second half of the twentieth century were designed and operated to serve all classes of society, and that they were no longer intended to serve principally as a refuge for the sick poor. This change of the hospital's specialized function from that of an almshouse to a modern hospital, and the resultant increased accessibility of hospital services to entire communities, clearly warranted a change in the criteria used to determine a hospital's entitlement to tax-exempt status. Although enactment of the Medicare and Medicaid programs in 1965 undoubtedly provided an important impetus to the IRS to embrace the promotion of health as a charitable purpose, the enactment of that legislation could not alone have served as a reason to change the standards. By 1969, the role of hospitals in most of the United States had changed dramatically in that most had developed into community-based resources that generally provided services to all segments of the communities in which they were located.

The publication of Revenue Ruling 69-545 did not resolve all questions concerning the criteria that should be used to determine whether a nonprofit hospital is entitled to exemption. Questions were raised at the time as to whether an emergency room was required or merely was one of several factors that would be taken into consideration in determining eligibility for § 501(c)(3) exemption. In addition, specialty and children's hospitals presented different types of questions, such as whether they even had to have emergency rooms at all or were required to participate in the Medicare program other than for end-stage renal disease.

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[19] 1969-2 C.B. 117.
[20] *Id.* at 117-18.
[21] *Id.*

In 1983, the IRS published Revenue Ruling 83-157,[22] which involved a nonprofit hospital identical to Hospital A of Revenue Ruling 69-545, but without an emergency room. The state health planning agency had determined that the operation of an emergency room by the hospital was unnecessary because it would duplicate emergency services and facilities that were adequately provided by another medical institution in the community. After discussing the factual development of Revenue Ruling 69-545, the IRS examined other factors which showed that the hospital was promoting the health of a class of persons sufficiently broad enough to constitute a charitable class.[23] The IRS concluded that, in doing so, the hospital benefited the community sufficiently to warrant the grant of exemption, notwithstanding the fact that it did not operate an emergency room. The ruling went on to note that:

> [c]ertain specialized hospitals, such as eye hospitals and cancer hospitals, offer medical care limited to special conditions unlikely to necessitate emergency care and do not, as a practical matter, maintain emergency rooms. These organizations may also qualify under section 501(c)(3) if they present similar, significant factors that demonstrate that the hospitals operate exclusively for the benefit of the community.[24]

Revenue Ruling 69-545 modified but did not revoke Revenue Ruling 56-185. Therefore, hospitals could continue to qualify for exemption under *either* the promotion of health rationale or the relief of poverty rationale. However, the IRS and the courts seem increasingly to focus on requiring some element of free or below cost care as a condition of exemption.

III. ROLE OF IRS IN SHAPING HEALTH CARE POLICY

As the discussion of the development of the standards for exemption in Revenue Ruling 56-185 and Revenue Ruling 69-545 in the preceding section indicates, the IRS generally has been reactive to health care policy changes and changes in the methods of delivery of health care services. Until the late 1800s, hospitals were generally considered to be almshouses and in many cases were actually hazardous to a patient's health. With advances in surgical techniques, anesthesiology and asepsis, hospitals emerged in the late nineteenth cen-

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[22] 1983-2 C.B. 94.
[23] *Id.* at 95.
[24] *Id.*

tury as places where high quality, safe care could be obtained by all members of the communities they served. Similarly, the IRS was reactive in 1969 to modes of change in reimbursement for health care services by its recognition that hospitals could evidence that they served the communities to a sufficient degree by participating in a Medicare program and, later in 1983, adding the Medicaid program.

Today, however, through its rulings positions and its litigating positions, the IRS has intentionally been trying to reshape the standards it promulgated in Revenue Ruling 69-545 without actually amending or revoking that revenue ruling.

A. Example One: Medical Staff Membership

Early in the development of the modern hospital, physicians recognized that medical staff membership was important to their professional and economic success. In a large urban teaching hospital, medical staff membership might result in increased professional status, increased opportunities for referrals, and access to the most sophisticated medical technology. In the small suburban or rural hospital, medical staff membership might mean increased opportunities for generation of fee income and independence of professional judgment.

The IRS recognized the importance of medical staff membership to exemption in Revenue Rulings 56-185 and 69-545. In Revenue Ruling 56-185, the IRS stated that the hospital "must not restrict the use of its facilities to a particular group of physicians and surgeons, such as a medical partnership or association, to the exclusion of all other qualified doctors."[25] The IRS held that such a limitation was "inconsistent with the public service concept inherent in section 501(c)(3) and the prohibition against the inurement of benefits to private shareholders or individuals."[26] Nonetheless, Revenue Ruling 56-185 recognized that there must be "some discretionary authority in the management to approve the qualifications of those [physicians] applying for the use of the medical facilities."[27] The revenue ruling added that "[t]he size and nature of facilities may also make it necessary to impose limitations on the extent to which [the facilities] may be made available to all reputable and competent physicians in the area."[28]

Revenue Ruling 69-545[29] dealt with the medical staff issue by using two examples. Hospital A, a 250-bed hospital, had 150 doctors on

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[25] Rev. Rul. 56-185, 1956-1 C.B. 202, 203.
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] 1969-2 C.B. 117.

its active staff and 200 on its courtesy staff. Hospital B, by contrast, had an extremely small medical staff. In fact, the five physicians who originally owned the hospital composed the hospital's medical committee and thereby controlled the selection and admission of other physicians to the medical staff. While other physicians were granted medical staff privileges, patients of the five original physicians accounted for a large majority of all hospital admissions over the years. The IRS found Hospital A to be tax-exempt under § 501(c)(3) because no private interest was being served; however, the IRS concluded that Hospital B did not qualify for tax exemption because the "facts indicate that the hospital is operated for the private benefit of its original owners, rather than for the exclusive benefit of the public."[30]

Neither revenue ruling established any definitive criteria for medical staff membership that a nonprofit hospital must have in order to qualify for or retain its exempt status. However, the absence of any specific requirements did not prevent the IRS from arguing in *Harding Hospital, Inc. v. United States*[31] that a hospital had to have an open medical staff in order to qualify for exemption. In *Harding*, the hospital ultimately lost its tax-exempt status on other grounds.[32] However, the court rejected the IRS's assertion that a closed medical staff comprised of physicians with a particular psychiatric specialty was *per se* inimical to exemption, stating that:

> we know of no authority for the legal argument that because a hospital is needed by doctors to practice their specialty the hospital cannot claim a tax exemption. Acceptance of such a proposition might eliminate tax exemptions for a substantial number of hospitals in that nearly all medical specialists require a hospital in which to practice, e.g., surgeons and heart transplant specialists require highly specialized hospital facilities.
>
> Equally misfounded is the Government's contention that we should penalize the Hospital with loss of its tax exemption because the Associates' milieu therapy type of treatment acts as a *de facto* limitation on the staff of the Hospital.... To adopt such proposition might effectively read out of the law the ability of any specialized hospital, e.g., milieu therapy psychiatric institution, cancer research hospital, skin treatment clinic, to acquire tax exempt status. To our knowledge, neither Congress nor the Commissioner, has ever manifested

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[30] *Id.* at 118.
[31] 505 F.2d 1068 (6th Cir. 1974).
[32] *Id.* at 1075.

such an intent, and it is not mandated by the third requirement of Rev. Rul. 56-185.[33]

As can be seen from the foregoing rebuke of the IRS, the Sixth Circuit rejected the notion that an open medical staff is a required characteristic of a hospital in order for it to have its tax-exempt status recognized under § 501(c)(3). Indeed, that conclusion would be supported by a plain reading of the Revenue Ruling 56-185 statement that "the size of and nature of facilities may make it necessary to infuse limitations on the extent to which they may be made charitable to all reputable and competent physicians in the area."[34] However, because it advanced its litigating position, the IRS nevertheless made the argument.

B. Example Two: Board Composition

The board of directors of a nonprofit hospital plays a critical role in its operations because, in most instances, the board is ultimately responsible for the hospital's finances and operations.

Despite the importance of the board of directors' role, the IRS has never clearly articulated any requirements regarding board selection and composition. For example, Revenue Ruling 56-185 made no mention of the board of directors' relevance to the determination of whether a hospital is entitled to exemption.[35] However, in Revenue Ruling 69-545, the IRS compared one hospital that qualified for exemption with one that did not; the hospital that qualified for exemption was governed by a board composed of "prominent citizens" of the community, while the board that failed to qualify for exemption consisted of seven persons, the five physicians who originally owned the hospital, their accountant, and their lawyer.[36] Subsequently, in Revenue Ruling 83-157, the IRS observed that a "significant" factor evidencing that a nonprofit hospital promotes the health of a sufficiently broad class of persons to benefit the community was the presence of "a board of directors drawn from the community."[37] However, even the latter revenue ruling provided no further guidance concerning the relevance of such a board or its composition to charitable exemption.

It is fairly clear that the composition and functions of a hospital's board of directors are relevant to tax exemption in at least two re-

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[33] *Id.* at 1076-77 (citations omitted).
[34] Rev. Rul. 56-185, 1956-1 C.B. 202.
[35] *Id.*
[36] Rev. Rul. 69-545, 1969-2 C.B. 117.
[37] Rev. Rul. 83-157, 1983-2 C.B. 95.

spects. First, the composition of the board can provide important circumstantial evidence that the hospital serves public rather than private purposes. For example, it is fair to presume that a board of directors chosen from the community would place the interests of the community above those of either the management or the medical staff of the hospital. Conversely, significant physician membership on a board raises a legitimate concern that such a board might *not* always put community interests above physician interests, particularly in transactions involving physicians, such as physician recruitment or joint venture transactions. Such a board is not incapable of pursuing community interests, but it might bear a heavier burden of proving that its processes for reviewing and approving transactions through which private persons could benefit are well-designed to ensure that the transactions are, in fact, fair.

Second, the composition of the board becomes relevant when a question is raised concerning whether a program, an expenditure, or an activity of the hospital has resulted in the inurement of net earnings to the benefit of a private shareholder or individual. For example, approval of a management compensation program, a physician recruitment program, or expenditure of hospital resources by a board of directors should be supported by evidence that the program or expenditure was undertaken after arm's length consideration and in the best interest of the hospital, and that it was not intended to provide unwarranted benefits to the program's or expenditure's direct beneficiaries.

Despite the fact that Revenue Ruling 69-545, as modified by Revenue Ruling 83-157, does not mandate the use of a community representative board, the IRS has often treated the presence of a community representative board as a requirement rather than merely as evidence of community benefit. For example, in *IHC Health Plans, Inc. v. Commissioner*, the IRS successfully raised the question in the Tax Court proceedings concerning the composition of the Board of Directors of IHC Health Plans, Inc. notwithstanding the absence of any facts in the records suggesting that the Board, however comprised, acted inappropriately in any single instance.[38] Similarly, in the

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[38] IHC Health Plans, Inc. v. Commissioner, 82 T.C.M. (CCH) 246, 246, 249-50 (2001):

> [P]etitioner's bylaws stated that its board of trustees would be composed of a plurality of a plurality of representatives from the buyer-employer community, with an approximately equal number of physicians and hospital representatives. The composition of petitioner's board of trustees, lacking in representation of the community at large, furthers the inference that petitioner predominately served the private interests of the larger employers participating in its plans. In the absence of an explanation in the record, the

mid-1990s, as the IRS was seeing increasing numbers of exemption applications for integrated delivery systems, the IRS first mandated a board composition requirement that at least fifty-one percent of the board be comprised of independent directors, and the increased that to at least eighty percent in some instances.[39] Furthermore, even though the actual adoption of formal conflict of interest policies is not a stated requirement anywhere, the IRS is effectively imposing a requirement that boards adopt conflict of interest policies when it considers exemption applications or ruling requests.[40]

In short, the composition of a board of directors of a nonprofit hospital, or other type of § 501(c)(3) organization, has been changed from merely being a factor evidencing the existence of community benefit to a mandatory requirement in many cases.

C. Example 3: Charity Care

The relationship of charity care to exemption under § 501(c)(3) is one that requires careful scrutiny. Many commentators, especially those that advocate a "donative" theory of exemption, suggest that some meaningful level of charity care should be a precondition of exemption. However, as is often the case with such broad-based propositions, the real world circumstances surrounding many health care organizations and the environments in which they operate argue for a markedly different, more nuanced conclusion.

In several recent cases, and then in a Field Service Advice Memorandum issued by the IRS in 2001, the IRS and the courts have seemed to elevate the importance of providing charity care in order to qualify for exemption under the promotion-of-health rationale. For example, in *Redlands Surgical Services v. Commissioner*,[41] the Tax Court upheld the denial of an exemption sought by an organization involved in a partnership formed to acquire and operate a free-standing ambulatory surgery center. The Tax Court rejected the petitioner's argument that its low level of Medicaid care should not serve as part of the basis for denying exemption:

Court is left with doubt as to petitioner's provision of a community benefit. Petitioner has the burden of proof.

[39] *See* Charles F. Kaiser & John F. Reilly, *Integrated Delivery Systems*, *in* EXEMPT ORGANIZATIONS: CONTINUING PROFESSIONAL EDUCATION TECHNICAL INSTRUCTION PROGRAM FOR FY 1994 (1994) *available at* http://www.irs.gov/pub/irs-tege/eotopicn94.pdf (last visited Feb. 17, 2005).

[40] In fact, the new Form 1023, *Application for Recognition of Exemption Under Section 501(c)(3) of the Internal Revenue Code*, has several questions concerning conflicts of interest policies. I.R.S. Form 1023 (Oct. 2004) *available at* http://www.irs.gov/pub/irs-pdf/f1023.pdf.

[41] 113 T.C. 47, 47-48 (1999), *aff'd per curiam*, 242 F.3d 904 (9th Cir. 2001).

> [t]he facts remain that the Surgery Center provides no free care to indigents and only negligible coverage for [Medicaid] patients. That low-income individuals may not typically seek the types of services the Surgery Center offers may partially explain the virtual absence of relief it provides for such individuals. But it provides no independent basis for establishing practitioner's charitable purposes in its involvement with the Surgery Center. Moreover, the activities of Redlands Hospital in effecting some negligible degree of [Medicaid] coverage at the Surgery Center and in increasing the number of managed care contracts do not provide a basis for establishing petitioner's exemption.[42]

Similarly, in three decisions[43] involving HMOs, the Tax Court upheld the IRS' denials of exemption because, among other things the organizations were not providing charity care. In *IHC Health Plans v. Commissioner*, the court noted that "[p]etitioner did not institute any program whereby individuals were permitted to become members while paying reduced premiums. Aside from the free health screenings [that petitioner conducted in 1999] ..., petitioner did not provide or arrange to provide any free or low cost health care services."[44] In a related case, the court observed that because the HMO had no medical facility of its own and did not employ physicians, petitioner "could not provide free medical care to those otherwise unable to pay for medical services."[45] Additionally, "petitioner did not establish a subsidized premiums program, conduct research, or offer free education programs to the public."[46]

These three Tax Court memorandum decisions were consolidated on appeal before the Court of Appeals for the Tenth Circuit.[47] The court of appeals concluded that "a health-care provider must make its services available to all in the community *plus* provide additional community or public benefits."[48] The court of appeals clearly implied that the provision of free or low cost products or services would be

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[42] *Id.* at 87.

[43] IHC Health Plans, Inc. v. Commissioner, 82 T.C.M. (CCH) 593 (2001), IHC Group, Inc. v. Commissioner, 82 T.C.M. (CCH) 606 (2001), and IHC Care, Inc. v. Commissioner, 82 T.C.M. (CCH) 617 (2001).

[44] *IHC Care, Inc.*, 82 T.C.M. (CCH) at 601.

[45] *IHC Group, Inc.*, 82 T.C.M. (CCH) at 615.

[46] *Id.*

[47] IHC Health Plans, Inc. v. Commissioner, 325 F.3d 1188 (10th Cir. 2003).

[48] *Id.* at 1198.

one type of "plus" that would provide evidence of community benefit.[49]

Finally, nonprecedential guidance from the IRS could also be interpreted as enhancing the importance of "charity care" in this analysis. In early 2001, the IRS released Field Service Advice Memorandum 200110030, which concludes as follows:

> [a] hospital's stated policies to provide health care services to the indigent are not sufficient to satisfy the charity care requirement of the community benefit standard under the operational test in Treas. Reg. § 1.501(c)(3)-1(c), unless the hospital demonstrates that such policies actually result in the delivery of significant health care services to the indigent.[50]

The field service advice memorandum then identified fourteen questions that should be used by agents in the course of an audit to determine whether the free care policy of the hospital actually resulted in the delivery of significant health care services to the indigent.[51] Shortly after this field service advice memorandum was released, IRS personnel in various speeches tended to dismiss the field service advice memorandum as not precendential and not subject to high level of review, thereby attempting to distance themselves from the legal position described therein.[52] However, the language found in the field service advice memorandum suggested that at least at some levels of the IRS there remains a view that charity care is not only relevant to the presence or absence of community benefit but also a required element of it.

As these various authorities suggest, a record of charity care can serve as evidence of community benefit. It is, however, highly questionable whether a record of charity care should be relevant to the question of whether private interests are being served more than incidentally, which is the proper legal standard under the promotion of health rationale for exemption. Indeed, in suggesting that a record of charity care is a requirement of the community benefits standards, the field service advice memorandum appears to diverge sharply from the IRS's long-standing published position. Notwithstanding the intima-

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[49] *Id.* at 1200.

[50] Internal Revenue Service, Field Service Advice, FSA 200110030 at 2 (Feb. 5, 2001).

[51] *Id.* at 5-6.

[52] *See* Fred Stokeld, *IRS Branch Chief Clarifies Guidance on Hospitals Joint Ventures*, 33 EXEMPT. ORG. TAX REV. 203 (2001); *see also* Carolyn D. Wright, *Officials Discuss FSAs, Business Plan, Simplification with EO, Bond Practitioners at ABA Meeting*, 32 EXEMPT. ORG. TAX REV. 401 (2001).

tions of the field service advice memorandum and any broad statements in court decisions, there are a number of reasons why a record of charity care should not of itself be a precondition to exemption under the promotion of health rationale; rather, the record of charity care should be considered in the context of the specific organization.

First, Revenue Ruling 56-185 recognized that a grant of § 501(c)(3) exemption to a hospital under a relief-of-poverty exemption or theory of exemption required only that the hospital provide free or below-cost care to the extent of its financial ability.[53] Thus, those organizations with no or little financial ability to provide free or below-cost care should be relieved of this requirement.

Second, in an era of multi-corporate health care systems, the evaluation of charity care records should be examined on a system-wide basis, rather than on the single entity-by-entity basis. Thus, to the extent that other corporate members within an organization's system provide substantial levels of free or below-cost care, that organization should not have to demonstrate a record of charity care as a prerequisite to exemption.

Third, the importance of a charity care policy to a particular organization's exemption should depend on the nature of the services provided by the organization. Revenue Ruling 69-545 clearly was not intended to require a nonprofit hospital to provide all services to all persons. If it were read that way, literally thousands of hospitals would face the loss of their exemption. Rather, unlike the view embraced by the Tax Court in *Redlands Surgical Services v. Commissioner*,[54] the nature of the services provided by an organization, whether it be a hospital or another type of health care organization, should be taken into consideration in determining whether the presence or absence of a high level of charity care is relevant to the determination of whether the organization is entitled to exemption under § 501(c)(3).

Finally, the role of charity care must be considered in the context of other factors, such as the presence or absence of a governmental hospital that is expressly funded to provide care to the indigent, or the presence or absence of federal or state governmental regulations affecting the decisions being made by indigent persons as to where to obtain care.

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[53] Rev. Rul. 56-185, 1956-1 C.B. 202, 203.

[54] 113 T.C. 47, 92-93 (1999), *aff'd per curiam*, 242 F.3d 904 (9th Cir. 2001).

IV. MANAGED CARE ORGANIZATIONS

When prepaid health plans such as HMOs were first established during the 1920s and 1930s, there was little guidance on standards for determining whether these organizations qualified for exemption. Instead, parallels were drawn between the prepaid health plans and the hospital and medical service organizations (i.e., Blue Cross and Blue Shield organizations) that also were being developed at the time. Because Blue Cross and Blue Shield organizations were classified for tax-exempt status as social welfare organizations under the predecessor to § 501(c)(4), the IRS administratively classified prepaid health plans in the same fashion, allowing them to qualify for tax-exempt status as § 501(c)(4) social welfare organizations.[55] Despite the fact that the IRS preferred to classify prepaid health plans as § 501(c)(4) organizations, and many plans qualified for tax-exempt status under that section, a few organizations were in fact recognized as exempt under § 501(c)(3) during the early 1970s.

When the Health Maintenance Organization Act of 1973[56] was enacted, funding through loans and grant programs was provided to nonprofit HMOs that qualified for § 501(c)(3) exemption as a means of stimulating their formation and growth. The existence of the this funding, along with the statutory requirements concerning eligibility, stimulated interest on the part of HMO sponsors to obtain § 501(c)(3) exemption rather than just § 501(c)(4) exemption. Also, as certain staff and group model HMOs grew, their facilities development increased and was in fact stimulated by exemptions from state certificate of need laws designed to stimulate the growth of HMOs. Thus, § 501(c)(3) exemption became more desirable than § 501(c)(4) exemption because it would enable such HMOs to gain access to the tax-exempt bond market to finance the construction and equipping of such facilities.

Notwithstanding a clear public policy rationale for encouraging the growth of HMOs, and the clear Congressional expression of a preference for HMOs that are described in § 501(c)(3), the IRS remains resistant to granting exemption under § 501(c)(3) to HMOs and, although initially unsuccessful, the IRS has continued to object to granting § 501(c)(3) exemption to most HMOs other than staff model and dedicated-group model HMOs.

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[55] *See, e.g.*, James J. McGovern, *Federal Tax Exemption of Prepaid Health Care Plans*, 7 TAX ADVISOR 76 (1976). See also Priv. Ltr. Rul. 9201039 (July 24, 1991), which discusses the administrative development of the IRS's position concerning the exempt status of Blue Cross and Blue Shield organizations.

[56] Health Maintenance Act of 1973, Pub. L. No. 93-222, 42 U.S.C. § 300e (2000).

Sound Health Association v. Commissioner[57] was the first litigated case in which the promotion-of-health rationale was used to determine whether an HMO qualified for exemption under § 501(c)(3). In some respects, Sound Health Association, because it was a "staff" model HMO and owned certain of its medical facilities, was a good candidate for establishing precedent for granting § 501(c)(3) exemption to HMOs. However, its unique facts and proposed methods of operation made the Tax Court decision highly fact-specific, which has resulted in controversy and confusion concerning the appropriate operational characteristics an HMO must have if it wishes to obtain § 501(c)(3) exemption.

The Tax Court observed that while the operation of an HMO is not specifically listed as a qualifying exempt activity within the meaning of § 501(c)(3), an HMO could qualify for § 501(c)(3) status if it were operated in furtherance of a charitable purpose.[58] It concluded that "the tests applied to determine the status of a hospital are relevant to a determination on the status of an HMO. Clearly, both types of organizations must qualify as charitable under section 501(c)(3) on the basis of the health care services that they provide."[59]

The opinion then focused on the basic question of whether Sound Health Association was organized and operated for charitable purposes because it promoted health for the benefit of the community.[60] In describing the community benefit approach, the court noted that "[a] charity will benefit the community if the class served is not so small that its relief is not of benefit to the community."[61] It added that "[t]he requirement that the community must benefit from a charity's activities has, as its natural corollary, that private interests must not so benefit in any substantial degree."[62]

After discussing the organizational test and concluding that the HMO readily passed it, the Tax Court focused its attention on the operations of the HMO to determine whether those operations evidenced that a charitable or exempt purpose was being served by the organization. The Tax Court observed that Sound Health Association had several characteristics similar to Hospital A described in Revenue Ruling 69-545 that helped demonstrate that it was operated for charitable purposes. The characteristics identified by the Tax Court were as follows:

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[57] 71 T.C. 158 (1978).
[58] *Id.* at 177.
[59] *Id.* at 178-79.
[60] *Id.* at 181.
[61] *Id.*
[62] *Id.*

1. The HMO had established programs and facilities similar to those of a hospital, including opening its clinics to emergency patients whether or not they were financially able to pay, and whether or not they were members.

2. The HMO established the research program to help study better ways of delivering health care services.

3. The HMO established an education program.

4. The HMO adopted a plan to establish a fund to receive contributions that would be used to subsidize persons who wanted a membership but who could not make the full monthly payments required for membership. The Tax Court expressly noted that this action was "more charitable than any undertaken by Hospital A."

5. The HMO maintained a courtesy staff that was open to all qualified physicians; no physician had been turned down for admission to the courtesy staff as of the time the exemption application had been filed.

6. The Board of Directors of the HMO was made up of prominent citizens of the community, although the board was elected from among the HMO's members.[63]

The Tax Court's focus on these various operational characteristics was not intended to prescribe a definitive set of requirements that an HMO had to meet in order to qualify for § 501(c)(3) exemption. However, from almost the very outset, the IRS attempted to use the operational factors recited by the Tax Court as a list of requirements that must be met for an HMO to qualify for exemption.[64]

As noted, the IRS has sought to limit the application of the Tax Court's decision in *Sound Health Association v. Commissioner* to those prepaid health plans and HMOs that have all of the characteristics of the health plan operated by Sound Health Association. If that view were adopted, only HMOs that, at a minimum, employed physicians and owned their own clinics, would be entitled to § 501(c)(3) exemption. The IRS continues to take the position that to qualify for § 501(c)(3) exemption, an HMO must do something more than simply operate an HMO that is accessible to a broad cross-section of the

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[63] *Id.* at 184-85.

[64] *See* Gen. Couns. Mem. 38,735 (May 29, 1981).

community, including individuals, small employers and persons eligible for managed care coverage under a governmental program such as Medicare or Medicaid. In *IHC Health Plans, Inc. v. Commissioner*,[65] the IRS was successful in convincing the Court of Appeals for the Tenth Circuit to embrace a restrictive definition of the promotion of health, at least as it applies to HMOs.

The court began its analysis of whether the IHC HMOs were entitled to § 501(c)(3) exemption by observing that "[i]n defining 'charitable,' our analysis must focus on whether petitioners' activities conferred a *public* benefit.... The public-benefit requirement highlights the *quid pro quo* nature of tax exemptions: the public is willing to relieve an organization from the burden of taxation in exchange for the public benefit it provides."[66] After reviewing Revenue Rulings 69-545 and 83-157, the court concluded that "we must determine whether the taxpayer operates *primarily for the benefit of the community*. And while the concept of 'community benefit' is somewhat amorphous, we agree with the IRS, the Tax Court, and the Third Circuit that it provides a workable standard for determining tax exemption under section 501(c)(3)."[67]

The court then made a number of points in creating a definition of community benefit. First, it stated that "engaging in an activity that promotes health, *standing alone*, offers an insufficient indicium of an organization's purpose. Numerous for-profit enterprises offer products or services that promote health."[68]

It then cited Revenue Rulings 69-545 and 83-157 for the proposition that

> an organization cannot satisfy the community-benefit requirement based solely on the fact that it offers health-care services to all in the community in exchange for a fee. Although providing health-care products or services to all in the community is necessary under those rulings, it is insufficient, standing alone, to qualify for tax exemption under section 501(c)(3). Rather, the organization must provide some additional 'plus'.[69]

It then discussed the need for quantifying the required community benefit and observed that difficulties will inevitably arise in attempting to do so.

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[65] 325 F.3d 1188, 1203 (10th Cir. 2003).
[66] *Id.* at 1195.
[67] *Id.* at 1197.
[68] *Id.*
[69] *Id.*

The Tenth Circuit, then proffered a brand new community benefit test couched as a "plus" test, which it described as follows:

> under section 501(c)(3), a health-care provider must make its services available to all in the community *plus* provide additional community or public benefits. The benefit must either further the function of government-funded institutions or provide a service that would not likely be provided within the community but for the subsidy. Further, the additional public benefit conferred must be sufficient to give rise to a strong inference that the public benefit is the *primary purpose* for which the organization operates. In conducting this inquiry, we consider the totality of the circumstances.[70]

Having created a completely new test of exemption, the Tenth Circuit then went on to apply the test to the three IHC HMOs and concluded that none of the three HMOs operated primarily for the benefit of the community within the meaning of its test.[71]

The Tenth Circuit's opinion began by analyzing the nature of the product or service and the character of the transaction involved and observed that the HMOs did not provide health care services directly. It then observed that "[t]he fact that an activity is normally undertaken by commercial for-profit entities does not necessarily preclude tax exemption, particularly where the entity offers its services at or below-cost."[72]

Because none of the HMOs provided free or below cost services, the court concluded that the HMOs' sole activity of arranging for health care services in exchange for a fee argued against granting charitable exemption to the organizations.[73] The court also noted that the absence of research or educational programs bolstered its conclusion that the HMOs did not operate for the purpose of promoting health for the benefit of the community.[74]

The court also looked at other factors such as the membership requirement and the composition of their boards of trustees and used negative inferences drawn from both of those characteristics to support its ultimate conclusion that the HMOs, standing alone, do not qualify for exemption under § 501(c)(3).[75]

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[70] Sound Health Ass'n v. Commissioner, 325 F.3d 1188, 1198 (10th Cir. 2003).

[71] *Id.* at 1198-1201.

[72] *Id.* at 1200.

[73] *Id.*

[74] *Id.* at 1200-01.

[75] *Id.* at 1201-02.

From the standpoint of an HMO, § 501(c)(3) exemption is preferable to § 501(c)(4). By supporting § 501(c)(3) exemption only for HMOs are organized around the staff model or dedicated group model, while at the same time denying § 501(c)(3) status to other types of HMOs, the IRS rulings and litigating positions are effectively shaping health care policy by providing incentives for selected modes of HMO organization and operational characteristics. It is fairly clear today that the benefits of HMO membership are less dependent on the model than they were in 1973. All emphasize preventive care and disease management and even traditional "staff" model HMOs have morphed into mixed models.

V. CONCLUSION

For more than thirty-five years, the IRS and the courts have distinguished between the legal definition of the charitable purpose "relief of poor and the distressed," and the legal definition of the charitable purpose "promotion of health for the benefit of the community." The role of charity care in relation to exemption of organizations formed to relieve the poor and the distressed is self-evident, because that is the very basis upon which exemption is granted. However, the role of charity care under the promotion of health for the benefit of the community rationale is less clear.

In 1969, the IRS effectively acknowledged that it was publishing Revenue Ruling 69-545 in response to changing conditions in the health care field and argued this position as it aggressively defended the propriety of Revenue Ruling 69-545.[76] In more recent years, however, the IRS has advocated a more subtle position. Through its ruling positions as well as in litigation, the IRS is effectively requiring health care organizations to do more than conduct the basic functions they were formed to undertake. Instead, as is evidenced by the Tenth Circuit opinion in *IHC Health Plans, Inc. the Commissioner*, something more is required, such as the provision of charity care, the provision of educational programs or the conduct of medical research. It is fairly clear that this is a requirement beyond that called for by Reve-

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[76] *See* E. Ky. Welfare Rights Org. v. Simon, 506 F.2d 1278 (D.C. Cir. 1974). The court stated that

> [i]f these procedural protections [i.e. the medical needs of the poor] had been provided, doubtless it would have been disclosed that millions of Americans are indeed too poor to pay for hospital services and have no means of obtaining those services except as charity patients at our nonprofit hospitals. With this fact established as a matter of record, I confidently believe that Revenue Ruling 69-545 would never have been promulgated in the first place.

nue Ruling 69-545 and the promotion of health for the benefit of the community rationale as expressed in that revenue ruling. The issue of how much charity care, as well as board and medical staff composition, involve specific operational characteristics that should not be dictated by tax law – they should reflect the then-current health care policies of persons charged with establishing health care, not tax policy. For this reason, it would be good "tax" policy for the IRS to reaffirm its more flexible "facts and circumstances" approach embraced in Revenue Ruling 69-545 and eschew its current prescriptive approach.