

UNCHARITABLE HOSPITALS: WHY THE IRS NEEDS INTERMEDIATE SANCTIONS TO REGULATE TAX-EXEMPT HOSPITALS

Abstract: Tax-exempt hospitals receive millions of dollars worth of tax breaks each year for the purpose of providing care to their communities. Despite these tax breaks, however, there is little evidence to suggest that such breaks significantly benefit the hospitals' communities. When a hospital no longer meets the federal standard for tax exemption, the Internal Revenue Service currently has two enforcement options: (1) do nothing; or (2) move to revoke the hospital's tax-exempt status. Revocation, however, is a harsh option that is not appropriate for every circumstance where a hospital fails to meet one or more of the requirements for exemption. As a result, many tax-exempt hospitals fail to meet the exemption standard but do not have their tax-exempt status revoked. Commentators have recommended modifying the qualifying standard for hospital tax exemption to address this growing problem. This Note takes a different position and argues that Congress should give the IRS statutory authority to impose excise tax intermediate sanctions on underperforming hospitals as an enforcement tool short of revocation. Intermediate sanctions would provide the IRS with the flexibility to regulate the boundaries of a hospital's tax-exempt status while ensuring that communities continue to benefit from the services of tax-exempt hospitals.

INTRODUCTION

In the late 1990s, Sondra Henderson was unemployed and struggling to make ends meet after a divorce destroyed her family business.¹ After seeking treatment for her heart condition at Yale-New Haven Hospital, Ms. Henderson—while uninsured—was sued by the hospital in its effort to recover the \$4000 costs of her treatment.² In addition, the hospital placed a lien on Ms. Henderson's home without her knowledge and initiated foreclosure proceedings to satisfy the debt.³ Ms. Henderson appealed to relatives to help her pay a lump sum to settle the debt—the \$4000 along with growing interest, foreclosure expenses, and attorney's fees.⁴ The day after Yale-New Haven's attorneys received Ms. Henderson's \$10,313 payment, they nailed a foreclosure sign to a

¹ CONN. CTR. FOR A NEW ECON., UNCHARITABLE CARE: YALE-NEW HAVEN HOSPITAL'S CHARITY CARE AND COLLECTIONS PRACTICES 6 (2003), available at http://www.ctneweconomy.org/wp-content/uploads/uncharitable_care.pdf, archived at <http://perma.cc/F855-Z42M>.

² *Id.*

³ *Id.*

⁴ *Id.* at 7.

tree in front of her house, claiming that she was still liable for \$875 in attorney's fees.⁵ Ultimately, Ms. Henderson paid her own attorney \$1000 to get the hospital to drop its additional claim.⁶

It is clear from this episode that Yale-New Haven Hospital acted in violation of its mission as a tax-exempt "charitable" organization.⁷ Under Section 501(c)(3) of the Internal Revenue Code, hospitals are exempted from federal taxation as "charitable" organizations if they meet the "community benefits" standard.⁸ Under this standard, hospitals must promote health in a manner that benefits the whole community and are prohibited from acting in ways that solely benefit the organization economically.⁹ The IRS considers multiple factors—with no one factor being determinative—to determine whether a hospital merits tax-exempt status.¹⁰

Despite the existence of the community benefits standard, tax-exempt hospitals routinely act in ways that stretch or violate the standard and the IRS has no meaningful way to redress this problem.¹¹ When a hospital does not meet the standard, the IRS currently has two enforcement options: (1) do nothing; or (2) move to revoke the hospital's tax-exempt status.¹² Revocation,

⁵ *Id.*

⁶ *Id.*

⁷ *Id.* at 1; see I.R.C. § 501(c)(3) (2012) (providing the tax exemption for certain charitable organizations). Yale-New Haven Hospital is Connecticut's largest, most prestigious hospital. CONN. CTR. FOR A NEW ECON., *supra* note 1, at 1. Its state and federal tax exemptions are estimated to be worth millions of dollars. *Id.*

⁸ I.R.C. § 501(c)(3); Bobby A. Courtney, *Hospital Tax-Exemption and the Community Benefit Standard: Considerations for Future Policymaking*, 8 IND. HEALTH L. REV. 365, 368 (2011); Alice A. Noble et al., *Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives*, 26 J.L. MED. & ETHICS 116, 118 (1998); Gail Rebecca Floyd, *Nonprofit Joint Ventures and Community Benefit: A New Approach*, FED. LAW., June 2001, at 23, 23–24; see Jessica Berg, *Putting the Community Benefit Back into the "Community Benefit" Standard*, 44 GA. L. REV. 375, 380 (2010); Jack E. Karns, *Justifying the Nonprofit Hospital Tax Exemption in a Competitive Market Environment*, 13 WIDENER L.J. 383, 402 (2004). For a discussion of the community benefits standard, see *infra* notes 44–52 and accompanying text.

⁹ See Rev. Rul. 69-545, 1969-2 C.B. 118; Charles B. Gilbert, *Health-Care Reform and the Non-profit Hospital: Is Tax-Exempt Status Still Warranted?*, 26 URB. LAW. 143, 150 (1994); Karns, *supra* note 8, at 404–05.

¹⁰ Rev. Rul. 69-545, 1969-2 C.B. 118; see Amanda W. Thai, Note, *Is Senator Grassley Our Savior?: The Crusade Against "Charitable" Hospitals Attacking Patients for Unpaid Bills*, 96 IOWA L. REV. 761, 768 (2011).

¹¹ See I.R.C. § 501; Mary Crossley, *Tax-Exempt Hospitals, Community Health Needs and Addressing Disparities*, 55 HOW. L.J. 687, 691 (2012); George A. Nation, III, *Non-Profit Charitable Tax-Exempt Hospitals—Wolves in Sheep's Clothing: To Increase Fairness and Enhance Competition in Health Care All Hospitals Should Be For-Profit and Taxable*, 42 RUTGERS L.J. 141, 170 (2010); Thai, *supra* note 10, at 770–71.

¹² See Berg, *supra* note 8, at 382; David M. Studdert et al., *Regulatory and Judicial Oversight of Nonprofit Hospitals*, 356 NEW ENG. J. MED. 625, 626 (2007); David A. Levitt, *Excess Benefit Transactions Under Section 4958 and Revocation of Tax-Exempt Status*, PRAC. TAX LAW., Spring 2009, at 13, 14.

however, is a harsh option that is not appropriate for every circumstance.¹³ As a result, many tax-exempt hospitals fail to meet the exemption standard but are not subjected to revocation.¹⁴

To remedy this problem, the IRS needs authority to impose intermediate sanctions on hospitals.¹⁵ Intermediate sanctions would allow the IRS to tailor penalties for a specific violation.¹⁶ Moreover, where the community benefits standard is very flexible, the IRS, too, needs flexible tools to enforce it.¹⁷

This Note explains why the IRS has been unsuccessful in regulating tax-exempt hospitals' activities and proposes a solution that would ensure that citizens and communities benefit from their services.¹⁸ Part I begins by examining the legal framework that hospitals must follow to obtain federal tax-exempt status.¹⁹ Part I also examines the IRS's limited options in enforcing the community benefits standard.²⁰ Part II then discusses how the IRS's lack of enforcement options allows hospitals to act uncharitably.²¹ Finally, Part III argues that Congress should enact legislation that enables the IRS to use intermediate sanctions to bring the actual behavior of tax-exempt hospitals in line with the expected behavior of a "charitable" organization.²²

I. REQUIREMENTS FOR HOSPITAL TAX EXEMPTION AND THE IRS'S RELATED ENFORCEMENT POWERS

In 1954, Congress enacted Section 501 of the Internal Revenue Code, creating the modern statutory tax exemption for selected organizations, including nonprofit hospitals.²³ Specifically, Section 501(a) creates a federal income tax

¹³ See Berg, *supra* note 8, at 382 (discussing how the IRS has only sought revocation in egregious circumstances); Studdert et al., *supra* note 12, at 626 (noting the severity of revocation); Levitt, *supra* note 12, at 14 (highlighting that revocation may not be appropriate for every circumstance).

¹⁴ See Berg, *supra* note 8, at 382; Studdert et al., *supra* note 12, at 626; Levitt, *supra* note 12, at 14.

¹⁵ See *The Tax-Exempt Hospital Sector: Hearing Before the H. Comm. on Ways and Means*, 109th Cong. 9 (2005) [hereinafter *Tax-Exempt Hospital Sector*] (statement of Mark Everson, Commissioner, Internal Revenue Service) (calling for increased enforcement flexibility to better regulate hospitals through intermediate sanctions); Studdert et al., *supra* note 12, at 626 (discussing the use of intermediate sanctions for related violations).

¹⁶ See Berg, *supra* note 8, at 382; Studdert et al., *supra* note 12, at 626; Levitt, *supra* note 12, at 14.

¹⁷ See Berg, *supra* note 8, at 382; Studdert et al., *supra* note 12, at 626; Levitt, *supra* note 12, at 14.

¹⁸ See *infra* notes 23–243 and accompanying text.

¹⁹ See *infra* notes 23–72 and accompanying text.

²⁰ See *infra* notes 73–92 and accompanying text.

²¹ See *infra* notes 93–161 and accompanying text.

²² See *infra* notes 162–243 and accompanying text.

²³ See I.R.C. § 501 (2012); John D. Colombo, *The Role of Tax Exemption in a Competitive Health Care Market*, 31 J. HEALTH POL. POL'Y & L. 623, 623–24 (2006); Karns, *supra* note 8, at 392.

exemption for certain types of organizations described in Section 501(c)(3).²⁴ “Charitable” organizations qualify for the exemption.²⁵ To qualify as charitable, the organization must meet an organizational test and an operational test.²⁶ An organization satisfies the organizational test if its articles of organization limit its purpose to one or more of the exempt purposes listed in Section 501(c)(3) and restrict the organization from engaging in more than an insubstantial amount of non-exempt activities.²⁷ An organization satisfies the operational test if it engages primarily in activities that accomplish one or more of the exempt purposes listed in Section 501(c)(3) and its net earnings do not inure to the benefit of private individuals or shareholders.²⁸ If a tax-exempt organization’s net earnings inure to the benefit of private individuals or shareholders—thereby failing both the organizational and operational tests—the IRS can impose intermediate sanctions before moving to revoke an organization’s status.²⁹ If these tests are satisfied, however, a hospital is considered a charitable organization and receives an exemption.³⁰

Congress and the IRS frequently expound upon the precise conditions that hospitals must meet to be considered charitable under Section 501(c)(3).³¹ For example, over the years, the IRS has issued guidance about its expectations for tax-exempt hospital behavior.³² In addition, in 2010, Congress amended the Internal Revenue Code to add several new actions that hospitals must perform

²⁴ I.R.C. § 501(a), (c)(3). Although this Note focuses on organizations that have obtained or seek to obtain tax-exempt status by operation of § 501(c)(3), the § 501(a) exemption is not limited to such organizations. *See id.*

²⁵ *Id.* § 501(c).

²⁶ Treas. Reg. § 1.501(c)(3)-1(a) (as amended in 2008); Floyd, *supra* note 8, at 24. Eligible organizations also must refrain from lobbying for legislation and participating in political campaigns. I.R.C. § 501(c).

²⁷ Treas. Reg. § 1.501(c)(3)-1(b) (as amended in 2008); *see* Floyd, *supra* note 8, at 24. In addition to charitable organizations, religious, scientific, literary, and educational organizations are also considered to be organized for exempt purposes. I.R.C. § 501(c)(3).

²⁸ Treas. Reg. § 1.501(c)(3)-1(c) (as amended in 2008); *see* Floyd, *supra* note 8, at 24.

²⁹ *See* I.R.C. § 501 (2012); *id.* § 4958 (2012); Berg, *supra* note 8, at 382. For a detailed discussion on intermediate sanctions, *see infra* notes 129–161 and accompanying text.

³⁰ *See* I.R.C. § 501; Colombo, *supra* note 23, at 623–24; Michele R. Goodman, Note, *Putting the Community Back in Community Benefit: Proposed State Tax Exemption Standard for Nonprofit Hospitals*, 84 IND. L.J. 713, 717 (2009).

³¹ *See, e.g.*, Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9007, 124 Stat. 119, 128 (2010), *amended by* Healthcare and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (adding new requirements for hospitals to be treated as charitable organizations); Treas. Reg. § 1.501(c)(3)-1 (as amended in 2008) (revising the test for hospitals to be treated as charitable organizations); Rev. Rul. 83-157, 1983-2 C.B. 94–95 (clarifying the types of hospitals that are eligible for treatment as charitable organizations).

³² *See, e.g.*, Rev. Rul. 83-157, 1983-2 C.B. 94–95; Rev. Rul. 69-545, 1969-2 C.B. 117–18; Rev. Rul. 56-185, 1956-1 C.B. 202–03.

in order to qualify for tax-exempt status.³³ This ad-hoc collection of requirements is called the community benefits standard,³⁴ and hospitals are required to satisfy this standard in addition to the other statutory requirements of Section 501(c)(3) in order to obtain tax-exempt status.³⁵

The governments tax exemption for nonprofit hospitals is grounded in two primary justifications.³⁶ First, under government subsidy theory, the tax exemption is justified because it relieves the government from the obligation of performing necessary functions for society that it would otherwise have to perform; this relief counterbalances the government's lost tax revenues.³⁷ Second, the exemption is often justified as necessary to safeguard against deprofessionalized medicine, which prioritizes turning a profit over treating patients.³⁸ This makes sense because, where for-profit hospitals have a primary goal of profit maximization, tax exemption can promote the incidence of non-profit hospitals which, alternatively, are exclusively committed to providing quality health care rather than seeking profits.³⁹ Conversely, tax-exempt hospitals purport to serve the broad needs of society as opposed to the economic interests of their organizers.⁴⁰

This Part explains the standard and enforcement mechanisms for hospital tax exemption.⁴¹ Section A examines the community benefits standard and the new requirements that emerged from the 2010 amendment to the I.R.C.⁴² Then, Section B explores the IRS's limited enforcement mechanisms.⁴³

³³ See Patient Protection and Affordable Care Act § 9007; I.R.C. § 501(r) (codified as amended I.R.C. § 501); *id.* § 4959 (2012); *id.* § 6033(b) (2012); Nina J. Crimm, *Evolutionary Forces: Changes in For-Profit and Not-for-Profit Health Care Delivery Structures; A Regeneration of Tax Exemption Standards*, 37 B.C. L. REV. 1, 54 (1995) (discussing how the IRS determined that a hospital deserved tax-exempt status prior to the 2010 amendments).

³⁴ See Berg, *supra* note 8, at 381; Crimm, *supra* note 33, at 54.

³⁵ See I.R.C. § 501(c)(3) (2012); Berg, *supra* note 8, at 381; Crimm, *supra* note 33, at 54; *supra* notes 25–30 (outlining the other statutory requirements for obtaining tax-exempt status).

³⁶ U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-08-880, VARIATION IN STANDARDS AND GUIDANCE LIMITS COMPARISON OF HOW HOSPITALS MEET COMMUNITY BENEFIT REQUIREMENTS 1 (2008) [hereinafter GAO REPORT]; Gilbert, *supra* note 9, at 150; Karns, *supra* note 8, at 404–05; Nation, *supra* note 11, at 158–59.

³⁷ GAO REPORT, *supra* note 36, at 1 (“The exemption is based on the principle that the government’s loss of tax revenues is offset by its relief from financial burdens that it would otherwise have to meet with appropriations from public funds, and by the benefits resulting from the promotion of general welfare.”); Gilbert, *supra* note 9, at 150; Karns, *supra* note 8, at 519.

³⁸ See Karns, *supra* note 8, at 404–05.

³⁹ See *id.*

⁴⁰ Gilbert, *supra* note 9, at 150; see Karns, *supra* note 8, at 404–05.

⁴¹ See *infra* notes 44–92 and accompanying text.

⁴² See *infra* notes 44–72 and accompanying text.

⁴³ See *infra* notes 73–92 and accompanying text.

A. The Community Benefits Standard: A Flexible Approach to Hospital Tax Exemption

In order to obtain tax-exempt status as charitable organizations, hospitals must first satisfy the community benefits standard.⁴⁴ Although the I.R.C. does not define the term “charitable,” the IRS has explained that the “promotion of health” is a charitable purpose because it generally benefits the community as a whole.⁴⁵ Regardless of the level of free care offered, a hospital is considered organized and operated exclusively for charitable purposes so long as the class of persons it serves is broad enough that the whole community benefits.⁴⁶

Under this standard, the IRS recognizes six hospital practices as providing community benefits: (1) operating an emergency room open to all; (2) providing care to all persons who are able to pay; (3) accepting patients enrolled in public programs like Medicare and Medicaid; (4) creating a board of trustees composed of independent civic leaders; (5) providing for an open medical staff with privileges available to all qualified persons; and (6) reinvesting any surplus funds into operations to improve the quality of patient care.⁴⁷ Accordingly, the IRS conducts a fact-sensitive inquiry when evaluating

⁴⁴ Rev. Rul. 69-545, 1969-2 C.B. 117-18; see Berg, *supra* note 8, at 380-81; John D. Colombo, *The Failure of Community Benefit*, 15 HEALTHMATRIX 29, 30-31 (2005); Crossley, *supra* note 11, at 690; Goodman, *supra* note 30, at 719; Floyd, *supra* note 8, at 24. The IRS establishes the standards that hospitals must meet to obtain tax-exempt status as charitable organizations. See I.R.C. § 7805 (2012); see, e.g., Treas. Reg. § 1.501(c)(3)-1 (as amended in 2008) (establishing an organizational test and operational test for hospitals to maintain tax-exempt status); Rev. Rul. 83-157, 1983-2 C.B. 95 (refining the standard for hospitals to qualify as charitable organizations); Rev. Rul. 69-545, 1969-2 C.B. 117-18 (describing whether two hypothetical hospitals qualify as charitable organizations); Rev. Rul. 56-185, 1956-1 C.B. 202-04 (providing criteria for hospitals seeking tax-exempt status).

⁴⁵ See I.R.C. § 501 (2012); Rev. Rul. 69-545, 1969-2 C.B. 118.

⁴⁶ Rev. Rul. 69-545, 1969-2 C.B. 118 (stating the “[t]he promotion of health . . . 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”).

⁴⁷ *Id.*; see GAO REPORT, *supra* note 36, at 11; Berg, *supra* note 8, at 381-82; Noble et al., *supra* note 8, at 118. The IRS established the community benefits standard in one of its Revenue Rulings in 1969. Rev. Rul. 69-545, 1969-2 C.B. 118. Revenue Rulings are official IRS interpretations that represent the IRS’s conclusions about how the I.R.C. applies to a particular set of facts. Treas. Reg. § 601.601 (2001); Donald L. Korb, *The Four R’s Revisited: Regulations, Rulings, Reliance, and Retroactivity in the 21st Century: A View from Within*, 46 DUQ. L. REV. 323, 330 (2008). They differ from regulations, which function as general interpretative and policy statements. Korb, *supra*, at 332. For a detailed account of the history and policy behind IRS Revenue Rulings, see Kristin E. Hickman, *IRB Guidance: The No Man’s Land of Tax Code Interpretation*, 2009 MICH. ST. L. REV. 239, 243-46; Korb, *supra*, at 330-35. In particular, Revenue Ruling 69-545 examined the tax-exempt status of two hypothetical hospitals. Rev. Rul. 69-545, 1969-2 C.B. 117-18. Under the Revenue Ruling’s analysis, Hospital A is exempted from tax because it operates an emergency room open to all; provides hospital care to persons in the community who are able to pay for it; maintains an open medical staff; uses its surplus funds on expanding facilities, improving quality of care, and on medical training, education and research; and the hospital is operated by a board of trustees composed of independent civic lead-

whether a hospital meets these criteria—though the presence or absence of any one criterion is not determinative on the IRS’s final determination.⁴⁸

Despite the enumeration of the above criteria, the IRS defines the community benefits standard as broadly as possible in recognition of the diverse needs of each tax-exempt hospital’s surrounding community.⁴⁹ For example, a hospital that does not operate an emergency room can still qualify for a tax exemption if a state agency determines that an additional emergency room would duplicate services already being provided elsewhere in the community.⁵⁰ This is particularly important for many specialty hospitals that lack emer-

ers. *Id.* Meanwhile, Hospital B is not exempted because it is not operated for the exclusive benefit of the public, but instead is substantially operated for the private benefit of its previous owners. *Id.* Hospital B’s original owners transferred ownership to a nonprofit organization but retained control of the hospital through the board of trustees and medical committee, and used that control to restrict medical staff privileges, limit emergency room care and hospital admission, and enter into favorable rental agreements with the hospital for office space. *Id.*

⁴⁸ Rev. Rul. 69-545, 1969-2 C.B. 117–18. There is considerable debate in the hospital industry about whether the community benefits criteria should evaluate whether the hospital has bad debt and Medicaid or Medicare shortfalls. CONG. BUDGET OFFICE, PUB. NO. 2707, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS 3, 17 (2006) [hereinafter 2006 CBO REPORT] (noting how some industry experts consider Medicaid shortfalls to be a community benefit); Courtney, *supra* note 8, at 382–83 (discussing the conflicting positions of major U.S. hospital associations regarding inclusion of bad debt and shortfalls in the community benefits standard analysis); Nancy M. Kane, *Tax-Exempt Hospitals: What Is Their Charitable Responsibility and How Should It Be Defined and Reported?*, 51 ST. LOUIS U. L.J. 459, 465–66 (2007) (highlighting differences among U.S. hospital associations’ positions on bad debt and shortfalls). Bad debt represents uncollectible patient bills. Courtney, *supra* note 8, at 382. It is calculated as the difference between the amounts a hospital expects to receive as payment for services rendered and the actual payment a hospital receives. 2006 CBO REPORT, *supra*, at 2; Courtney, *supra* note 8, at 382. Similarly, Medicaid and Medicare shortfalls are the unreimbursed costs of services to Medicaid and Medicare beneficiaries. 2006 CBO REPORT, *supra*, at 17; Courtney, *supra* note 8, at 382. Shortfall is calculated as the difference between the cost a hospital incurs in treating a Medicare or Medicaid beneficiary and the actual payment it receives from Medicare or Medicaid as reimbursement. 2006 CBO REPORT, *supra*, at 17; Courtney, *supra* note 8, at 382. The IRS and the Centers for Medicare and Medicaid Services—the federal agency that administers these programs—have not taken positions on the issue, but both agencies allow hospitals to include data on bad debt and shortfall expenses when making these calculations. Courtney, *supra* note 8, at 382–83.

⁴⁹ Thai, *supra* note 10, at 768; see Rev. Rul. 83-157, 1983-2 C.B. 95; Rev. Rul. 69-545, 1969-2 C.B. 118.

⁵⁰ See Rev. Rul. 83-157, 1983-2 C.B. 94; Karns, *supra* note 8, at 404. This was not always the case. See *E. Ky. Welfare Rights Org. v. Simon*, 506 F.2d 1278, 1289 (D.C. Cir. 1974), *vacated*, 426 U.S. 26 (1976); Rev. Rul. 69-545, 1969-2 C.B. 117–18. Prior to 1983, the community benefits standard required a tax-exempt hospital to operate an emergency room open to all, regardless of one’s ability to pay. See *E. Ky. Welfare Rights Org.*, 506 F.2d at 1289. This change was somewhat controversial because in 1974, in *Eastern Kentucky Welfare Rights Organization v. Simon*, the United States Court of Appeals for the D.C. Circuit upheld the IRS’s broad definition of “charitable” in part because the standard then in place required hospitals to provide a minimal level of free care through the operation of an emergency room open to all, regardless of the ability to pay. See *id.* The community benefits standard as currently formulated has never been challenged, however. See Goodman, *supra* note 30, at 719–20.

gency rooms (e.g., surgical facilities) or other hospitals that typically treat very few Medicare patients (e.g., children's hospitals).⁵¹ Thus, given the broad interpretation of the community benefits standard, a hospital can obtain tax-exempt status as a charitable organization even if it does not provide any charitable care.⁵²

In addition to the community benefits standard, hospitals also must comply with the provisions of the Patient Protection and Affordable Care Act (ACA) to maintain their tax-exempt status.⁵³ The ACA mandates certain behavior and places new constraints on the activities of tax-exempt hospitals.⁵⁴ First, it requires a tax-exempt hospital to conduct a community health needs assessment ("CHNA") every three years and to make its findings widely available to the public.⁵⁵ Specifically, the CHNA should consider input from various representatives from the community that the hospital serves—including

⁵¹ See Rev. Rul. 83-157, 1983-2 C.B. 95; Karns, *supra* note 8, at 404.

⁵² See Rev. Rul. 83-157, 1983-2 C.B. 94-95; Rev. Rul. 69-545, 1969-2 C.B. 118.

⁵³ See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9007, 124 Stat. 119, 128 (2010), *amended by* Healthcare and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (adding provisions to the Internal Revenue Code regarding tax-exempt hospitals). Passed in 2010, the ACA introduced comprehensive reforms to the U.S. health insurance system, including the imposition of new requirements on tax-exempt hospitals. See *id.* Section 9007 of the ACA added § 501(r) and § 4959 to the Internal Revenue Code and amended § 6033(b). *Id.* Section 501(r) details several new requirements that hospitals must meet to receive or retain tax-exempt status. I.R.C. § 501(r) (2012). The provisions of § 501(r) became effective for tax years beginning after March 23, 2010, except for the community health needs assessment ("CHNA") requirement, which became effective for tax years beginning after March 23, 2012. *Id.* Sections 4959 and 6033(b) deal with the monitoring and enforcement associated with § 501(r). *Id.* § 4959 (2012); *id.* § 6033(b) (2012). The IRS and the Treasury Department recently proposed rules to guide hospitals in the implementation of § 501(r). Prop. Treas. Reg. § 1.501(r)-1-7, 77 Fed. Reg. 38,148, 38,160-69 (June 26, 2012). The IRS and Treasury Department solicited comments and instructed taxpayers to rely on the proposed regulations unless or until final or temporary regulations are issued. Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38,159; see, e.g., Letter from Melinda Reid Hatton, Senior Vice President, Am. Hosp. Ass'n, to IRS (Aug. 23, 2012) [hereinafter American Hospital Association Comment], available at <http://www.regulations.gov/#!docketDetail;D=IRS-2012-0036> (responding to request for comments on § 501(r)). The rules clarified that the new legislation did not replace the requirements on tax-exempt hospitals that were already in place. Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38,148. Accordingly, hospitals must continue to comply with the community benefits standard as well as the new ACA requirements. See Rev. Rul. 69-545, 1969-2 C.B. 117-18; Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38,148; D. Greg Goller & Scott M. Sherman, *Thoughts and Comments on New Section 501(r)*, 22 TAX'N OF EXEMPTS 13, 14 (2010).

⁵⁴ See I.R.C. § 501(r). Unlike the Senate Finance Committee's initial proposal, the new law does not require hospitals to provide a minimum level of free, charitable care in exchange for their charitable tax exemption. See *id.*; Crossley, *supra* note 11, at 693; Michael N. Fine & Christopher M. Jedrey, *Hospital Exemption Under Section 501(r) Remains a Work in Progress*, 24 TAX'N OF EXEMPTS 34, 34 (2012).

⁵⁵ I.R.C. § 501(r).

public health experts.⁵⁶ Thereafter, the hospital must adopt an “implementation strategy” that is designed to meet the community’s health needs as identified in the CHNA,⁵⁷ and the hospital must submit a report to the IRS describing how it is addressing the needs identified in its CHNA.⁵⁸ If a hospital fails to comply with the CHNA requirement, it is subject to a \$50,000 excise tax.⁵⁹

Second, under the ACA, tax-exempt hospitals are required to adopt a written financial assistance policy and an emergency care policy.⁶⁰ A hospital’s financial assistance policy complies with the ACA if it specifies the type of financial assistance that is available and the eligibility criteria that an individual must meet to receive such assistance.⁶¹ The statute and the proposed rules do not establish any specific eligibility criteria that a hospital’s financial assistance policy must meet, nor do they mandate a fixed amount or type of financial assistance a hospital must provide.⁶² In a hospital’s emergency care policy, the hospital must obligate itself to provide emergency medical services to all persons, regardless of ability to pay or eligibility for financial assistance.⁶³ The emergency care policy also must prohibit debt collection activities from occur-

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.* § 6033(b). In addition, the report must include a statement of any needs that are not being addressed and the reasons why such needs are being overlooked. *Id.*

⁵⁹ *Id.* § 4959 (2012). The proposed regulations do not address the application of the excise tax. See Additional Requirements for Charitable Hospitals, 77 Fed. Reg. 38,148, 38,150–51 (June 26, 2012). In a Notice and Request for Comments, the IRS advised that it planned to impose the \$50,000 excise tax on hospitals that fail to conduct CHNAs in any three-year period. I.R.S. Notice 2011-52, 2011-30 I.R.B. 60, 65. For example, if a hospital does not conduct CHNAs in 2011, 2012, 2013, and 2014, it will be subject to an excise tax for both the 2013 or 2014 taxable years. See *id.* Section 4959’s \$50,000 excise tax is the only new remedy for the IRS to enforce the ACA’s additional requirements. See I.R.C. § 501(r) (2012); *id.* § 4959; *id.* § 6033(b) (2012); I.R.S. Notice 2011-52, *supra*, at 65.

⁶⁰ I.R.C. § 501(r).

⁶¹ *Id.*; Prop. Treas. Reg. § 1.501(r)-4, 77 Fed. Reg. 38,148, 38,161 (June 26, 2012). The financial assistance policy must discuss: (1) the hospital’s eligibility criteria for financial assistance; (2) the basis for calculating fees to patients; (3) the method patients must follow to apply for financial assistance; (4) for hospitals that lack a separate billing and collections policy, actions that the hospital may take if a patient fails to pay; and (5) the measures that the hospital will take to widely publicize the policy within the community it serves. Prop. Treas. Reg. § 1.501(r)-4, 77 Fed. Reg. at 38,161.

⁶² Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38,149; Fine & Jedrey, *supra* note 54, at 37; see I.R.C. § 501(r); Prop. Treas. Reg. § 1.501(r)-4, 77 Fed. Reg. at 38,161.

⁶³ I.R.C. § 501(r); Prop. Treas. Reg. § 1.501(r)-4, 77 Fed. Reg. at 38,164. This requirement essentially mirrors existing federal law under the Emergency Medical Treatment and Labor Act (“EMTALA”). Fine & Jedrey, *supra* note 54, at 38; see 42 U.S.C. § 1395dd (2012). EMTALA requires all hospitals—tax-exempt and for-profit—to provide stabilizing treatment to any individual who comes to the hospital with an emergency medical condition, regardless of the person’s ability to pay. 42 U.S.C. § 1395dd. Section 501(r) states that a hospital’s financial assistance policy must require it to provide care for emergency medical conditions within the meaning of EMTALA. I.R.C. § 501(r); see 42 U.S.C. § 1395dd (defining “emergency medical condition” to include any severe condition that, if left without immediate treatment, could reasonably lead to “placing the health of the individual . . . in serious jeopardy”).

ring in places where they could interfere with the treatment of emergency medical conditions.⁶⁴

Third, the ACA prohibits tax-exempt hospitals from applying gross charges to any health care services used by individuals who are eligible for financial assistance.⁶⁵ In addition, the charges to such patients for emergency or medically necessary care are capped at the amounts generally billed to persons who have insurance coverage.⁶⁶ Hospitals may choose between two methods of calculating the amount that is generally billed for a particular service.⁶⁷ The “look-back” method uses actual past claims paid to the hospital—by both Medicare and private health insurers—to determine the applicable amount.⁶⁸ Alternatively, the “prospective” method enables hospitals to estimate the amount that Medicare would reimburse the hospital for the care in question if the eligible patient were actually a Medicare fee-for-service beneficiary.⁶⁹

Finally, tax-exempt hospitals are now prohibited from engaging in extraordinary collection actions before making a reasonable effort to determine a patient’s eligibility for financial assistance.⁷⁰ Extraordinary collection actions occur when a hospital engages a legal or judicial process to procure payment of a hospital bill for care that is covered under the hospital’s financial assistance policy.⁷¹ It is also considered an extraordinary collection action to sell an

⁶⁴ Prop. Treas. Reg. § 1.501(r)-4, 77 Fed. Reg. at 38,164.

⁶⁵ I.R.C. § 501(r) (2012); Prop. Treas. Reg. § 1.501(r)-5, 77 Fed. Reg. 38,148, 38,165–66 (June 26, 2012). The proposed regulations define gross charges as “a hospital facility’s full, established price for medical care that the hospital facility consistently and uniformly charges all patients before applying any contractual allowances, discounts, or deductions.” Prop. Treas. Reg. § 1.501(r)-1, 77 Fed. Reg. 38,148, 38,161 (June 26, 2012). It is standard in the health care industry for hospitals to list the amount of gross charges on a hospital bill as an explanatory item and starting point for employing various discounts and deductions. Additional Requirements for Charitable Hospitals, 77 Fed. Reg. 38,148, 38,155 (June 26, 2012). The IRS will continue to permit this practice so long as the gross amount listed is not in fact charged to patients eligible for financial assistance. *Id.*

⁶⁶ I.R.C. § 501(r).

⁶⁷ Prop. Treas. Reg. § 1.501(r)-5, 77 Fed. Reg. at 38,165.

⁶⁸ *Id.* Medicare is a federal insurance program that pays the costs of hospital care, related post-hospital care, home health services, and hospice care for individuals aged sixty-five or older. 42 U.S.C. § 1395c (2012). Medicare beneficiaries are individuals who enjoy Medicare insurance. *See id.* Providers that treat Medicare patients are reimbursed under a fee-for-service model at rates set by the Secretary of Health and Human Services. 42 U.S.C. § 1395g (2012).

⁶⁹ Prop. Treas. Reg. § 1.501(r)-5, 77 Fed. Reg. at 38,165.

⁷⁰ I.R.C. § 501(r).

⁷¹ Prop. Treas. Reg. § 1.501(r)-6, 77 Fed. Reg. 38,148, 38,166 (June 26, 2012). Actions that require a legal or judicial process include: (1) obtaining a lien on an individual’s property; (2) foreclosing on an individual’s real property; (3) attaching or seizing an individual’s personal property; (4) commencing a civil suit against an individual; (5) causing an individual’s arrest; (6) subjecting an individual to a writ of body attachment; and (7) garnishing an individual’s wages. *Id.*

individual's debt to a third party or to report adverse information about an individual to consumer credit reporting agencies.⁷²

B. Revoke or Do Nothing: A Dearth of Options for Community Benefits Standard Enforcement

Although the IRS receives significant information regarding the activities of tax-exempt hospitals, it is limited in its enforcement options against a hospital that ceases to meet the community benefits standard.⁷³ In response to such information, the IRS can either overlook the bad conduct or revoke the hospital's tax-exempt status—there is no middle ground.⁷⁴ Furthermore, the IRS does not have the ability to tailor penalties for a specific violation.⁷⁵

The IRS—recognizing that revocation is a drastic action with far-reaching effects—has determined that revocation of tax-exempt status is generally inappropriate when a hospital meets some but not all of the community benefits requirements.⁷⁶ This hesitance to revoke tax-exempt statutes, however, has far-reaching effects: estimates as to the exact value of federal income tax exemptions for all charitable hospitals range from \$6.1 billion to \$50 billion.⁷⁷ More-

⁷² *Id.*

⁷³ See I.R.C. § 501 (2012); Berg, *supra* note 8, at 382; Crossley, *supra* note 11, at 691; Studdert et al., *supra* note 12, at 626; Levitt, *supra* note 12, at 14. The IRS monitors hospitals' compliance with the community benefits standard and the new ACA requirements by requiring that hospitals file annual returns using Form 990. I.R.C. § 6033 (2012); INTERNAL REVENUE SERV., U.S. DEP'T OF THE TREASURY, INSTRUCTIONS FOR FORM 990 RETURN OF ORGANIZATION EXEMPT FROM INCOME TAX 2 (2013), available at <http://www.irs.gov/pub/irs-pdf/i990.pdf>, archived at <http://perma.cc/Q37B-9JZE>. Form 990 solicits information regarding an organization's exempt and other activities, finances, governance, compliance with federal tax filings, and compensation paid to certain persons. INTERNAL REVENUE SERV., *supra*, at 2–3. Tax-exempt hospitals also use Schedule H to report on community benefits activities, including: charity care, bad debt, collections and billings practices, unreimbursed costs of government health care programs, and other supplemental information. INTERNAL REVENUE SERV., U.S. DEP'T OF THE TREASURY, OMB 1545-0047, SCHEDULE H (FORM 990) HOSPITALS 1 (2012), available at <http://www.irs.gov/pub/irs-pdf/f990so.pdf>, archived at <http://perma.cc/HRV3-7BH7> [hereinafter SCHEDULE H].

⁷⁴ See Studdert et al., *supra* note 12, at 626 (reiterating that revocation is the IRS's sole enforcement tool); Levitt, *supra* note 12, at 14 (describing revocation as the "only penalty" available). The one exception is the IRS's authority to impose intermediate sanctions when an organization fails the requirement that no net earnings inure to the benefit of any individual or private shareholder. Studdert et al., *supra* note 12, at 626; Levitt, *supra* note 12, at 14.

⁷⁵ See Berg, *supra* note 8, at 382; Studdert et al., *supra* note 12, at 626; Levitt, *supra* note 12, at 14. *But see* Evelyn Brody, *A Taxing Time for the Bishop Estate: What Is the I.R.S. Role in Charity Governance?*, 21 U. HAW. L. REV. 537, 543 (1999) (arguing that, as a practical matter, the IRS is able to use the threat of revocation to exact specific changes from tax-exempt organizations in the educational trust context).

⁷⁶ See Berg, *supra* note 8, at 382; Studdert et al., *supra* note 12, at 626; Levitt, *supra* note 12, at 14.

⁷⁷ See Colombo, *supra* note 23, at 624; Crossley, *supra* note 11, at 691 n.16. In 2002, the Congressional Budget Office estimated that the tax benefit received by exempt hospitals was worth \$6.1

over, these hospitals also are exempt from the federal unemployment payroll tax and the communications services excise tax.⁷⁸ Additionally, many state and local governments exempt Section 501(c)(3) organizations from state and local sales, income, and property taxes.⁷⁹ Correspondingly, when the IRS revokes a hospital's tax-exempt status, many states and municipalities often follow suit.⁸⁰ Thus, when a hospital's tax-exempt status is revoked, it incurs large federal and state tax bills.⁸¹ As a result, these large tax bills may cause hospitals to reduce the quality of care provided to patients or even close.⁸²

The harm from revocation of tax-exempt status, however, is broader than simply the effects of new tax liabilities.⁸³ Revocation of this status is also likely to affect the viability of the hospital's ongoing grants that fund medical research and quality health care.⁸⁴ This is the case because it is the hospital's

billion. Crossley, *supra* note 11, at 691 n.16. More recently, in 2007, the Senate Finance Committee estimated that exempt hospitals receive \$12.6 to \$20 billion in tax benefits each year. STAFF OF S. COMM. ON FIN., 110TH CONG., TAX-EXEMPT HOSPITALS: DISCUSSION DRAFT 2 (Comm. Print 2007), available at <http://www.grassley.senate.gov/releases/2007/07182007.pdf>, archived at <http://perma.cc/6BVJ-T2DV>; Nation, *supra* note 11, at 174 n.173. A second estimate by the Senate Finance Committee that year valued the benefit to hospitals at \$50 billion. Nation, *supra* note 11, at 174 n.173. These estimates only reflect hospital savings that directly stem from federal and state income tax exemptions. 2006 CBO REPORT, *supra* note 48, at 3; Crossley, *supra* note 11, at 691 n.16.

⁷⁸ I.R.C. § 3301 (2012) (establishing a federal unemployment payroll tax); *id.* § 3306(c)(8) (2012) (defining the term "employment" for the purposes of the federal unemployment payroll tax and excluding employment at a § 501(c)(3) organization); *id.* § 4251 (2012) (establishing a communications services excise tax); *id.* § 4253(h) (2012) (excluding tax-exempt nonprofit hospitals from the communications services excise tax).

⁷⁹ Berg, *supra* note 8, at 380; Crimm, *supra* note 33, at 7–8 n.19; see Crossley, *supra* note 11, at 691 n.16.

⁸⁰ Berg, *supra* note 8, at 380; Crimm, *supra* note 33, at 7–8 n.19; see Crossley, *supra* note 11, at 691 n.16. Approximately one-half of states automatically grant a state income tax exemption to hospitals that possess a federal exemption. Kathryn J. Jervis, *A Review of State Legislation and a State Legislator Survey Related to Not-for-Profit Hospital Tax Exemption and Health Care for the Indigent*, 32 J. HEALTH CARE FIN. 36, 38 (2005). Alternatively, one-third of states require hospitals to separately apply for a state income tax exemption, but base their decision on the hospital's federal status. *Id.* at 38–39.

⁸¹ See Colombo, *supra* note 23, at 624; Crossley, *supra* note 11, at 691 n.16.

⁸² See PRICEWATERHOUSECOOPERS' HEALTH RES. INST., ACTS OF CHARITY: CHARITY CARE STRATEGIES FOR HOSPITALS IN A CHANGING LANDSCAPE 1, 31 (2005), available at <http://www.pwc.com/us/en/healthcare/publications/act-of-charity.jhtml> (investigating the effects of revocation on a hypothetical nonprofit hospital and concluding that the hospital's 2.6% profit margin would change to a loss); Berg, *supra* note 8, at 382 (noting that revocation leads to new tax liabilities for hospitals, which could have a negative impact on patient care); Goodman, *supra* note 30, at 724 (discussing concerns that many small, urban tax-exempt hospitals could not survive revocation).

⁸³ See Crimm, *supra* note 33, at 7–8 n.19; Gilbert, *supra* note 9, at 155–56.

⁸⁴ Berg, *supra* note 8, at 382. Each year, the National Institute of Health provides millions of dollars to nonprofit teaching hospitals in the form of research grants. M. Gregg Bloche, *Corporate Takeover of Teaching Hospitals*, 65 S. CAL. L. REV. 1035, 1048 (1992); *NIH Awards by Location*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (last updated Feb. 28, 2013), <http://report.nih.gov/award/index.cfm?ot=IH&fy=2013&state=&ic=&fm=&orgid=&distr=&rfa=&om=n&pid=>, archived at

Section 501(c)(3) status that makes it eligible for both federal research grants and private grants from foundations.⁸⁵ Revocation also removes the intangible benefits that correspond with being labeled as a tax-exempt charitable organization, such as the public's increased trust and favorable perception of the hospital.⁸⁶

Moreover, revocation affects a hospital's ability to raise capital.⁸⁷ Donors prefer to give charitable contributions to Section 501(c)(3) organizations because they receive personal tax benefits when they calculate their own income tax, gift tax, and estate tax liability.⁸⁸ As a result, revocation affects previous donors who anticipated significant tax benefits from their donations to a tax-exempt organization.⁸⁹ These benefits disappear with revocation.⁹⁰ Finally, revocation also removes a hospital's ability to issue tax-exempt "qualified bonds," which provide Section 501(c)(3) qualified organizations with an attractive way raise capital.⁹¹ Given the wide-ranging effects of revocation, the IRS rarely takes action against hospitals that fail to fully meet the community benefits criteria because the results often exceed the severity of the infraction.⁹²

<http://perma.cc/6NZW-L44U>. An IRS revocation proceeding against a hospital signals to the NIH that the hospital is not a proper candidate for such grants. See Berg, *supra* note 8, at 382.

⁸⁵ Berg, *supra* note 8, at 380; Bloche, *supra* note 84, at 1048.

⁸⁶ Berg, *supra* note 8, at 380.

⁸⁷ See I.R.C. § 170 (2012); *id.* § 2055 (2012); *id.* § 2522 (2012); Crimm, *supra* note 33, at 7–8 n.19.

⁸⁸ I.R.C. § 170 (establishing a deduction from income tax for charitable contributions); *id.* § 2055 (reducing estate tax liability by the amount of all charitable transfers); *id.* § 2522 (establishing a deduction from gift tax for charitable gifts); Crimm, *supra* note 33, at 7–8 n.19 (cataloging the special tax benefits available to § 501(c)(3) organizations). Specifically, individual and corporate donors are eligible to receive income tax deductions for charitable donations at the federal and state levels. See I.R.C. § 170; Gilbert, *supra* note 9, at 156. Additionally, individuals are not liable for any federal gift taxes on inter vivos transfers to tax-exempt organizations. *Id.* § 2522; Gilbert, *supra* note 9, at 156. Individuals may also receive credit on estate taxes at the federal and state levels for such donations. See I.R.C. § 2055; Gilbert, *supra* note 9, at 156.

⁸⁹ Berg, *supra* note 8, at 382.

⁹⁰ See I.R.C. § 170; *id.* § 2055; *id.* § 2522; Crimm, *supra* note 33, at 7–8 n.19.

⁹¹ See I.R.C. § 145 (2012); Crimm, *supra* note 33, at 7–8 n.19. A § 501(c)(3) organization may issue qualified bonds with lower-than-market interest rates that are still attractive in the market because the bonds' after-tax rate of return will equal the market rate. See I.R.C. § 145.

⁹² See G. Edgar Adkins, Jr., *Executive Compensation and the Intermediate Sanctions*, 24 TAX'N OF EXEMPTS 26, 26 (2012) (describing revocation of status as the "death penalty" for tax-exempt organizations); Berg, *supra* note 8, at 382 (noting that the reluctance of the IRS to enforce the criteria is due to the draconian results of revocation); Studdert et al., *supra* note 12, at 626 ("The severity [of revocation proceedings] has tended to discourage its use."); Levitt, *supra* note 12, at 14 (discussing the lack of IRS enforcement flexibility due to revocation proceedings' excessive penalties); *supra* notes 77–91 and accompanying text (describing the wide-ranging effects of revocation). Individual states, however, have been far more active in challenging hospitals to provide concrete community benefits in exchange for their state tax exemptions, and revoking their status when they do not. Colombo, *supra* note 44, at 38–39; Nation, *supra* note 11, at 176.

II. THE FAILURE OF THE COMMUNITY BENEFITS STANDARD: HOW TAX-EXEMPT HOSPITALS ACT UNCHARITABLY

The IRS's lack of enforcement flexibility has allowed tax-exempt hospitals to reap huge economic benefits without giving comparable benefits back to their communities.⁹³ Remedies are being sought to address this problem.⁹⁴ The IRS has been given enhanced enforcement authority in other areas.⁹⁵ Section A first examines the ramifications of the IRS's failure to adequately enforce the community benefits standard.⁹⁶ Then, Section B discusses the use of intermediate sanctions to regulate the behavior of tax-exempt organizations.⁹⁷ Section B further explains how intermediate sanctions could work to redress the IRS's enforcement problem.⁹⁸

A. Hospitals Behaving Badly: The Consequence of the IRS's Failure to Properly Enforce the Community Benefits Standard

The IRS's enforcement of the community benefits standard has allowed hospitals to act quite uncharitably.⁹⁹ Most notably, the community benefits

⁹³ See Colombo, *supra* note 44, at 51 (arguing that "the community benefit test does not perform the function of consistently identifying nonprofits that produce socially worthy outputs meriting reward via exemption"); Nation, *supra* note 11, at 174–75 (characterizing the tax exemption as "a bad deal for taxpayers" because the community benefits standard was the result of poor judgment and historical error); Thai, *supra* note 10, at 768–69 (blaming uncharitable tax-exempt hospital behavior on the "vague" wording and indecisive enforcement of the community benefits standard). Supporters of the community benefits standard, however, posit that the proliferation of for-profit hospitals into the health care market—not the community benefits standard—caused tax-exempt hospitals to employ "aggressive business decisions." See Karns, *supra* note 8, at 494–95 (disagreeing with exemption critics who rebuke tax-exempt hospitals simply for utilizing sound business practices).

⁹⁴ See Beverly Cohen, *The Controversy over Hospital Charges to the Uninsured—No Villains, No Heroes*, 51 VILL. L. REV. 95, 95–97 (2006); Crossley, *supra* note 11, at 691; Lisa Kinney Helvin, *Caring for the Uninsured: Are Not-for-Profit Hospitals Doing Their Share?*, 8 YALE J. HEALTH POL'Y L. & ETHICS 421, 424–27 (2008); Nation, *supra* note 11, at 175–76; Thai, *supra* note 10, at 772.

⁹⁵ See Cohen, *supra* note 94, at 96–97; Helvin, *supra* note 94, at 424–27; Nation, *supra* note 11, at 175–76; Thai, *supra* note 10, at 772. Most states have adopted the federal tax exemption rules and community benefits standard. Nation, *supra* note 11, at 175. Moreover, the new I.R.C. § 501(r) enables the IRS to impose a \$50,000 penalty on hospitals that fail to complete a community health needs assessment. I.R.C. § 501(r) (2012); Thai, *supra* note 10, at 772.

⁹⁶ See *infra* notes 99–128 and accompanying text.

⁹⁷ See *infra* notes 129–161 and accompanying text.

⁹⁸ See *infra* notes 129–161 and accompanying text.

⁹⁹ See M. Gregg Bloche, *Health Policy Below the Waterline: Medical Care and the Charitable Exemption*, 80 MINN. L. REV. 299, 359 (1995) (arguing that because hospitals have virtually unrestricted access to tax exemptions, the benefits function like a general government subsidy for hospital services); Colombo, *supra* note 44, at 41–42 (discussing how the community benefits standard fails to isolate differences between tax-exempt and for-profit hospital behavior); Karns, *supra* note 8, at 520 (concluding that the tax exemption has not achieved the goal of providing additional health care); Goodman, *supra* note 30, at 719 (criticizing the community benefits standard because it does not dif-

standard does not explicitly require hospitals to provide free care to qualify for tax exemption.¹⁰⁰ Through the use of a flexible standard with no explicit charitable care requirements, the IRS has sought to recognize that each hospital is unique and has diverse needs that stem from its surrounding community.¹⁰¹ As a result, the flexibility of the community benefits standard allows specialty hospitals that benefit their communities in many ways but lack emergency rooms or have few or no indigent patients—such as surgical facilities and children’s hospitals—to obtain exemptions.¹⁰² Accordingly, the IRS anticipates that these tax-exempt hospitals will make up for the foregone taxes by serving their communities in other ways by, for example, conducting research or offering health education to the public.¹⁰³ These other activities are expected to bestow tangible economic and social benefits to the community—as is necessary—in order to justify the government’s forfeiture of millions of dollars in tax revenue.¹⁰⁴ In practice, however, there is rarely such a reciprocal exchange of benefits.¹⁰⁵

Although the IRS expects that a tax-exempt hospital with no charitable care would be the exception, this scenario is quite common.¹⁰⁶ Many tax-exempt hospitals provide little free care, with some provide no free care whatsoever.¹⁰⁷ In practice, most of the exceptional tax-exempt hospitals that provide significant charitable care are those that are government-run or serve as teaching hospitals—not private nonprofit hospitals.¹⁰⁸ Thus, the responsibility of picking up the tab for care to indigent patients—as is it primarily performed by government and teaching hospitals, both of which are publically support-

ferentiate between the necessary behavior of a tax-exempt hospital vis-à-vis a regular for-profit hospital).

¹⁰⁰ Nation, *supra* note 11, at 170; see Rev. Rul. 83-157, 1983-2 C.B. 95; Rev. Rul. 69-545, 1969-2 C.B. 118; Colombo, *supra* note 44, at 49. But see Helvin, *supra* note 94, at 444–45 (arguing that it is considerably difficult for a hospital to obtain tax-exempt status without a charitable care program).

¹⁰¹ Thai, *supra* note 10, at 768; see Rev. Rul. 83-157, 1983-2 C.B. 95; Rev. Rul. 69-545, 1969-2 C.B. 118.

¹⁰² See Rev. Rul. 83-157, 1983-2 C.B. 94; Karns, *supra* note 8, at 404.

¹⁰³ See Rev. Rul. 69-545, 1969-2 C.B. 118; Colombo, *supra* note 23, at 626; Nation, *supra* note 11, at 168; Goodman, *supra* note 30, at 719–20.

¹⁰⁴ See Courtney, *supra* note 8, at 366.

¹⁰⁵ See Colombo, *supra* note 44, at 46–47; Karns, *supra* note 8, at 521; Nation, *supra* note 11, at 174. For example, in 2007, ten Massachusetts hospital companies received \$638 million in tax benefits, which exceeded the value of community benefits they provided—including indigent care and other charity work—by more than \$264 million. Courtney, *supra* note 8, at 366.

¹⁰⁶ Cohen, *supra* note 94, at 103–04; Colombo, *supra* note 44, at 49.

¹⁰⁷ See Cohen, *supra* note 94, at 103–04 (detailing investigational reports about tax-exempt hospitals that did not provide any charity care or failed to publicize their limited charity care programs); Colombo, *supra* note 44, at 47–49 (studying empirical data that shows the lack of differences between tax-exempt and for-profit hospitals); Nation, *supra* note 11, at 170–72 (arguing that the billions of dollars that tax-exempt hospitals save in taxes is ultimately paid by taxpayers).

¹⁰⁸ Colombo, *supra* note 44, at 49.

ed—primarily falls on the government and taxpayers.¹⁰⁹ The IRS, however, has no way to remedy this problem because of its “all or nothing” enforcement tools.¹¹⁰

As a result, the IRS has been unsuccessful in challenging a medical organization’s Section 501(c)(3) status when the organization minimally meets the community benefits standard.¹¹¹ In 1978, in *Sound Health Ass’n v. Commissioner*, the Tax Court determined that a medical organization must only minimally satisfy the community benefits standard in order to maintain its tax-exempt status.¹¹² In *South Health Ass’n*, the organization was able to maintain its tax-exempt status even though it required prepayment for services that lacked a donative element and provided preferential medical treatment to its paying subscribers.¹¹³ The court reasoned that the organization minimally met the community benefits standard because it operated an emergency room open to all, established a research program that studied ways to improve health care delivery, maintained a medical staff open to all qualified physicians, and had a board of directors composed of prominent members of the community.¹¹⁴ After *South Health Ass’n*, it became clear that when a hospital minimally meets the community benefits standard, the IRS is powerless to change the hospital’s behavior.¹¹⁵

The IRS is equally powerless when tax-exempt hospitals—engaging in particularly egregious behavior—flagrantly disregard the community benefits standard.¹¹⁶ One common—yet flagrant—course of action involves charging uninsured indigent persons much higher rates than the insured for the same

¹⁰⁹ *Id.*; Cohen, *supra* note 94, at 103–04.

¹¹⁰ See I.R.C. § 501 (2012); *Sound Health Ass’n v. Comm’r*, 71 T.C. 158, 159 (1978); Rev. Rul. 69-545, 1969-2 C.B. 118; *supra* notes 73–75 and accompanying text (describing the “all or nothing” enforcement tools of the IRS).

¹¹¹ See, e.g., *Sound Health Ass’n*, 71 T.C. at 188.

¹¹² See *id.* at 187–88. Sound Health Association operated as a Health Maintenance Organization (HMO), not a hospital. *Id.* at 174. The court determined, however, that the tests for granting HMOs tax-exempt status should be substantially similar to those applied to determine the status of hospitals. *Id.* at 178–79. As is the case with hospitals, the basis of an HMO’s tax-exempt status rests on its provision of charitable health care services. *Id.* at 179.

¹¹³ *Id.* at 167–68.

¹¹⁴ *Id.* at 184–85; see Rev. Rul. 69-545, 1969-2 C.B. 117.

¹¹⁵ See 71 T.C. at 187–88 (overruling the IRS and reinstating tax-exempt status to a hospital that minimally met the community benefits standard).

¹¹⁶ See Crossley, *supra* note 11, at 691 (noting accounts of hospitals treating indigent patients in a “distinctly uncharitable fashion”); Nation, *supra* note 11, at 170 (discussing charitable hospitals’ harsh treatment of the poor); Thai, *supra* note 10, at 770–71 (reviewing the high prices hospitals charge to uninsured patients and their predatory collection practices). See generally Cohen, *supra* note 94 (providing extensive discussion of the many investigational reports and newspaper articles that highlighted aggressive hospital practices); Helvin, *supra* note 94 (examining the highly publicized cases of egregious hospital behavior).

services.¹¹⁷ Indigent patients routinely are denied non-emergency care if they are unable to pay upfront.¹¹⁸ Moreover, when treatment is provided before payment, tax-exempt hospitals often engage in aggressive collection techniques if the full bill is not paid on time.¹¹⁹ Such aggressive collection techniques can involve sending excessive letters, making repeated phone calls, suing patients, garnishing wages and bank accounts, and taking liens on patients' homes.¹²⁰ This problem is exacerbated by the reality that patients often do not realize how large their hospital bills will be.¹²¹ When they fill out financial aid paperwork prior to treatment, they assume—often incorrectly—that the procedures will be covered.¹²² Despite this dynamic, the IRS remains reluctant to take enforcement action against tax-exempt hospitals that engage in such practices because revocation is such a drastic step and the hospitals may otherwise be meeting community benefits standards.¹²³ Federal courts have also been unwilling to get involved to prevent these uncharitable practices.¹²⁴

¹¹⁷ Nation, *supra* note 11, at 170. Hospitals are required to formulate a “chargemaster,” which is a list of prices for their health care services. STAFF OF S. COMM. ON FIN., *supra* note 77, at 13. Private insurance companies negotiate their reimbursement rates with hospitals and receive large discounts off the “chargemaster” price. *Id.*; Cohen, *supra* note 94, at 100; Helvin, *supra* note 94, at 424. Medicare and Medicaid also set their own reimbursement rates, which are typically lower than the “chargemaster” rates. STAFF OF S. COMM. ON FIN., *supra* note 77, at 13; Cohen, *supra* note 94, at 100; Helvin, *supra* note 94, at 424. Alternatively, uninsured patients are charged the full “chargemaster” rates. STAFF OF S. COMM. ON FIN., *supra* note 77, at 13 (noting that self-paying patients are sometimes charged two or three times more than private and public payers for the same services); Cohen, *supra* note 94, at 101 (“Through ‘the insanity of the system,’ uninsured patients, those who are least able to pay, are charged at the highest point of the rate scale.”); see Helvin, *supra* note 94, at 424 (explaining how 1980s reforms that cut hospital reimbursement rates from third-party payers caused hospitals to aggressively seek full payment from self-paying patients).

¹¹⁸ Nation, *supra* note 11, at 170.

¹¹⁹ *Id.*; Thai, *supra* note 10, at 770–71.

¹²⁰ Thai, *supra* note 10, at 771. For example, in one year, Carilion Clinic, a Virginia-based 501(c)(3) hospital, sued 9888 patients, garnished the wages of 5478 former patients, and placed liens on the homes of 3920 former patients. *Id.*

¹²¹ *Id.*

¹²² *Id.*

¹²³ See *Tax-Exempt Hospital Sector*, *supra* note 15, at 16 (statement of Mark Everson, Commissioner, Internal Revenue Service) (stating that the IRS has not been able to do enough enforcement regarding tax-exempt hospitals because revocation causes “disproportionate hardship”); Berg, *supra* note 8, at 382 (discussing the IRS’s hesitancy to enforce the community benefits standard through revocation because of the “drastic” effects); Thai, *supra* note 10, at 771 (highlighting inappropriate activities of some tax-exempt hospitals); see also Cecilia M. Jardon McGregor, *The Community Benefit Standard for Non-Profit Hospitals: Which Community, and for Whose Benefit?*, 23 J. CONTEMP. HEALTH L. & POL’Y 302, 338–39 (2007) (considering the negative effects of eliminating a hospital tax exemption); Kane, *supra* note 48, at 471 (discussing the consequences of revoking tax-exempt status for hospitals).

¹²⁴ See Helvin, *supra* note 94, at 427; Mitchell Zamoff & Christopher Zaetta, *Plaintiff’s Lawyers Launch “Second Offensive,”* AHA NEWS, Mar. 7, 2005, at 4, 4. In 2004, a group of plaintiffs’ lawyers filed a series of class action lawsuits against tax-exempt hospitals in federal courts around the country.

In sum, the IRS has been unsuccessful in regulating tax-exempt hospital behavior.¹²⁵ The community benefits standard—which evaluates a number of factors—leaves the IRS only has one real enforcement option: revocation of Section 501(c)(3) status.¹²⁶ As a result, it is currently very difficult for the IRS to shape hospital behavior regarding any one factor in particular.¹²⁷ As the IRS looks on, tax-exempt hospitals continue to engage in egregiously uncharitable behavior.¹²⁸

B. Intermediate Sanctions: A Limited Attempt to Control the Behavior of Tax-Exempt Organizations

To address the IRS's "all or nothing" enforcement problem, Congress passed the 1996 Taxpayer Bill of Rights, which created intermediate sanctions as a limited enforcement tool.¹²⁹ Prior to the enactment of this legislation, if a charitable organization did not comply with the Section 501 requirement that

Zamoff & Zaetta, *supra*. They claimed that the hospitals charged uninsured patients higher rates than insured patients and engaged in abusive collections practices in violation of their obligations as tax-exempt organizations. *Id.* The plaintiffs contended that Section 501(c)(3) created a private cause of action and sought to recover as damages the taxes that the hospitals had not paid due to their tax-exempt status. *Id.* Alternatively, they sought to hold the hospitals liable under state law theories that included breach of contract, breach of the duty of good faith and fair dealing, and unjust enrichment. Cohen, *supra* note 94, at 112–13; Zamoff & Zaetta, *supra*. Federal courts resoundingly rejected both theories of liability. Zamoff & Zaetta, *supra*; see, e.g., *Maldonado v. Ochsner Clinic Found.*, 493 F.3d 521, 523–24 (5th Cir. 2007) (affirming the denial of class certification for a group of uninsured patients, who received medical care from their tax-exempt provider and were then billed at undiscounted rates, because “individualized issues . . . overwhelm class cohesiveness”); *Urquhart v. Manatee Mem’l Hosp.*, No. 8:06-CV-1418-T-17-EAJ, 2007 WL 781738, at *2, *6 (M.D. Fla. Mar. 13, 2007) (granting a motion to dismiss claim against tax-exempt hospital because plaintiffs failed to allege any damages that were related to hospital’s charging of allegedly unreasonable rates for medical treatment); *Ferguson v. Centura Health Corp.*, 358 F. Supp. 2d 1014, 1019 (D. Colo. 2004) (“The plaintiffs’ claims under § 501(c)(3) fail because formulating federal health care policy is not a proper function of an Article III court.”).

¹²⁵ *Tax-Exempt Hospital Sector*, *supra* note 15, at 10 (statement of Mark Everson, Commissioner, Internal Revenue Service) (testifying that the IRS does not have sufficient enforcement tools and cannot properly differentiate between for-profit and tax-exempt hospitals); Colombo, *supra* note 44, at 41–42 (describing how the community benefits standard fails to distinguish for-profit and tax-exempt profit behavior).

¹²⁶ See I.R.C. § 501 (2012); *Geisinger Health Plan v. Comm’r*, 985 F.2d 1210, 1219 (3d Cir. 1993); Rev. Rul. 69-545, 1969-2 C.B. 118.

¹²⁷ See Rev. Rul. 69-545, 1969-2 C.B. 118.

¹²⁸ See *Tax-Exempt Hospital Sector*, *supra* note 15, at 8–9 (statement of Mark Everson, Commissioner, Internal Revenue Service); Colombo, *supra* note 44, at 46–47; Karns, *supra* note 8, at 521; Goodman, *supra* note 30, at 719.

¹²⁹ See Taxpayer Bill of Rights 2, Pub. L. No. 104-168, 110 Stat. 1475 (1996) (codified as amended at I.R.C. § 4958 (2012)); *Caracci v. Comm’r*, 118 T.C. 379, 414 (2002) (explaining how the Treasury Department realized that revocation “might be inappropriate when the exempt organization did not conform to all the applicable rules but was nevertheless capable of functioning for a charitable purpose”), *rev’d on other grounds*, 456 F.3d 444 (5th Cir. 2006).

no net earnings inure to the benefit of any individual or private shareholder, the IRS's sole recourse was to revoke the organization's exemption.¹³⁰ Section 4958 of the legislation—now incorporated as Section 4958 of the I.R.C.—solved this problem, as it permits the IRS to impose excise taxes on persons who gain from “excess benefit” transactions with tax-exempt organizations, including hospitals.¹³¹ An excess benefit transaction—as defined by Section 4958—is “any transaction in which an economic benefit is provided by an applicable tax-exempt organization directly or indirectly to or for the use of any disqualified person if the value of the economic benefit provided exceeds the value of the consideration.”¹³² For example, an excess benefit transaction occurs when a tax-exempt hospital acquires a product for higher than market value from a board member or another “disqualified” person.¹³³

Disqualified persons are persons who are in a position, or who have been in a position in the last five years prior to the transaction, to exercise substantial influence over the organization's affairs.¹³⁴ Accordingly, persons who make substantial charitable contributions to the organization and persons who have control over all or part of the budget of an organization also are disqualified persons.¹³⁵ Under this standard, the IRS has the burden of proof to show that

¹³⁰ See *Caracci*, 118 T.C. at 414. This same problem—as this Note has explained—continues to exist with regard to enforcement of the community benefits standard. See *supra* notes 111–124 and accompanying text (discussing the difficulties with enforcement of the community benefits standard).

¹³¹ See I.R.C. § 4958; *Caracci*, 118 T.C. at 414; Adkins, *supra* note 92, at 26; Noble et al., *supra* note 8, at 119; Studdert et al., *supra* note 12, at 626; Levitt, *supra* note 12, at 14.

¹³² I.R.C. § 4958.

¹³³ See *id.* Other common excess benefit transactions involve the compensation of disqualified persons, the sale of property between a tax-exempt organization and a disqualified person, a loan between an organization and a disqualified person, and the use by a disqualified person of an organization's assets. Levitt, *supra* note 12, at 14.

¹³⁴ I.R.C. § 4958; see Treas. Reg. § 53.4958-3 (as amended in 2009) (expounding on the definition of a disqualified person). Disqualified persons include the directors, certain officers, and key employees of the organization, as well as their family members. Levitt, *supra* note 12, at 14; see I.R.C. § 4958; see also I.R.S. Priv. Ltr. Rul. 201225016 (June 22, 2012) (determining that an organization's corporate officers and office manager Councilman were disqualified persons under § 4958); I.R.S. Priv. Ltr. Rul. 201131024 (Aug. 5, 2011) (determining that an organization's founder and his daughter were disqualified persons under § 4958); I.R.S. Priv. Ltr. Rul. 200829049 (July 18, 2008) (determining that a board member of an organization was a disqualified person under § 4958). An entity is considered a disqualified person when disqualified individuals control thirty-five percent of the entity. I.R.C. § 4958. In the case of a corporation, this occurs when persons, who are in positions to exercise substantial influence over the organization's affairs, or their family members, own more than thirty-five percent of the total combined voting power. *Id.* For a partnership, this occurs when such persons own more than thirty-five percent of the profits interest. *Id.* A trust or estate is considered a disqualified person when such persons own more than thirty-five percent of the beneficial interest. *Id.*

¹³⁵ Levitt, *supra* note 12, at 14; see I.R.C. § 4958 (2012).

an excess benefit transaction has occurred between a disqualified person and an applicable tax-exempt organization.¹³⁶

If the IRS satisfies its burden, it may impose tax liability—on top of ordinary income tax liability—as a sanction on the benefitting disqualified person, or on both the person and the participating organization's managers.¹³⁷ A disqualified person who benefits from an excess benefit transaction may be taxed on twenty-five percent of the excess benefit received.¹³⁸ The value of the excess benefit is calculated by subtracting the economic benefit that the disqualified person provided to the applicable organization from the economic benefit the disqualified person received from the organization.¹³⁹ The disqualified person also must correct the excess benefit by returning it to the organization within the taxable period.¹⁴⁰ If the excess benefit is not corrected during this time, the IRS additionally may tax the disqualified person's excess benefit at two hundred percent.¹⁴¹ Moreover, the managers of an organization who knowingly, willfully, and without reasonable cause take part in an excess benefit transaction can be held liable individually for a tax of ten percent of the excess benefit.¹⁴² A manager's tax liability, however, cannot exceed \$20,000 for any individual excess benefit transaction.¹⁴³

The focus of these intermediate sanctions is exclusively on the Section 501(c)(3) requirement that no net earnings inure to the benefit of any individual or private shareholder.¹⁴⁴ Section 4958 is designed to prevent persons with influence over a tax-exempt organization from using their power to extract a personal, private benefit from the operation of the organization.¹⁴⁵ Accordingly, these intermediate sanctions are not available remedies in the instances when organizations fail to meet or maintain the community benefits standard.¹⁴⁶

¹³⁶ Treas. Reg. § 53.4958-6 (2006) (giving disqualified persons a rebuttable presumption of reasonableness in transactions with the organization under a compensation arrangement).

¹³⁷ I.R.C. § 4958.

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ *Id.* An excess benefit transaction is corrected when the disqualified person acts to undo the excess benefit to the extent possible and takes any additional necessary measures to place the organization back in a financial position that is not worse than the position that it would have been in had the disqualified person acted under the highest fiduciary standard. *Id.* In order to avoid additional tax liability, the disqualified person must correct the transaction within the taxable period. *Id.* The taxable period begins on the date that the transaction occurs and ends on the earlier of the date of mailing the excess benefit tax deficiency notice and the date of the excess benefit tax assessment. *Id.*

¹⁴¹ I.R.C. § 4958 (2012).

¹⁴² *Id.*

¹⁴³ *Id.*

¹⁴⁴ See I.R.C. § 501(c)(3) (2012); *id.* § 4958.

¹⁴⁵ See Berg, *supra* note 8, at 382; Studdert et al., *supra* note 12, at 626.

¹⁴⁶ Berg, *supra* note 8, at 382; see I.R.C. § 4958.

Although intermediate sanctions have rarely been imposed in the hospital setting, they have been used successfully in other contexts.¹⁴⁷ The IRS engaged in two major projects designed to discover and cease excess benefit transactions from 2004 to 2007, looking specifically at the compensation and benefits that tax-exempt organizations paid to their executives and directors.¹⁴⁸ Approximately 2000 tax-exempt organizations—including hospitals and other health care organizations—were sent compliance check letters.¹⁴⁹ Ultimately, the IRS either proposed to assess or actually assessed excise taxes under Section 4958 on twenty-five organizations.¹⁵⁰ None of the selected organizations, however, were hospitals.¹⁵¹ Although the IRS recognized that some hospitals' executive compensation levels would "appear high to some," it concluded that they were not so high as to constitute any excess benefit transactions.¹⁵²

Intermediate sanctions—like the sanction available under Section 4958—may implicate complex issues of valuation.¹⁵³ For example, in 2006, in *Caracci v. Commissioner*, the U.S. Court of Appeals for the Fifth Circuit considered the imposition of excise taxes on three privately held home-health agencies that had converted from nonprofit tax-exempt entities to for-profit entities.¹⁵⁴ The Tax Court applied Section 4958 and found that the taxpayers owed \$69,702,390 in excise taxes because they had received a net excess benefit.¹⁵⁵ The Fifth Circuit reversed.¹⁵⁶ The court held that the IRS and the Tax Court had made a "cascade of errors" in their valuation methods and in other areas.¹⁵⁷ First, the IRS levied the initial tax based on calculations that the Fifth

¹⁴⁷ See INTERNAL REVENUE SERV., IRS EXEMPT ORGANIZATIONS HOSPITAL STUDY: EXECUTIVE SUMMARY OF FINAL REPORT 1, 4 (2009), available at http://www.irs.gov/pub/irs-tege/execsum_hospprojrept.pdf, archived at <http://perma.cc/BR4Y-VG8R> [hereinafter HOSPITAL STUDY EXECUTIVE SUMMARY]; Berg, *supra* note 8, at 382; Studdert et al., *supra* note 12, at 626.

¹⁴⁸ Lawrence E. Singer, *Leveraging Tax-Exempt Status of Hospitals*, 29 J. LEGAL MED. 41, 50–51 (2008); *IRS Sharpens Focus on Tax-Exempt Organization Compensation*, MCDERMOTT WILL & EMERY (Mar. 14, 2007), <http://www.mwe.com/publications/uniEntity.aspx?xpST=PublicationDetail&pub=5380>, archived at <http://perma.cc/DR2X-QRR9>.

¹⁴⁹ *IRS Sharpens Focus on Tax-Exempt Organization Compensation*, *supra* note 148.

¹⁵⁰ *Id.* Excise taxes were also proposed or assessed against forty disqualified persons and organizational managers. *Id.* The taxes were worth over \$21 million in the aggregate, not including the cost that organizations would have to pay to correct the excess benefits. *Id.*

¹⁵¹ HOSPITAL STUDY EXECUTIVE SUMMARY, *supra* note 147, at 4.

¹⁵² *Id.*

¹⁵³ See *Caracci v. Comm'r*, 456 F.3d 444, 447 (5th Cir. 2006); Bernadette M. Broccolo et al., *The Price Is Right!—Taxpayers Prevail in the First Case to Review IRS Imposition of Intermediate Sanctions*, HEALTH LAW., Oct. 2006, at 1, 1.

¹⁵⁴ See 456 F.3d at 450.

¹⁵⁵ *Caracci*, 118 T.C. at 417.

¹⁵⁶ *Caracci*, 456 F.3d at 450.

¹⁵⁷ *Id.* at 456.

Circuit described as “brief, intermediate internal analysis.”¹⁵⁸ And, second, the excise tax amount ordered was not offset by a calculation of the liabilities that the entities had assumed when converting from tax-exempt to nonexempt entities.¹⁵⁹ The Fifth Circuit also held that the Tax Court acted improperly because it failed to place the burden of proof on the IRS to show that the taxpayers owed the correct amount of taxes.¹⁶⁰ For these reasons, *Caracci* underscores the valuation difficulties that can affect a Section 4958 excess benefit analysis.¹⁶¹

III. RIGHTING A WRONG: HOW TO ENFORCE THE COMMUNITY BENEFITS STANDARD USING INTERMEDIATE SANCTIONS

Scholars have suggested a variety of solutions to change the way in which the IRS evaluates whether a hospital qualifies as charitable.¹⁶² The solutions proposed thus far all have something in common: they all examine the test that nonprofit hospitals must meet in order to qualify for tax exemption.¹⁶³ Because the community benefits standard has proven difficult to administer,¹⁶⁴ it is un-

¹⁵⁸ *Id.* (noting that the analysis itself stated that it was intermediate and would require further study).

¹⁵⁹ *Id.* at 450, 457 (describing how the failure to offset led to a vast overstatement of tax liability).

¹⁶⁰ *Id.* at 457–58 (noting that the failure to place the burden of proof on the IRS was an “error”).

¹⁶¹ See *id.* at 447; Allen D. Hahn, *Caracci and the Valuation of Exempt Organizations*, 40 J. HEALTH L. 267, 279–88 (2007) (discussing *Caracci*’s lessons for properly conducting the § 4958 valuation analysis); Broccolo et al., *supra* note 153, at 4 (identifying *Caracci*’s implications for the valuation of excess benefits in the health care industry).

¹⁶² See Colombo, *supra* note 44, at 29, 52–53; Crimm, *supra* note 33, at 103; Nation, *supra* note 11, at 206; Noble et al., *supra* note 8, at 131. Some have called for a repeal of the community benefits standard entirely. See Bloche, *supra* note 99, at 404–05 (arguing for the repeal of the community benefits standard and, ultimately, for the phase-out of all tax exemptions for nonprofit hospitals); Crimm, *supra* note 33, at 103 (proposing a completely different tax regime as an alternative to the community benefits standard); Nation, *supra* note 11, at 206 (proposing that the community benefits standard be replaced by limiting the definition of “charitable” to the provision of free care to the public). Others propose tying tax-exempt status to set levels of charity care. See Noble et al., *supra* note 8, at 131. For example, Texas has statutorily mandated charity care as a requirement for a state tax exemption. *Id.* At least one scholar has discussed reformulating the community benefits standard based on enhancing access to desirable health care services. See Colombo, *supra* note 44, at 62–63. Another has proposed reformulating the system for tax exemptions entirely, and making available a tax deduction or credit to reward both for-profit and nonprofit health care providers that engage in certain desirable charitable activities. Crimm, *supra* note 33, at 103–04.

¹⁶³ See Colombo, *supra* note 44, at 62–63 (proposing to reformulate the community benefits test based on enhancing access to desirable health care services); Crimm, *supra* note 33, at 103–04 (advocating for repeal of the tax exemption to be replaced by a system of tax deductions and government subsidies to reward nonprofit and for-profit hospitals that engage in broadly defined charitable activities); Nation, *supra* note 11, at 206 (endorsing a narrow definition of charitable so that hospitals are allowed only a tax deduction for the marginal cost of any free care provided); Noble et al., *supra* note 8, at 131 (recommending national consistency with regard to state and federal attempts to define “charity” and “community benefits”).

¹⁶⁴ See Cohen, *supra* note 94, at 95–97; Crossley, *supra* note 11, at 691; Helvin, *supra* note 94, at 424–27; Nation, *supra* note 11, at 175–76; Thai, *supra* note 10, at 772.

deniably beneficial for academics and lawmakers to thoroughly evaluate the standard to see how it can be better implemented.¹⁶⁵ As the health care environment in the United States continues to evolve, it has become even more worthwhile to challenge the standard and tweak it accordingly.¹⁶⁶

The currently proposed solutions, however, do not address the most serious problem facing the administration of tax-exempt status for hospitals: the lack of flexibility with the IRS's enforcement powers.¹⁶⁷ The IRS has not vigorously enforced the community benefits standard because its only option is revocation of status, which often sounds the death knell for the hospital.¹⁶⁸ This Part argues that Congress should give the IRS statutory authority to employ intermediate sanctions against hospitals that fail to uphold their obligations under the community benefits standard and the ACA.¹⁶⁹ Giving the IRS this power would enable the service to target discrete unsatisfactory hospital practices and take action against them.¹⁷⁰ Moreover, intermediate sanctions would allow the IRS to better regulate tax-exempt hospital behavior while ensuring that communities benefit from their services.¹⁷¹

Accordingly, Section 4958 intermediate sanctions should be adapted to work with the community benefits regime to determine whether a hospital should incur tax liability.¹⁷² The current intermediate sanctions available to the IRS are only penalty excise taxes that may be imposed on a disqualified person who benefits from an excess benefit transaction with a tax-exempt organization.¹⁷³ Under these existing sanctions, the IRS may levy a tax upon the disqualified person and the participating organization's managers, but not the organiza-

¹⁶⁵ See Colombo, *supra* note 44, at 62–63; Crimm, *supra* note 33, at 103–04; Nation, *supra* note 11, at 206; Noble et al., *supra* note 8, at 131.

¹⁶⁶ See Colombo, *supra* note 44, at 52–63 (addressing scholarly arguments for and against the community benefits standard and proposing an access-based solution).

¹⁶⁷ See, e.g., *id.* at 62–63 (proposing an “enhancing access” standard for exemption); Crimm, *supra* note 33, at 103–05 (arguing for favorable tax treatment for broadly defined charitable behaviors); Nation, *supra* note 11, at 206 (advocating for a narrower standard for exemption); Noble et al., *supra* note 8, at 131 (recommending a nationally consistent standard for exemption); *supra* notes 111–124 and accompanying text (discussing the difficulties that the IRS and courts have faced in enforcing the community benefits standard).

¹⁶⁸ See *supra* notes 73–92 and accompanying text (discussing the lack of appropriate enforcement options and the negative consequences of revocation).

¹⁶⁹ See *infra* notes 172–243 and accompanying text.

¹⁷⁰ See I.R.C. § 4958 (2012); *Tax-Exempt Hospital Sector*, *supra* note 15, at 8–9 (statement of Mark Everson, Commissioner, Internal Revenue Service); Studdert et al., *supra* note 12, at 626.

¹⁷¹ See Berg, *supra* note 8, at 382 (discussing the IRS's reluctance to enforce the standard due to the draconian results of revocation); Studdert et al., *supra* note 12, at 626 (“The severity [of revocation proceedings] has tended to discourage its use.”); Levitt, *supra* note 12, at 14 (noting the absence of IRS enforcement flexibility with regards to the community benefits standard).

¹⁷² See I.R.C. § 4958; Rev. Rul. 69-545, 1969-2 C.B. 118.

¹⁷³ I.R.C. § 4958; see *supra* notes 129–161 and accompanying text (providing background on I.R.C. § 4958 and its application).

tion itself.¹⁷⁴ In a similar way, in the community benefits context, the IRS should have the authority to impose tax liability directly on a violating hospital.¹⁷⁵

To enforce the community benefits standard, however, the valuation methodology for Section 4958 intermediate sanctions would need to be modified.¹⁷⁶ Under Section 4958, a disqualified person is taxed on twenty-five percent of the excess benefit received.¹⁷⁷ Additionally, if the benefit is not returned to the organization within a certain timeframe, the person is taxed on two hundred percent of the benefit retained.¹⁷⁸ The IRS calculates the value of the excess benefit by subtracting the economic benefit that the disqualified person provided to the tax-exempt organization from the economic benefit the disqualified person received from the organization.¹⁷⁹

The intermediate sanctions imposed to enforce the community benefits standard should mirror the ACA's community health needs assessment penalties.¹⁸⁰ Such intermediate sanctions could expand the new \$50,000 penalty applied to hospitals that fail to comply with the community health needs assessment requirement.¹⁸¹ Specifically, legislation could give the IRS authority to

¹⁷⁴ I.R.C. § 4958.

¹⁷⁵ See *id.* (imposing tax liability on a disqualified person or on an organization's managers, but not the organization itself). Section 4958 created intermediate sanctions to deter or punish a disqualified person engaging in an inappropriate transaction. See *id.*; Caracci v. Comm'r, 118 T.C. 379, 417 (2002) ("[I]ntermediate sanctions are the sole sanction imposed in those cases in which the excess benefit does not rise to a level where it calls into question whether . . . the organization functions as a charitable . . . organization." (quoting H.R. REP. NO. 104-506, at 106 n.15 (1996), reprinted in 1996 U.S.C.C.A.N. 1143, 1191) (internal quotation marks omitted)), *rev'd on other grounds*, 456 F.3d 444 (5th Cir. 2006); Adkins, *supra* note 92, at 26. Conversely, the proposed model encourages hospitals to follow the community benefits standard to avoid *organizational* exposure to intermediate sanctions because revocation has not served a proper deterrent function. See *Tax-Exempt Hospital Sector*, *supra* note 15, at 9 (statement of Mark Everson, Commissioner, Internal Revenue Service); Colombo, *supra* note 44, at 41–42; Crossley, *supra* note 11, at 701.

¹⁷⁶ See I.R.C. § 4958 (2012); Hahn, *supra* note 161, at 279–88 (discussing proper valuation methods for applying intermediate sanctions).

¹⁷⁷ I.R.C. § 4958. In addition, an organization's managers who knowingly, willfully, and without reasonable cause take part in an excess benefit transaction can be held liable for a tax of ten percent of the excess benefit, not to exceed \$20,000. *Id.*

¹⁷⁸ *Id.*

¹⁷⁹ *Id.* For a more complete description of the methodology for valuing § 4958 intermediate sanctions, see *supra* notes 132–143 and accompanying text.

¹⁸⁰ See I.R.C. § 4958; *Tax-Exempt Hospital Sector*, *supra* note 15, at 9 (statement of Mark Everson, Commissioner, Internal Revenue Service) (explaining that the IRS does not currently have the tools to properly enforce the community benefits standard); Hahn, *supra* note 161, at 279–88 (describing the function of intermediate sanctions in the excess benefit context); Colombo, *supra* note 44, at 41–42 (critiquing the lack of a "specific, quantifiable" community benefits standard); Crossley, *supra* note 11, at 701 (arguing that hospitals are unlikely to change behavior without "meaningful prodding" in the form of economic sanctions).

¹⁸¹ I.R.C. § 4959 (2012) (establishing a \$50,000 penalty excise tax for any hospital that fails to conduct a community health needs assessment). For a comprehensive explanation of the community

impose a \$50,000 excise tax on any tax-exempt hospital that engages in a discrete behavior that is contrary to the purpose and intent of the community benefits standard.¹⁸² For example, the IRS could use this tool if hospitals offer too little charity care or fail to provide health education to the public.¹⁸³

Furthermore, legislation could allow the IRS to impose a twenty-five percent tax on hospitals that continued to engage in undesirable behavior.¹⁸⁴ This scheme could resemble Section 4958's twenty-five percent tax on individuals who benefit from excess benefit transactions.¹⁸⁵ Under this scheme, the IRS first would calculate a hospital's income tax as if that hospital were not tax-exempt.¹⁸⁶ It would then calculate the estimated costs of all the hospital's community benefits activities.¹⁸⁷ Next, the IRS would subtract the sum of the value of the hospital's community benefits activities from the hospital's hypothetical income tax liability.¹⁸⁸ This number represents the approximate benefit that the hospital receives for being tax-exempt, over and above the amount it returns to the community in the form of community benefits activities.¹⁸⁹ Under this Note's proposed plan, the IRS could be given authority to tax the hospital twenty-five percent of that value as a more extreme measure—short of revocation—to pressure hospitals into full compliance with the community benefits standard.¹⁹⁰

The \$50,000 excise tax on isolated, unsatisfactory practices helps to pair the flexible community benefits standard with a correspondingly flexible enforcement mechanism.¹⁹¹ This is necessary in this instance because, although a flexible standard for tax exemption is desirable, it is only workable when

health needs assessment requirement that was recently enacted as part of the ACA, see *supra* notes 55–59 and accompanying text.

¹⁸² See I.R.C. § 4959. The amount of \$50,000 is simply a suggested measure that mirrors the § 4959 tax. See *id.* As an alternative, the IRS could create a sliding scale of excise tax rates based on either the hospital's size and ability to pay or the degree of improper activity. See *id.* Regardless, the IRS would have to use its discretion as to which behaviors would merit imposition of such a tax. See *id.*; I.R.S. Notice 2011-52, *supra* note 59, at 65 (explaining the IRS's enforcement plan for when it will seek to impose the \$50,000 penalty).

¹⁸³ See Rev. Rul. 69-545, 1969-2 C.B. 118; Colombo, *supra* note 23, at 626; Nation, *supra* note 11, at 168; Goodman, *supra* note 30, at 719–20.

¹⁸⁴ See I.R.C. § 4958 (2012).

¹⁸⁵ See *id.* Again, the twenty-five percent tax is merely a suggested rate of taxation mirroring the tax rate under § 4958. See *id.* Clearly, additional study would be necessary before definitively valuing such taxes. See *id.*

¹⁸⁶ See *id.*

¹⁸⁷ See *id.*

¹⁸⁸ See *id.*

¹⁸⁹ See *id.*

¹⁹⁰ See I.R.C. § 4958 (2012).

¹⁹¹ See Colombo, *supra* note 44, at 46–47; Karns, *supra* note 8, at 520; Nation, *supra* note 11, at 174.

paired with a flexible enforcement mechanism.¹⁹² Flexibility is desirable because every community has distinct needs in terms of what it wants or requires from a tax-exempt hospital.¹⁹³ For example, some communities may have a large population of indigent patients who require significant amounts of subsidized or free care.¹⁹⁴ Other communities, however, may be less in need of free care, but have a large percentage of Medicare or Medicaid enrollees and need their local hospitals to address Medicare and Medicaid shortfalls.¹⁹⁵ Yet other communities may benefit from substantial health education and outreach programs.¹⁹⁶

Because of each community's varying needs, the current system allows the IRS to look at the totality of the circumstances to determine whether tax-exempt status for a hospital is warranted.¹⁹⁷ If a hospital engages in a discrete undesirable practice, such as providing extremely little charitable care, an exemption may still be granted if this practice is balanced by desirable hospital characteristics.¹⁹⁸ The current model, however, allows hospitals to flagrantly disregard the community benefits standard without consequences.¹⁹⁹ With the flat excise tax, however, the IRS could correct any harmful hospital practices, while still allowing an otherwise deserving hospital to keep its exemption.²⁰⁰

The proposed intermediate sanctions model also would rationally link the enforcement of the hospital tax exemption to the policy underlying it.²⁰¹ A central policy justification for the exemption is that the government's lost tax rev-

¹⁹² See Colombo, *supra* note 44, at 60; Thai, *supra* note 10, at 768.

¹⁹³ See Crossley, *supra* note 11, at 688 (discussing the prevalence of health disparities based on gender, race, and socio-economic status); Thai, *supra* note 10, at 768 (noting how the community benefits standard is flexible so that hospitals may respond to the specific needs of their communities).

¹⁹⁴ See 2006 CBO REPORT, *supra* note 48, at 4 (highlighting the benefits of providing uncompensated care to indigent patients); Thai, *supra* note 10, at 768 (discussing the purpose of a flexible community benefits standard).

¹⁹⁵ See 2006 CBO REPORT, *supra* note 48, at 17–19; Courtney, *supra* note 8, at 382; Kane, *supra* note 48, at 465–66; Thai, *supra* note 10, at 768.

¹⁹⁶ See Bloche, *supra* note 99, at 389 (postulating that nonprofit hospitals are more likely than for-profit hospitals to offer outreach services for low-income community members); Colombo, *supra* note 44, at 40 (noting the significance of outreach programs like wellness education and medical research); Thai, *supra* note 10, at 768.

¹⁹⁷ See *Geisinger Health Plan v. Comm'r*, 985 F.2d 1210, 1219 (3d Cir. 1993); Rev. Rul. 69-545, 1969-2 C.B. 118.

¹⁹⁸ See Rev. Rul. 69-545, 1969-2 C.B. 118. Desirable characteristics include maintaining an open medical staff membership, a board of trustees made up of prominent community members, and providing health education and outreach programs to the public. *Id.*

¹⁹⁹ See *supra* notes 99–128 and accompanying text.

²⁰⁰ See I.R.C. § 4958 (2012); *Caracci*, 118 T.C. at 414; Adkins, *supra* note 92, at 26; Noble et al., *supra* note 8, at 119; Studdert et al., *supra* note 12, at 626; Levitt, *supra* note 12, at 14. The IRS would still have the authority to revoke a hospital's status in extreme situations. See I.R.C. § 501 (2012); *Caracci*, 118 T.C. at 417; Adkins, *supra* note 92, at 26.

²⁰¹ See I.R.C. § 4958; GAO REPORT, *supra* note 36, at 1.

enues are offset by its relief from obligations that it would otherwise have to meet in promoting the general welfare.²⁰² Here, challenged hospitals that fail to clean up their acts are effectively taxed on the value of their exemption to the extent that such value exceeds the benefits that they are giving back to the community.²⁰³ Giving the IRS the ability to impose—or perhaps more importantly, to threaten to impose—such penalty taxes on tax-exempt hospitals should motivate the hospitals to change their behavior in a way that simply revising the test for exemption or threatening revocation has not.²⁰⁴

This model will likely prompt two key challenges.²⁰⁵ First, critics may argue that such a revision to the IRS's enforcement powers would be premature at best, and superfluous at worst, in light of the new ACA requirements.²⁰⁶ They may claim that the proposed intermediate sanctions model and the ACA requirements are designed to achieve the same purpose.²⁰⁷ Because the ACA requirements are still being implemented, a case could be made that Congress should hold off on passing new legislation directed at tax-exempt hospitals until they are fully evaluated.²⁰⁸

Upon further reflection, however, the ACA's relevant provisions readily address this challenge.²⁰⁹ The ACA merely adds new conditions that tax-exempt hospitals must satisfy besides the community benefits standard.²¹⁰ Although the new requirements are a step in the right direction, they do not go far enough to solve the problems associated with enforcement of the hospital tax

²⁰² GAO REPORT, *supra* note 36, at 1; *see supra* notes 36–40 and accompanying text (discussing this justification).

²⁰³ *Geisinger Health Plan*, 985 F.2d at 1219; Rev. Rul. 69-545, 1969-2 C.B. 118.

²⁰⁴ *See* I.R.C. § 4958; Brody, *supra* note 75, at 543. Indeed, this was the primary purpose of enacting § 4958 intermediate sanctions. Caracci, 118 T.C. at 417 (“[T]he intermediate sanction regime was enacted in order to provide a less drastic deterrent to the misuse of a charity than revocation of that charity’s exempt status.”).

²⁰⁵ *See* I.R.C. § 501(r); *id.* § 4959 (2012); *id.* § 6033(b) (2012); Caracci v. Comm’r, 456 F.3d 444, 456–57 (5th Cir. 2006); *infra* notes 206–238 and accompanying text.

²⁰⁶ *See* I.R.C. § 501(r) (2012); *id.* § 4959; *id.* § 6033(b); *see also* Nation, *supra* note 11, at 148 (arguing against hospital tax exemption in general); American Hospital Association Comment, *supra* note 53, at 2 (lamenting that proposed rules implementing § 501(r) are inflexible and compliance will “divert resources from patient care”).

²⁰⁷ *See, e.g.,* Thai, *supra* note 10, at 776–77 (arguing that the ACA amendments will “redraw the fading distinction between charitable, nonprofit hospitals worthy of federal tax exemption and for-profit hospitals”); American Hospital Association Comment, *supra* note 53, at 2–3 (requesting flexibility with implementation of § 501(r) because additional requirements on hospitals diverts resources from patient care and initiatives to improve quality and efficiency).

²⁰⁸ *See* Crossley, *supra* note 11, at 702; Thai, *supra* note 10, at 773; American Hospital Association Comment, *supra* note 53, at 2–3.

²⁰⁹ *See* I.R.C. § 501(r); *id.* § 4959; *id.* § 6033(b); *supra* notes 53–72 and accompanying text (presenting an overview of the ACA amendments).

²¹⁰ I.R.C. § 501(r); *id.* § 6033(b).

exemption.²¹¹ With the exception of a \$50,000 excise tax imposed on hospitals that fail to complete a community health needs assessment, the IRS is still left with only two enforcement choices: do nothing or revoke a hospital's exemption.²¹² Imposing more specific prohibitions on certain practices without simultaneously enhancing the enforcement powers of the IRS is unlikely to affect hospital behavior.²¹³

Although the ACA places additional obligations on tax-exempt hospitals, this Note's proposed intermediate sanctions model will serve to increase hospitals' accountability to keep up their end of the exemption bargain.²¹⁴ For example, the ACA limits the rates that tax-exempt hospitals may bill to persons who are eligible for financial assistance and places restrictions on hospitals' collection practices.²¹⁵ These provisions are designed to address reports of egregious tax-exempt hospital behavior, including the practice of charging indigent patients higher rates than insured patients and using aggressive collection techniques without evaluating a patient's financial constraints.²¹⁶

Nevertheless, hospitals are unlikely to take the new legislation seriously.²¹⁷ Many hospitals have already turned over control of Section 501(r) compliance to their marketing departments.²¹⁸ Others view the new reporting requirements "simply as a new hoop to jump through with the least possible effort expended."²¹⁹ Presently, the IRS is reluctant to take enforcement action against tax-exempt hospitals that engage in such conspicuous practices because revocation is a drastic step, and the hospitals may otherwise be meeting the

²¹¹ See I.R.C. § 501(r); *id.* § 6033(b) (2012); *Tax-Exempt Hospital Sector*, *supra* note 15, at 9 (statement of Mark Everson, Commissioner, Internal Revenue Service) (testifying that the IRS needs better enforcement tools to effectively regulate tax-exempt hospitals); Crossley, *supra* note 11, at 701 (warning that hospitals will not change their behavior significantly—despite § 501(r)—without "meaningful prodding by the IRS").

²¹² See I.R.C. § 4959 (2012).

²¹³ See Berg, *supra* note 8, at 382 (blaming the IRS's failure to take action against hospitals that do not meet the community benefits standard on the "draconian result" of revocation). *But see* Thai, *supra* note 10, at 773 (arguing that the new ACA amendments will have a profound impact on hospital behavior).

²¹⁴ See I.R.C. § 501(r) (2012); *id.* § 4959; *id.* § 6033(b); *supra* notes 180–190 and accompanying text.

²¹⁵ See I.R.C. § 501(r).

²¹⁶ See *id.*; *supra* notes 116–124 and accompanying text (reviewing the inappropriate practices of some tax-exempt hospitals).

²¹⁷ See Crossley, *supra* note 11, at 701–02.

²¹⁸ See *id.* at 702 n.69.

²¹⁹ See *id.* at 702.

community benefits standard.²²⁰ Accordingly, expanding the requirements for tax-exempt hospitals does not confront this problematic dynamic.²²¹

Furthermore, the new requirements are unlikely to delineate a line between the expected behavior of tax-exempt hospitals and their for-profit equivalents.²²² The ACA requires tax-exempt hospitals to conduct a community health needs assessment and develop written financial assistance and emergency care policies.²²³ Yet, the legislation does not establish any specific eligibility criteria for financial assistance or mandate a minimum level of coverage.²²⁴ Thus, tax-exempt hospitals do not necessarily have to change their financial assistance or emergency care policies to comply with this provision; rather, all they must do is write it down and distribute it to patients.²²⁵ Although the ACA's provisions are a step in the right direction, layering on new requirements alone will not be sufficient to influence tax-exempt hospitals to change their behavior.²²⁶

An additional anticipated challenge to the intermediate sanctions model is that its use could trigger complex valuation issues.²²⁷ This, however, will not be an issue here.²²⁸ This is because the \$50,000 excise tax on discrete behavior can be straightforwardly applied.²²⁹ The twenty-five percent tax on hospitals that fail to change their behavior, however, requires two estimates: the hospital's hypothetical income tax obligation and the value of its community benefits activities.²³⁰ These amounts arguably could be difficult to assess.²³¹ There are many possible valuation methods and the IRS would require extensive in-

²²⁰ See Berg, *supra* note 8, at 382.

²²¹ See *id.* (noting the IRS's historical reluctance to enforce the community benefits standard through revocation); Crossley, *supra* note 11, at 701–02 (questioning whether hospitals will fully comply with the new requirements without “prodding” from the IRS).

²²² See I.R.C. § 501(r) (2012); Berg, *supra* note 8, at 390; Colombo, *supra* note 44, at 46–47; Crossley, *supra* note 11, at 701–02; Karns, *supra* note 8, at 521; Goodman, *supra* note 30, at 725. *But see* Thai, *supra* note 10, at 776–77 (predicting that the new ACA amendments will create distinctions between the behavior of tax-exempt hospitals and that of their for-profit counterparts).

²²³ I.R.C. § 501(r).

²²⁴ Additional Requirements for Charitable Hospitals, 77 Fed. Reg. 38,148, 38,149 (June 26, 2012); see I.R.C. § 501(r).

²²⁵ See I.R.C. § 501(r). Section 501(r) at least requires hospitals to widely distribute their financial assistance policies. See *id.* This will prevent the current practice of some hospitals that actively conceal their financial assistance programs in order to limit their use. See *id.*; see, e.g., Utah Cnty. v. Intermountain Health Care, Inc., 709 P.2d 265, 274 (Utah 1985).

²²⁶ See Crossley, *supra* note 11, at 701–02; Noble et al., *supra* note 8, at 130.

²²⁷ See I.R.C. § 4958 (2012); Caracci, 456 F.3d at 456–57.

²²⁸ See *infra* notes 233–238 and accompanying text.

²²⁹ See I.R.C. § 4959 (2012) (straightforwardly stating when the \$50,000 tax should be applied).

²³⁰ See *supra* 184–190 and accompanying text (discussing this tax scheme).

²³¹ See GAO REPORT, *supra* note 36, at 7 (“[S]tandards and guidance vary on . . . the method hospitals may use to measure costs of charity care, government health care programs, and other activities that benefit the community.”).

formation about hospitals' operating expenses and community benefits practices to complete the valuation process.²³²

The intermediate sanctions model that this Note proposes addresses the valuation problem in two ways.²³³ First, the additional tax is designed for the uncommon circumstance of a hospital failing to change its behavior after a \$50,000 tax is levied upon it.²³⁴ Thus, valuation concerns would only be an issue on the rare occasions when the IRS might seek to impose the additional twenty-five percent tax.²³⁵ Second, hospitals are already required to annually report the estimated costs of their community benefits activities to the IRS.²³⁶ Thus, the IRS is already in possession of all the information it would need to calculate the twenty-five percent tax.²³⁷ Moreover, Section 4958 intermediate sanctions for excess benefit transactions have been very valuable to the IRS when utilized properly.²³⁸

The community benefits standard is often blamed for creating a system where tax-exempt hospitals reap extensive economic benefits without sharing such benefits with their communities.²³⁹ In fact, the absence of a flexible IRS enforcement mechanism is the culprit.²⁴⁰ To address this systemic issue, Congress should adopt this Note's proposed intermediate sanctions model, which would allow the IRS to better regulate tax-exempt hospitals' activities.²⁴¹ The model proposed herein goes beyond the ACA's requirements because it targets specific undesirable practices and gives the IRS the proper tools to eradicate

²³² See *Caracci*, 456 F.3d at 456–57; Hahn, *supra* note 161, at 279–88; Broccolo et al., *supra* note 153, at 4.

²³³ See *infra* notes 234–238 and accompanying text.

²³⁴ See *supra* notes 191–200 and accompanying text (proposing a \$50,000 excise tax and discussing the need for a flexible community benefits standard).

²³⁵ See I.R.C. § 4959 (2012) (establishing a \$50,000 excise tax for hospitals that fail to conduct a community health needs assessment).

²³⁶ See generally SCHEDULE H, *supra* note 73 (collecting community benefits and financial information from hospitals).

²³⁷ See generally *id.* (collecting community benefits and financial information from hospitals).

²³⁸ See *IRS Sharpens Focus on Tax-Exempt Organization Compensation*, *supra* note 148. For example, following an aggressive compliance initiative in 2006, the IRS proposed or assessed at least \$21 million in excise taxes under § 4958 against forty disqualified persons or organization managers. *Id.* The large-scale exposure of the affected organizations to sizeable tax liability put all tax-exempt organizations on notice that the IRS would not stand idly by in cases of excess benefit transactions. *Id.*

²³⁹ See Colombo, *supra* note 44, at 53.

²⁴⁰ See *Tax-Exempt Hospital Sector*, *supra* note 15, at 8–9 (statement of Mark Everson, Commissioner, Internal Revenue Service) (pushing Congress to give the IRS increased enforcement flexibility); Colombo, *supra* note 44, at 53 (“[M]odern empirical evidence shows little difference in the quantifiable behavior of for-profit and nonprofit hospitals with respect to cost, quality of care and charity care.”); *supra* notes 99–128 and accompanying text (drawing attention to the egregious behaviors that resulted from poor enforcement of the community benefits standard).

²⁴¹ See *supra* notes 169–200 and accompanying text.

such behavior.²⁴² Although the IRS may encounter some valuation difficulties when assessing intermediate sanctions, it can overcome them by utilizing the reported hospital data that it already possesses.²⁴³

CONCLUSION

Tax-exempt hospitals receive millions of dollars worth of tax breaks each year, yet many of them act less than charitably. The IRS regulates the standard that hospitals must meet in order to qualify for a tax exemption. When a tax-exempt hospital fails to live up to its charitable requirements, the IRS has two options: (1) do nothing; or (2) move to revoke the hospital's tax-exempt status. Revocation is a drastic option that cannot be particularized to a hospital's specific shortcomings, and as a result, the IRS rarely takes enforcement action against hospitals that fail to meet the community benefits standard. Commentators have suggested modifying the qualifying standard for tax-exempt hospitals to address this problem. Alternatively, Congress should give the IRS statutory authority to impose excise tax intermediate sanctions on underperforming hospitals as an enforcement tool short of revocation. Intermediate sanctions would provide the IRS with flexibility to regulate the boundaries of tax-exempt status and ensure that communities continue to benefit from the services of tax-exempt hospitals. Although more time is needed to realize the impact of the Affordable Care Act—which imposes additional requirements—on tax-exempt hospital behavior, one thing is certain: uncharitable hospitals are not and can never be “charitable” organizations.

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²⁴² See I.R.C. § 501(r) (2012); *id.* § 4959 (2012); *id.* § 6033(b) (2012); *supra* notes 191–200 and accompanying text (highlighting that communities may have different needs in terms of what it requires from tax-exempt hospitals).

²⁴³ See *supra* notes 236–237 and accompanying text.

