American Hospital Association

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

Statement
of the
American Hospital Association
submitted to the
Committee on Finance
of the
United States Senate
on
Bipartisan Tax Reform

April 15, 2015

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) urges you to retain certain key tax code provisions related to section 501(c)(3) hospitals as you work to reform the current tax code.

Hospitals do more to assist the poor, sick, elderly and infirm than any other entity in health care. Since 2000, hospitals of all types have provided more than $459.5 billion in uncompensated care to their patients. In 2013 alone, hospitals delivered more than $46.4 billion (based on costs) in uncompensated care to patients and uncounted billions more in value to their communities through services, programs and other activities designed to promote and protect health and well-being. This broad array of benefits includes wellness programs, community outreach, basic research, medical education and unprofitable services such as burn intensive care, emergency department care, high-level trauma care and neonatal intensive care services.

The ability to obtain tax-exempt financing and to accept tax-deductible charitable contributions are two key benefits of hospital tax-exemption that work to make access to hospital services available where needed. The current exemption for hospital services, governed and guided by the community benefit standard, allows the community in which the hospital operates to determine the needs of its residents, and the hospital to tailor its activities accordingly. That approach continues to work well for communities across the nation. Confirmation of the positive return communities receive from hospital tax-exemption comes from the Internal Revenue Service (IRS) Form 990 Schedule H that hospitals file. The IRS recently reported to Congress that tax-exempt hospitals' financial assistance and certain other community benefit activities represented 9.67% of their total expenses for Tax Year 2011. In addition, an analysis of 2012 Schedule H data prepared for AHA by Ernst & Young shows that the value of total benefits to the community averaged more than 12 percent of the hospitals' total expenses.

As the committee reviews various tax reform proposals, we ask you to retain current tax code incentives for the provision of health care that effectively promote the important policy objective of providing access to the broad array of health care services provided by hospitals in communities large and small across the country.

COMMUNITY BENEFIT STANDARD

Since the 1960s, Congress and the courts have examined, refined and affirmed hospital tax exemption. Most recently, as part of the Affordable Care Act (ACA), Congress established further refinements of the 1969 community benefit standard, the basic framework for hospital exemption. Hospitals have been required to comply with the law since it was enacted in 2010. The IRS recently finalized the rules implementing the law and hospitals are making any needed refinements to their policies and procedures to comply with the details of the regulations. Decades ago, the courts and Congress rejected setting a percentage of charity care as a condition for hospitals' gaining or maintaining tax-exempt status. The rejection was not based on unfulfilled hope that the Medicare and Medicaid programs would fully address concerns about the uninsured, but rather the changing nature of hospitals themselves. As the United States Supreme Court found:

> [T]he concept of the nonprofit hospital and its appropriate and necessary activity has vastly changed and developed since the enactment of the Nonprofit Institutions Act in 1938. The intervening decades have seen the hospital assume a larger community character. Some hospitals, indeed, truly have become centers for the 'delivery' of health care. The nonprofit hospital no longer is a receiving facility only for the bedridden, the surgical patient, and the critical emergency. It has become a place where the community is readily inclined to turn, and because of increasing costs, physician specialization, shortage of general practitioners, and other factors is often compelled to turn, whenever a medical problem of import presents itself." *Abbott Laboratories v. Portland Retail Druggists Ass'n.*, 425 U.S. 1, 11 (1976).

As hospitals assumed "a larger community character," it became increasingly clear to the courts, and to Congress, that a percentage test was outdated and needed to be replaced with a standard that reflected hospitals' need to serve the entire community. The leading commentator on hospital tax-exempt status, Robert Bromberg, described it as the "humanitarian approach": "[I]n determining whether a nonprofit hospital is operated in furtherance of charitable purposes, the proper touchstone should be the more widely accepted humanitarian approach, which focuses on the hospital's delivery of health care to the community, rather than the public burden approach, which refuses to look beyond the quantum of free or below-cost care provided to the poor." In keeping with the humanitarian approach, in 1969 the IRS replaced its outdated percentage test with the community benefit standard in Revenue Ruling 69-545.

The current community benefit standard ensures that hospitals fulfill their charitable obligations through the appropriate mix of free care, financial assistance to low-income patients, subsidized

health care, research, education and other community-building activities tailored to the needs of their communities. The IRS has long recognized five factors that would support a nonprofit hospital's tax-exempt status: (1) the operation of an emergency room open to all members of the community without regard to ability to pay; (2) a governance board composed of community members; (3) the use of surplus revenue for facilities improvement, patient care, and medical training, education and research; (4) the provision of inpatient hospital care for all persons in the community able to pay, including those covered by Medicare and Medicaid; and (5) an open medical staff with privileges available to all qualifying physicians.

The ACA created four new requirements for tax-exempt hospitals: (1) adoption of a written financial assistance policy and a policy relating to emergency medical care; (2) limitations on the amounts a hospital charges to individuals eligible for financial assistance for emergency or other medically necessary care; (3) limits on engaging in extraordinary collection actions before making reasonable efforts to determine an individual's eligibility for financial assistance; and (4) that a community health needs assessment (CHNA) be conducted every three years. These provisions became effective for tax years beginning after March 23, 2010, except for the CHNA requirement, which is effective for tax years beginning after March 23, 2012. Failure to meet these requirements can result in fines, excise taxes or loss of tax exemption.

BENEFIT TO SOCIETY

America's communities receive a positive return on their investment from the tax-exemption of non-profit hospitals. The IRS recently reported to Congress that tax-exempt hospitals' financial assistance and certain other community benefit activities represented 9.67% of their total expenses for Tax Year 2011. For four consecutive years, the AHA has collected the community benefit information that tax-exempt hospitals file with the IRS in a form called "Schedule H," and asked Ernst & Young (E&Y) to analyze and report on it. Most recently, the Schedule H forms for tax year 2012 were obtained directly from more than 1,100 hospitals around the nation. The E&Y analysis shows that the value of total benefits to the community averaged more than 12 percent of the hospitals' total expenses. Direct benefits to patients, which include free care, financial assistance and spending to fill gaps in Medicaid underpayments, averaged 6.1 percent of expenses. This most recent E&Y analysis in final form is slated for release in late spring 2015.

Moreover, hospitals play a key role in the nation's emergency preparedness and response as part of America's health care infrastructure. In times of disaster, communities look to hospitals not only to mobilize resources to care for the ill and injured but also to provide food and shelter, and coordinate relief and recovery efforts. As part of this role, hospitals are pivotal to disaster response activities, whether they are rural, critical access hospitals (CAHs) or Level 1 trauma centers. Emergency preparedness requires a significant investment in staff and resources. Hospitals must be prepared to provide care and, as a result, they are expected to develop and test disaster response plans, train clinical and support staff, maintain and replace disaster response equipment and supplies, ensure communication and surveillance capabilities and enable patient transport and care.

Federal preparedness funding has not kept pace with the increasing demands placed on hospitals to ensure they are ready to respond to any disaster that hits their community, leaving hospitals to

shoulder this expanding challenge. An important recent example is the hospital response to the Ebola crisis. While the AHA supports the goal of system-wide readiness, in the instance of Ebola, readiness is centered on hospitals. Under current federal programs to address the crisis, hospitals that incurred extraordinary costs to prepare to care for Ebola patients may only receive funding to cover a portion of those costs, while some hospitals may not receive any funding for their Ebola preparedness efforts.

COMMUNITY BENEFIT STANDARD IN PRACTICE

Today, hospitals of all kinds — urban and rural, large and small — are making their communities healthier in ways that are as diverse as the needs of each community. The men and women who work in hospitals are not just mending bodies. Their work extends far beyond the literal and figurative four walls of the hospital to free clinics, job training efforts, smoking cessation classes, back-to-school immunizations, literacy programs and so many others. Below is just a sampling of the unique and innovative ways hospitals are improving the long-term health of their communities:

- **Dignity Health-St. Rose Dominican Hospitals, Henderson, Nev.**, established the Chronic Disease Self-Management Program to provide a free, six-week interactive program that teaches patients how to set personal goals and develop skills to overcome barriers needed to successfully manage chronic conditions. The program is offered in both English and Spanish in different community settings throughout the valley, including churches, senior centers and libraries. Last year, nearly 475 participants attended the program and reported overall improvement in six aspects of health self-management, including confidence in managing fatigue, discomfort, pain, emotional distress, and other symptoms.

- **Intermountain Healthcare, Salt Lake City, Utah**, created the Urban Central Region Low-Income Cancer Screening Initiative. Because no cancer screenings with follow-up were being offered through the county safety net, Intermountain provided cancer screenings to low-income and uninsured residents at Intermountain Healthcare Clinics. The screenings are staffed by the Intermountain School and Community Clinics, Intermountain Healthcare volunteers and the University of Utah School of Nurse Midwifery. Nurses follow up with results of each test and keep a log of all interventions and results. Since 2010, nearly 1,600 screenings have been provided to the community.

- **ProMedica, Toledo, Ohio**, addressed the link between hunger and poor health with Come to the Table, a community collaboration to ensure access to nutritious food among the underserved. Among its many programs, Come to the Table includes a food reclamation project and a hunger-screening program at ProMedica hospitals that provides food-insecure inpatients with an emergency supply of food and resources for further assistance. ProMedica has reclaimed more than 100,000 pounds of prepared but unserved food for area families. Employee food drives have raised more than 21,000 pounds of food, and ProMedica's Advocacy Fund has contributed more than $2 million to the community for food and other basic needs.

- **Samaritan Health Services, Corvallis, Ore.**, provides free, bilingual, culturally competent and age-appropriate care and screenings for pregnant women through the Samaritan Maternity Connection. Maternity care coordinators also offer social support by referring clients to GED programs at the local college, assisting with enrollment in food stamps and Medicaid, and making referrals to the community action agency for housing issues, county maternal child health programs and many other organizations. In 2013, more than 900 women and teenage girls were provided with prenatal risk assessments, screening and enrollment in Medicaid, referral to social services and counseling or treatment for alcohol, drug and tobacco use. Among program participants, the number of women delivering pre-term and low-birth weight babies decreased.

- **Mercy Health Muskegon, Muskegon, Mich.**, created Wheels of Mercy to bring health resources and screenings to hard-to-reach, low-income urban and rural communities. The program staffs two mobile service units that provide information, enrollment assistance and referrals. They also offer limited primary care screenings (diabetes, cholesterol, vision, hearing, pulmonary and blood pressure) and other community access programs. Targeted residents generally lack adequate health insurance and transportation that would enable them to access ongoing primary care, medications and behavioral health services. Since 2008, the program's 70 stops per year have reached 5,000 people annually. It has provided referrals and enrolled residents in Medicaid and other programs, and provided more than 1,600 screenings.

- **Catholic Health Initiatives (CHI), Englewood, Colo.**, launched United Against Violence in 2008 to help CHI facilities nationwide create or expand local violence-prevention programs. CHI's approach to violence prevention includes identification of violence-related initiatives; creation of community coalitions to leverage comprehensive, sustainable efforts to reduce violence; and development of a strategy, action plan and measurements. Since its formation, United Against Violence has received approximately $10 million in support from CHI. All of CHI's local health care organizations are working with their communities to achieve community-defined, sustainable violence-reduction goals by 2020. CHI's organizations have achieved significant, measurable reductions in child abuse in Roseburg, Ore.; violent crime in sections of Dayton, Ohio; and youth-on-youth violence in Reading, Pa.

- **Crozer-Keystone Health System, Springfield, Pa.,** responded to research showing a high incidence of risk-taking behaviors among young people in Chester and dismal high school graduation and college completion rates, by creating the Crozer Wellness Center. The center serves as an adolescent-focused primary care provider and operates an array of community-based youth leadership programs, as well as city-wide initiatives aimed at increasing opportunities for young people so they can become healthy, productive adults. Among the 100+ youth served per year in the youth leadership programs, there was a reduction in risk-taking behavior (substance abuse, violence, risky sexual behavior) and an increase in positive behavior (school attendance, on-time graduation, workforce skills and commitment to education, leadership and service). The training and technical assistance provided by the center to more than 20 youth-serving organizations improved services to more than 6,000 youth.

IRS IMPLEMENTATION

As the IRS plays a more active role in oversight of hospital activities in this area, it has assumed a regulatory role. However, the IRS frequently claims that its guidance is exempt from the notice-and-comment requirement of the Administrative Procedure Act (APA), and the agency has failed in the past to comply with the Paperwork Reduction Act.

The AHA has drafted a proposal (Attachment A) to ensure hospitals have the protection of these laws, which the committee should consider as part of any tax reform effort. A recent example is the IRS's sudden and unprecedented deviation from its decade's long position that medical and medically related research activities have counted as evidence of community benefit under the community benefit standard.

In December of 2013, the IRS suddenly eliminated research funded by grants from government and nonprofit sources (e.g., by the National Institute of Health (NIH)) from a hospital's calculation of the value of community benefit provided to its community. Now, hospitals must treat restricted research grants, which are those that specify what type of research is to be performed, as what is called "direct offsetting revenue," which effectively means that all such grants are excluded from hospitals' "community benefit" contribution.

This is no small matter. Restricted grants are central to medical research in this country. Every dollar expands the research in which institutions can engage. For example, NIH is the world's largest source of funding for medical research, and invests nearly $30.1 billion annually in medical research for the American people. More than 80 percent of that sizable budget funds third-party research, including by nonprofit hospitals. And this and all other NIH-supported research is funded primarily through what the IRS now labels restricted grants. This funding fuels important research into cancer, cardiovascular disease, diabetes, AIDS and scores of other health problems that confront our communities, nation and, indeed, the world.

Moreover, the exclusion of these grants results in a reduced and inaccurate picture of the actual community benefit provided by a hospital, which could confuse the public and trigger government audits, potentially imperiling the hospital's tax-exempt status.

The IRS made this unexpected about-face through a change in instructions to a form – the Form 990 Schedule H filed by hospitals – without any meaningful opportunity for hospitals to provide input. Worse still, the IRS applied the change retroactively to all of 2013, and finalized its rule reversal less than two weeks after issuing a draft of the new instructions, without a revenue ruling, notice-and-comment rulemaking, or any other formal procedures.

BACKGROUND

In 2006, the IRS began to revisit the community benefit standard. Responding to concerns that the standard was too flexible and open-ended – with, for example, no binding rules on how to measure or report community benefit activities – the IRS launched a study of nonprofit hospitals in an attempt to better understand how hospitals were meeting the standard (the Hospital Compliance Project). As part of this effort, the IRS embarked on a redesign of Form 990, the

form that tax-exempt organizations must file annually. The draft redesign required nonprofit organizations to submit schedules specific to the organization's type and activities. One of these draft schedules, Schedule H, was exclusively for nonprofit hospitals and required them to quantify and report their community benefit expenditures.

The IRS's draft of Schedule H asked hospitals to itemize their charity care, medical research, education and other types of community benefit expenditures. The draft schedule also included extensive instructions on how to complete the form, and called for hospitals to compute their community benefit expenditures as a percentage of their total expenses. *These instructions effectively functioned as a new rule delineating the IRS's position on which activities satisfied the community benefit standard (and, thus, supported tax-exempt status).*

Final instructions issued in August 2008, explicitly allowed expenses for research funded by restricted grants to count fully as community benefit expenditures. In highlighting changes from the draft instructions, the IRS explained that the final version "[c]larifies the organization may include . . . the cost of research that is funded by a tax-exempt or governmental entity . . . ." In addition, the final instructions to Schedule H unambiguously state that hospitals need not deduct (through "direct offsetting revenue") any "restricted or unrestricted grants or contributions that the organization uses to provide a community benefit."

Furthermore, in 2009, after Schedule H had been finalized, the IRS issued the Hospital Compliance Project final report. The report discusses medical research expenditures at length, and never suggests that such expenditures could be anything other than community benefit expenditures. The report does not even mention the question of whether research is funded by restricted or unrestricted grants.

That was not surprising. Under the instructions to Schedule H, as well as decades of prior practice, medical research funded by restricted grants counted as activity that promoted a community benefit. What would have been surprising was a suggestion to the contrary.

At the end of 2013, with no warning and no explanation, the IRS reversed its longstanding position on restricted grants. On Dec. 9, 2013, the IRS released a draft of Form 990 (including Schedule H) and the accompanying instructions for the 2013 tax year. Suddenly, without precedent, restricted research grants were to be treated differently by no longer being counted toward community benefit.

Despite the magnitude of this reversal, hospitals had no meaningful opportunity to raise their concerns with the IRS. Although the IRS *permitted* comments on the draft form (as the IRS does with all draft forms), the agency gave no deadline for comments. And just eleven days after releasing the draft form, on December 20, 2013, the IRS issued a final form and instructions adopting the change, and discarding decades of precedent on the treatment of research grants. The IRS did not explain the change in the instructions or any accompanying statement, nor did the agency even highlight the change in the "What's New" section of the instructions.

Notwithstanding the IRS's apparent efforts to avoid attention, affected parties quickly noticed the change. On Dec. 26, 2013, just 17 days after the draft was issued, the AHA, Healthcare

Financial Management Association and Association of American Medical Colleges submitted comments expressing great concern about the draft form – not only regarding the change on restricted grants, but also on another, unrelated change. In response, the IRS promptly revised the latter change, issuing a corrected version of the instructions on Jan. 15, 2014. The agency, however, did not even respond to the comments on the change regarding restricted grants. As a result, for the 2013 tax year, research grants – for the first time in the history of the community benefit standard – will not be counted as community benefit.

The AHA recently filed an amicus brief in the Supreme Court detailing the IRS's longstanding position and its peremptory reversal through an unannounced change in forms on the website (Attachment A).

AHA PROPOSAL

We urge you to enact legislation that would reverse the IRS's change in position and prevent this situation from reoccurring. We propose legislation be enacted to require the IRS to follow the notice and comment provisions of the APA when issuing forms and instructions.

Under the current provisions of the Internal Revenue Code related to the collection of information from tax-exempt organizations, the IRS may issue and materially amend the forms and instructions it uses to collect information from tax-exempt organizations without any notice to or comment from affected organizations, even if the forms and instructions impose new and burdensome requirements or make improvident changes such as discounting medical research The AHA believes it is imperative to rectify the IRS's lapse in process for revising forms and instructions or otherwise issuing informal guidance that binds tax-exempt organizations without any formal opportunity for input from them, such as in the example outlined above. Additionally, the legislation should ensure public participation and transparency in the IRS's process for issuing new or materially amended forms to collect information from tax-exempt organizations. (The legislative proposal is Attachment B.)

TAX-EXEMPT FINANCING

Meeting the health care demands of the future will require significant capital investment. Hospitals have put off major capital investments due to uncertainty about health care reform and future reimbursements. Consequently, the average age of plant for stand-alone hospitals has risen by almost a full year since 2006, to 10.5 years. Renovations, upgrades, investment in new technology and health information systems will be necessary to ensure the highest quality patient care. Raising capital at a reasonable cost is more difficult than ever for the majority of America's hospitals. Capital markets for non-profit hospitals still have not fully recovered from the 2008 financial meltdown. Three temporary federal financing options that helped ease the credit crunch expired in 2010.

Tax-exempt bonds reduce hospitals' borrowing costs because they normally can be sold at a lower rate of interest than can taxable debt of comparable risk and maturity. Non-profit hospital borrowers save, on average, an estimated two percentage points on their borrowing compared to

taxable bonds or bank financing. Lower borrowing costs translate into lower health care costs for patients. The lower cost of tax-exempt financing also makes possible necessary upgrades and modernizations that would not be possible for hospitals with weaker balance sheets. More costly alternatives, such as taxable bonds and bank loans, are out of reach for many community hospitals.

For many communities, tax-exempt financing has been the key to maintaining vital hospital services. Governments would otherwise be called upon to provide these necessary services. If that were the only alternative, the resulting increased borrowing cost to state and local governments would be borne by taxpayers and ratepayers in every local jurisdiction through the imposition of increased taxes and fees (e.g., *ad valorem* property taxes, special assessments, sales taxes, toll charges and utility rates) or through service cuts. These taxes or fees, including especially sales taxes, tolls or user fees, would fall disproportionately on lower- and middle-income households, as would service cuts.

If hospital access to tax-exempt financing is limited or eliminated entirely, the result could be devastating for both patients and their communities. The financial unraveling of a hospital has the potential to impact a community more profoundly than the unplanned closure of nearly any other institution. Patients will suffer as hospitals struggle to survive and slowly deteriorate. Prices will rise, equipment will wear down without being replaced, and physicians will leave. Ultimately, the health of the community will suffer. Furthermore, closure may result in reduced specialty services and overcrowding in hospital emergency departments, while patients may delay treatment if services are not readily available.

HOSPITAL FINANCIAL CONDITION

Moody's Investors Service is maintaining its negative outlook for the U.S. not-for-profit health care sector for 2015. The negative outlook reflects Moody's view that growth in operating cash flow will be weak, operating margins will continue to narrow, and revenue growth will remain limited. Moody's outlook has been negative since 2008, as the recession has left a lasting impact on hospital financial viability. The sector faces heightened pressure from all levels of government, as well as businesses, to lower the cost of health care services.

In the past five years alone, Medicare and Medicaid payments for hospital services have been slashed by more than $121.9 billion. These cuts are increasing the gap between Medicare payment to hospitals and the cost of delivering services to beneficiaries, as well as threatening the overall financial health of hospitals. In its March 2015 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) indicated that overall Medicare margins were negative 5.4 percent on average in 2013. The 2 percent sequester was in effect for roughly half of fiscal year (FY) 2013 and the full year in 2014, reducing 2014 payments relative to 2013 by almost 1 percentage point. Given the full-year effect of the sequester, it expected overall Medicare margins will decline slightly in 2014.

Even under this financial pressure, hospitals continue to be an economic mainstay for their communities. Hospitals directly employed nearly 5.6 million people in 2013 and are the second-

largest source of private-sector jobs. The $782 billion in goods and services hospitals purchased in 2013 from other businesses created additional economic value for their communities.

A hospital's ability to finance projects through tax-exempt bonds depends primarily on its credit rating, which is shorthand for its ability to access capital and the price at which it can borrow. A higher bond rating indicates a lower investment risk, which allows hospitals to pay a lower interest rate on the bonds. Even the slightest drop in bond rating – resulting in a slightly higher interest rate – may cost a hospital significantly more over the lifetime of a bond issue.

In 2009, 88 percent of hospitals reported that it was "more difficult or impossible to access capital from tax-exempt bonds" since the 2008 recession. Without capital expenditures, hospitals are unable to invest in new technology and equipment that benefits patients. They also may find it more difficult to recruit top physicians and other staff.

HEALTH CARE DELIVERY AND DEMOGRAPHICS

Aging baby boomers and an increasingly diverse population create demand for new and different services. The ACA's promise of expanded health insurance coverage will add to demand. Clinical procedures continue to evolve, as do diagnostic techniques and communication technologies.

Americans rely heavily on hospitals to provide 24/7 access to care for all types of patients, to serve as a safety-net provider for vulnerable populations and to have the resources and skills needed to respond to disasters. Emergency department visit volume has increased by nearly 26 percent since 2000, and will continue to grow.

Over the past 15 years, market, economic and regulatory forces have led hospitals and physicians to explore new ways to better align their interests and achieve greater integration in order to both reduce costs and improve the quality of care. With an eye on the future, hospitals across the country are in a constant state of renovation and improvement in order to provide the latest treatments and services to meet the increasing and changing needs of their communities.

Not only should access to tax-exempt financing be preserved, but present rules governing the use of tax-exempt proceeds should be updated to remove barriers to hospital compliance with new law in areas outside the tax code. Significant changes in the way in which government and private insurance companies reimburse hospitals (focusing on achieving prescribed quality measures) promote the alignment of interests between physicians and hospitals. These changes are intended to further the important public policy goals of more effective and affordable patient care. Major hurdles have arisen, however, in these attempts to implement innovative new hospital-physician arrangements as a result of limitations imposed on the use of tax-exempt bond financed facilities under Rev. Proc. 97-13. Further modifications to Rev. Proc. 97-13 are necessary if the goals of better integration and alignment of interests between hospitals and physicians are to be accomplished in light of the significant number of governmental and 501(c)(3) health care facilities that have been financed with tax exempt bonds.

Yet even with these increasing demands, the growth in spending on hospital care is at historic lows. This leveling of growth is evident across Medicare, Medicaid and private payers. The Congressional Budget Office recently revised its future projection of Medicare spending downward by $169 billion for the next decade. Growth in premium levels for employee health benefits are half of what they were in 2011, as new benefit care models begin to take hold.

DIRECT PAY BONDS

A variety of proposals have been made to restrict or alter tax-exempt financing mechanisms. One example is direct pay bonds, such as Build America Bonds (BABs). While these bonds were not available to nonprofits, some hospitals issued BABs when they were available. While the detail of any new proposals would need review, the AHA generally supports direct pay programs if they are designed with subsidies adequate to result in a financial instrument whose total costs are comparable with a tax-exempt bond. Should BABs be reinstated, eligibility should be expanded to private 501(c)(3) institutions. However, if continuity of federal subsidy payments is unreliable, as demonstrated under the recent sequestration order, direct pay bonds will not be a dependable budget and planning tool to lower borrowing costs. The committee should consider direct pay bonds and other proposals as complements, and not alternatives, to tax-exempt bonds.

TAX-EXEMPT FINANCING SHOULD BE MAINTAINED

At a time when hospital revenues are already strained, hospitals must respond to rapidly changing market and government forces, including: (1) reimbursement reductions and changes; (2) an increasing necessity to provide access to a broad range of health services to a growing population; and (3) limited access to capital. These market forces are driving an urgent need for hospitals to make significant capital investments while reducing costs, both of which require continued access to low-cost capital through tax-exempt financing. The AHA strongly recommends retention of the current law exemption from income for tax-exempt bond interest.

DEDUCTIBILITY OF CHARITABLE CONTRIBUTIONS

Hospitals recognize the responsibilities that come with tax-exemption and fully appreciate its benefits. One important benefit is the ability to attract community investment through tax-deductible giving. Hospitals are the backbone of the communities they serve, and people in those communities recognize their importance through generous philanthropic giving. In FY 2011, philanthropic support for nonprofit hospitals and health care organizations reached $8.9 billion, according to the Association of Healthcare Philanthropy (AHP). Needed construction and renovation projects receive almost a quarter of philanthropic dollars, but many hospitals rely on funds raised from community partners simply to meet operating expenses, allocating on average more than 15 percent of the funds they raise to general operations.

Philanthropic giving also is increasingly important as a source of capital financing as hospitals change to meet the health care needs of the future. Hospitals that are under significant financial strain — not profitable, not liquid and with a significant debt burden — often are shut out of traditional capital markets. They have a limited number of capital sources and incur higher costs

than hospitals with a brighter financial picture. For these hospitals, philanthropy is essential to finance the necessary facility upgrades and investments in information technology required if they are to continue to provide high-quality health care services in their communities. Community support for hospitals is strong, but incentives are necessary to retain this critical support. The AHA is concerned that, in an environment where hospitals rely increasingly on charitable giving, limiting or eliminating the current charitable contribution deduction would reduce the availability of resources that are critical to fund hospital operations. The most recent AHP survey of hospital and health care development professionals found that nine out of 10 agreed that proposed limits on charitable deductions would result in significant reductions in giving to their organizations. About 40 percent estimate that giving would decrease between 10 and 30 percent if significant changes are made to the current tax incentives for charitable donations, which conservatively could amount to a decrease of more than a $1.07 billion in total annual giving to nonprofit hospitals and health care providers, based on AHP's FY 2009 giving statistics.

We urge you to continue to encourage private giving by excluding charitable giving from any limitations on deductions and maintaining the existing federal tax charitable deduction.

CONCLUSION

America's hospitals are always open, serving their communities 24 hours a day, seven days a week, 365 days a year. As hospitals face new challenges to maintaining access to high-quality care to everyone who needs it, they need the support they find from generous members of the communities they serve now more than ever. As the committee engages in the important work of reforming the nation's tax code, we urge you to retain current tax code incentives for the provision of health care that continue to work to provide access to hospital services in communities large and small across the country.

(ATTACHMENT A)

Nos. 13-1041, 13-1052

IN THE

Supreme Court of the United States

THOMAS E. PEREZ, SECRETARY OF LABOR, ET AL.,
Petitioners,

v.

MORTGAGE BANKERS ASSOCIATION,
Respondent.

JEROME NICKOLS, RYAN HENRY, AND BEVERLY BUCK,
Petitioners,

v.

MORTGAGE BANKERS ASSOCIATION,
Respondent.

On Writs of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, AND HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION AS *AMICI CURIAE* SUPPORTING RESPONDENT

MELINDA REID HATTON
MAUREEN MUDRON
AMERICAN HOSPITAL ASSOCIATION
Two CityCenter, Suite 700
800 10th Street, N.W.
Washington, D.C. 20001

(Additional counsel listed on inside front cover)

BETH HEIFETZ
Counsel of Record
CATHERINE E. LIVINGSTON
RAJEEV MUTTREJA
JONES DAY
51 Louisiana Avenue, N.W.
Washington, D.C. 20001
202.879.3939
bheifetz@jonesday.com
Counsel for Amici Curiae

FRANK TRINITY
IVY BAER
ASSOCIATION OF AMERICAN
MEDICAL COLLEGES
Suite 100
655 K Street, N.W.
Washington, D.C. 20001

JAMES LANDMAN
HEALTHCARE FINANCIAL
MANAGEMENT ASSOCIATION
Suite 900
1825 K Street, N.W.
Washington, D.C. 20006

Additional Counsel for Amici Curiae

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES iii

STATEMENT OF INTEREST 1

INTRODUCTION AND SUMMARY OF THE ARGUMENT 2

ARGUMENT 6

AFTER DECADES OF CONSISTENT PRACTICE ON HOW NONPROFIT RESEARCH HOSPITALS CAN QUALIFY FOR OR CONFIRM TAX EXEMPTION, THE IRS RECENTLY AND RETROACTIVELY REVERSED ITS POLICY THROUGH AN INTERPRETIVE RULE. 9

A. For Decades, IRS Revenue Rulings Have Governed Tax Exemption for Nonprofit Hospitals and Recognized the Relevance of All Medical Research, Regardless of Funding Source. 10

B. In 2008, After Seeking Public Comments on the Community Benefit Standard, the IRS Reconfirmed the Relevance of All Medical Research Regardless of Funding Source. 12

C. In December 2013, the IRS Changed Its Rule on Medical Research Expenditures Retroactively, Without Notice, Explanation, or Relief for Past Reliance. 16

TABLE OF CONTENTS
(continued)

Page

CONCLUSION 20

TABLE OF AUTHORITIES

Page(s)

CASES

City of Richmond v. Richmond Mem'l Hosp., 116 S.E.2d 79 (Va. 1960) 11

Commissioner v. Schleier, 515 U.S. 323 (1995) 10

Paralyzed Veterans of Am. v. D.C. Arena L.P., 117 F.3d 579 (D.C. Cir. 1997) 4

Simon v. E. Ky. Welfare Rights Org., 426 U.S. 26 (1976) 10

STATUTES

5 U.S.C. § 551(4) 5

5 U.S.C. § 553(b) 5

IRC § 501(a) 10

IRC § 501(c)(3) 10

IRC § 6104(b) 13

IRC § 6652(c) 18

OTHER AUTHORITIES

2008 Schedule H (Form 990) Instructions – Draft, April 7, 2008 ..... 15, 17

TABLE OF AUTHORITIES
(continued)

Page(s)

About NIH, http://www.nih.gov/about 7

Announcement 92-83, 1992-22 I.R.B. 59 12

Background Paper, Changes to April Draft Instructions, August 19, 2008..... 15

Robert Bromberg, Tax Planning for Hospitals (1977) 11

Christopher Quay, Changes, New Schedule to Draft Redesign Form 990 Coming, Official Says, Tax Notes Today, Nov. 19, 2007 14

Charles Moore, Ebola Treatment Target of $28 Million NIH Award, BioNews Texas (Mar. 24, 2014)..... 8

Congressional Research Service, Brief History of NIH Funding: Fact Sheet (Dec. 23, 2013) 7

Douglas M. Mancino, "The Charity Care Conundrum for Tax-Exempt Hospitals," Taxation of Exempts, July/August 2008 10

Glossary of NIH Terms, http://www.grants.nih.gov/grants/glossary.htm 7

TABLE OF AUTHORITIES
(continued)

Page(s)

GuideStar Home Page, http://www.guidestar.org 13

Hospital Compliance Project, Final Report, Appendix B 12, 15

Internal Revenue Manual (Aug. 11, 2004) 10

Internal Revenue Service, Overview of Form 990 Redesign For Tax Year 2008 (Dec. 20, 2007) 14

IRS Exempt Organizations (TE/GE), Hospital Compliance Project, Final Report, Appendix B 12

IRS, Instructions for Schedule H (Form 990) 17

IRS Tax-Exempt Organizations, Background Paper: Redesigned Draft Form 990, June 14, 2007 ..... 13, 14

NIH Budget, http://www.nih.gov/about/budget.htm 7

NIH Grants Policy Statement, http://grants.nih.gov/grants/policy/nihgps_2013/index.htm 7

TABLE OF AUTHORITIES
(continued)

Page(s)

NIH Research Portfolio Online Reporting Tools, http://project reporter. nih.gov/reporter.cfm 7

Our Health, http://www.nih.gov/about/ impact/health.htm..... 7

Press Release, IRS Releases Discussion Draft of Redesigned Form 990 for Tax-Exempt Organizations, IR 2007-117 (June 14, 2007) 14

Press Release, NIH Grant to Support Mount Sinai Research Program to Create Biological Network Model of Alzheimer's Disease in Partnership with New York Stem Cell Foundation (Sept. 18, 2013)..... 8

Press Release, TGen, Barrow Neurological Institute and Phoenix Children's Hospital Receive $4 Million Grant to Study Genetic Basis of Brain Injuries (Dec. 4, 2013)..... 8

Press Release, University of Chicago Medicine and Advocate Children's Hospital Receive $1.2 Million NIH Grant to Establish the First Type 1 Diabetes TrialNet Center in Chicago (Aug. 12, 2014)..... 8

Rev. Rul. 56-185, 1956-1 C.B. 202 11

TABLE OF AUTHORITIES
(continued)

Page(s)

Rev. Rul. 69-545, 1969-2 C.B. 117 11

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

Treas. Reg. § 601.601(d)(2)(i)(a) 10

STATEMENT OF INTEREST[1]

The American Hospital Association, Association of American Medical Colleges, and Healthcare Financial Management Association respectfully submit this brief as *amici curiae.*

The American Hospital Association (AHA) represents nearly 5,000 hospitals, health systems, and other health care organizations, plus 43,000 individual members. AHA members are committed to improving the health of the communities they serve and to helping ensure that care is available to, and affordable for, all Americans. The AHA educates its members on health care issues and advocates to ensure that their perspectives are considered in formulating health care policy.

The Association of American Medical Colleges (AAMC) is a nonprofit educational association whose members include all 141 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems; and 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 83,000 medical students, and 110,000 resident physicians. Founded in 1876, the AAMC, through its many programs and services, strengthens the world's most advanced medical care by supporting the entire spectrum of education, research, and patient care activities conducted by its

---

[1] The parties have consented to the filing of this brief. No counsel for any party authored this brief in whole or in part, no such counsel or party made a monetary contribution to fund the preparation or submission of this brief, and no one other than the *amici curiae* and their counsel made any such monetary contribution.

member institutions. The AAMC's mission is to serve and lead the academic medicine community to improve the health of all.

The Healthcare Financial Management Association (HFMA) is the nation's leading membership organization for more than 40,000 healthcare financial management professionals. Its members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies. As part of its education, information, and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices, and standards.

Amici have a specific interest in this case because their members are subject to the wide variety of interpretive rules issued by federal agencies, including the Internal Revenue Service (IRS). These rules affect *amici*'s members significantly—and often depart dramatically from Petitioners' overly modest portrayal of the nature and purpose of interpretive rules. AHA, AAMC, and HFMA accordingly wish to illustrate both the breadth of agency action that may be implicated by this Court's ruling, as well as how agencies vary in their handling of such rules.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

Petitioners paint an exceedingly narrow picture of interpretive rules, under which such rules play only an ancillary role in an agency's regulatory agenda.

Under Petitioners' accounts, an agency's real work is done via legislative rules, which are promulgated through formal notice-and-comment procedures and bind citizens with "the force and effect of law." *E.g.*, Fed. Petitioners' Br. at 11. Interpretive rules, as Petitioners put it, function "simply to inform the public about the agency's own views on the meaning of relevant statutory and regulatory provisions." *Id.* at 21; *see also, e.g.*, Private Petitioners' Br. at 51 ("[I]nterpretive rules *merely reflect* the agency's present belief concerning the meaning of the statutes and regulations administered by the agency") (emphasis added) (internal quotation marks and brackets omitted).

Under this view, there is no actual need for interpretive rules. Such rules are more informative than regulatory: They are merely a way by which agencies provide optional insight into their thinking. *See, e.g.*, Fed. Petitioners' Br. at 24 ("Precluding an agency from publicly announcing an interpretive rule does not alter the agency's expert understanding of its legislative regulations."). According to Petitioners, then, the rule invoked below by the D.C. Circuit wrongly "requires an agency to undertake notice-and-comment rulemaking *simply to explain to the public* that the agency has corrected or revised its previous legal interpretation of a regulation in some significant way—even if no one has ever relied on the prior interpretation." *Id.* at 14 (emphasis added).

But Petitioners offer far too modest an account of agency action taken without notice-and-comment procedures. Agency action undertaken as an interpretive rule does much more than "simply explain to the public" how the agency understands

the law. Such action can and does impose real change on regulated entities, change that can be a wholesale reversal of longstanding agency policy, including policy originally adopted through more formal procedures.

Moreover, although Petitioners emphasize that the D.C. Circuit's *Paralyzed Veterans* doctrine can require notice-and-comment procedures to revise a rule when such procedures are not needed to issue the rule in the first instance, *see, e.g.*, Private Petitioners' Br. at 5 (discussing *Paralyzed Veterans of Am. v. D.C. Arena L.P.*, 117 F.3d 579 (D.C. Cir. 1997)), agencies often *choose* to use procedures more formal than needed for issuance. To the extent there is anything anomalous about the D.C. Circuit's rule, then, the opposite rule would be equally irregular: agencies that solicited and accounted for the public's comments when issuing a rule could revise or revoke the rule on a moment's notice, with no public input at all.

This concern is not just hypothetical—as *amici*'s members can attest. As described below, the IRS recently revised its longstanding position on how to demonstrate whether nonprofit hospitals qualify for tax-exempt status. For decades, under the "community benefit" standard, medical and medically related research activities counted as evidence of community benefit regardless of whether the research was funded by restricted (i.e., funds given for specific research) or unrestricted grants. In 2013, however, the IRS summarily reversed its long-held position. Now, hospitals must treat restricted research grants as what is called "direct offsetting revenue," which effectively means that such grants

are excluded from hospitals' "community benefit" contribution. This results in a reduced and inaccurate picture of the actual "community benefit" provided by a hospital. The IRS accomplished this very significant policy reversal—having reconfirmed the policy just a few years earlier following a public comment period—through a revision to the *instructions* for a tax form in December 2013.[2] Worse still, the IRS is applying the change retroactively to all of 2013, and finalized its rule reversal less than two weeks after issuing a draft of the new instructions, without ever once explaining the change or taking account of the impact on and views of affected parties.

This unexpected about-face departs dramatically from Petitioners' paradigm for revised interpretive rules. Far from this being the IRS "merely" keeping the public informed about how it is applying the law, this rule directly changes how hospitals must calculate their "community benefit" on IRS tax forms. Moreover, the IRS's precipitous decision to jettison the old rule directly and adversely impacts hospitals that provide a share of their "community benefit" through medical or related research. It will now appear (erroneously) to communities, local, state, and even federal officials as a retrenchment in these hospitals' commitment to community benefit, which

---

[2] The instructions appear to be an "interpretive rule" under the APA, as they constitute "an agency statement of general or particular applicability and future effect designed to . . . interpret . . . law or policy," 5 U.S.C. § 551(4)—here, what the term "charitable" means for a hospital. But even if the instructions might be classified differently (e.g., as a "rule[] of agency organization, procedure, or practice," under 5 U.S.C. § 553(b)(3)(A)), they nonetheless are binding on hospitals.

could confuse the public and trigger government audits, potentially imperiling hospitals' tax-exempt status.

Yet the agency's fundamental change to what constitutes "community benefit" was accomplished without formal notice and comment. This dramatically illustrates that agencies can and do effect significant change through all kinds of actions short of notice-and-comment rulemaking. Interpretative rule changes are thus not always as modest as Petitioners suggest—and can vary significantly in their impact and implementation.

ARGUMENT

The IRS's recent reversal on what constitutes hospitals' "community benefit" is an example of a significant change in agency position implemented through an interpretive rule—here, a revision of an instruction for completing a form.

For nearly a half century, nonprofit hospitals have been able to treat medical research activities, regardless of whether funded by restricted or unrestricted grants, as a "community benefit" when seeking or confirming tax-exempt status. In 2008, the IRS confirmed that very point after soliciting and accounting for public comments and conducting an extensive examination of the issue. But in 2013, by revising an instruction to a tax form, the IRS abruptly and with no notice reversed course. Now, for the first time—and in stark contrast with decades of past practice—the IRS will not treat medical research funded through restricted grants as a "community benefit." Restricted grants are those in which the project or activity to be undertaken is

specified, e.g., a grant to study some aspect of breast cancer.

This is no small matter. Restricted grants are central to medical research in this country. Every dollar expands the research in which institutions can engage. For example, the National Institutes of Health (NIH) is the world's "largest source of funding for medical research," and "invests nearly $30.1 billion annually in medical research for the American people." About NIH, http://www.nih.gov/about;[3] NIH Budget, http://www.nih.gov/about/budget.htm; *see also* Congressional Research Service, Brief History of NIH Funding: Fact Sheet (Dec. 23, 2013). Over 80% of that sizable budget funds third-party research, including by nonprofit hospitals. *See id.* Indeed, in 2013, the ten hospitals that received the most NIH funds were all nonprofit hospitals, and together received over $1 billion in grants.[4] And this and all other NIH-supported research is funded primarily through what the IRS now labels restricted grants.[5]

This funding fuels important research into cancer, cardiovascular disease, diabetes, AIDS, and scores of other health problems confronting our communities, nation, and, indeed, the world. *See, e.g.*, Our Health,

---

[3] This and all other websites cited in this brief were last visited on October 13, 2014.

[4] These and other statistics on NIH grants are available from the NIH RePORT database. *See* NIH Research Portfolio Online Reporting Tools, http://projectreporter.nih.gov/reporter.cfm.

[5] *See* NIH Grants Policy Statement, http://grants.nih.gov/grants/policy/nihgps_2013/index.htm; Glossary of NIH Terms, http://www.grants.nih.gov/grants/glossary.htm (defining a "grant" as focused on "an approved project or activity").

http://www.nih.gov/about/impact/health.htm. For example—and to pick only a tiny sampling of the enormous body of NIH-funded research—the NIH recently funded projects to find new ways to delay and prevent type 1 diabetes,[6] to develop treatments for the Ebola virus,[7] to identify potential cellular and molecular targets for Alzheimer's disease therapies,[8] and to improve the prompt detection of severe brain injuries.[9]

The sea change in IRS policy on restricted grants has immediate ramifications for nonprofit research hospitals. These hospitals' reported community benefit expenditures will decline, often quite

---

[6] Press Release, University of Chicago Medicine and Advocate Children's Hospital Receive $1.2 Million NIH Grant to Establish the First Type 1 Diabetes TrialNet Center in Chicago (Aug. 12, 2014), *available at* http://www.uchospitals.edu/news/2014/20140812-diabetes.html.

[7] Charles Moore, Ebola Treatment Target of $28 Million NIH Award, BioNews Texas (Mar. 24, 2014), *available at* http://bionews-tx.com/news/2014/03/24/ebola-treatment-target-28-million-nih-award.

[8] Press Release, NIH Grant to Support Mount Sinai Research Program to Create Biological Network Model of Alzheimer's Disease in Partnership with New York Stem Cell Foundation (Sept. 18, 2013), *available at* http://www.mountsinai.org/about-us/newsroom/press-releases/nih-grant-to-support-mount-sinai-research-program-to-create-biological-network-model-of-alzheimers-disease-in-partnership-with-new-york-stem-cell-foundation.

[9] Press Release, TGen, Barrow Neurological Institute and Phoenix Children's Hospital Receive $4 Million Grant to Study Genetic Basis of Brain Injuries (Dec. 4, 2013), *available at* https://www.tgen.org/home/news/2013-media-releases/$4-million-nih-grant-to-tgen-barrow-pch-to-study-brain-injuries.aspx.

precipitously, and perhaps enough to trigger audits. And federal law requires nonprofit hospitals' tax forms to be made public, both by the IRS and by the hospitals themselves—such that a sudden drop in community benefit expenditures will confuse the public and invite government scrutiny into research hospitals' tax-exempt status. These hospitals' standing may also needlessly suffer with Congress, for whom IRS tax forms are the primary source of standardized information on community benefit activities. Hospitals support transparency and welcome review of the *full* picture of their community benefit.

Instead, however, the IRS's recent revision to the instructions of a tax form has upended the regulatory landscape for nonprofit research hospitals, and could very well imperil the tax-exempt status of these hospitals. What follows below is a description of the agency's actions in this area over the course of nearly 50 years, vividly illustrating that even small, interpretive agency action can and does effect fundamental change.

AFTER DECADES OF CONSISTENT PRACTICE ON HOW NONPROFIT RESEARCH HOSPITALS CAN QUALIFY FOR OR CONFIRM TAX EXEMPTION, THE IRS RECENTLY AND RETROACTIVELY REVERSED ITS POLICY THROUGH AN INTERPRETIVE RULE.

Although nonprofit hospitals have long been exempt from income taxation, the Internal Revenue Code (the "IRC" or "Code") does not explicitly grant an exemption for hospitals. The Code does, however, provide exemptions to certain charitable

organizations. *See* IRC §§ 501(a), 501(c)(3). Since the inception of the federal income tax, nonprofit hospitals have qualified for this exemption. *See, e.g.*, Douglas M. Mancino, "The Charity Care Conundrum for Tax-Exempt Hospitals," Taxation of Exempts, July/August 2008. Whether a nonprofit hospital is charitable (and, in turn, tax-exempt) "is determined on a case-by-case basis by the IRS." *Simon v. E. Ky. Welfare Rights Org.*, 426 U.S. 26, 29 (1976). Exactly how the IRS goes about this "case-by-case" process has evolved over time, and has long involved interpretive rules.

A. For Decades, IRS Revenue Rulings Have Governed Tax Exemption for Nonprofit Hospitals and Recognized the Relevance of All Medical Research, Regardless of Funding Source.

The IRS first tackled hospital tax exemption in 1956, with a revenue ruling. A revenue ruling is an "interpretive ruling[]" by the IRS that lacks "the force and effect of regulations." *Commissioner v. Schleier*, 515 U.S. 323, 336 n.8 (1995). Nonetheless, a revenue ruling stands as "*an official interpretation* by the [IRS] of the Internal Revenue Code, related statutes, tax treaties, and regulations," announcing "the conclusion of the Service on how the law is applied to a specific set of facts." Internal Revenue Manual 32.2.2.3.1 (Aug. 11, 2004) (emphasis added); *see also* Treas. Reg. § 601.601(d)(2)(i)(a). In this 1956 revenue ruling, the IRS held that a hospital may be tax-exempt if it is operated "to the extent of its financial ability for those not able to pay for the services rendered," as opposed to being operated

"exclusively for those who are able and expected to pay." Rev. Rul. 56-185, 1956-1 C.B. 202.

In part due to difficulties applying this "financial ability" standard, however, the IRS revised its rule in 1969. *See, e.g.*, Robert Bromberg, Tax Planning for Hospitals, pp. 7-26 to 7-27 (1977). Through a new revenue ruling that remains in effect today, the agency announced what came to be known as the "community benefit" standard for hospital tax exemption. *See* Rev. Rul. 69-545, 1969-2 C.B. 117. The agency explained that "the promotion of health is considered to be a charitable purpose," and that a hospital qualifies as "charitable" when its "promotion of health" provides "benefit to the community." *Id.* Although this standard ultimately turns on the totality of the circumstances, the IRS specifically treated medical research as a community benefit, noting that a hospital "operate[s] in furtherance of its exempt purposes" when it "advance[s] its medical training, education and research programs." *Id.*[10]

In 1983, the IRS returned to the issue, and reiterated that hospitals could meet the community benefit standard through medical research and education. Rev. Rul. 83-157, 1983-2 C.B. 94.

These two revenue rulings, from 1969 and 1983, remained the leading authorities on the community benefit standard for over two more decades. Indeed,

[10] In the years before the IRS confirmed that hospitals that benefit the community as a whole qualify as charitable entities, the Virginia Supreme Court reached a similar conclusion. *See City of Richmond v. Richmond Mem'l Hosp.*, 116 S.E.2d 79, 84 (Va. 1960) ("Non-profit hospitals which are devoted to the care of the sick, which aid in maintaining public health, and contribute to the advancement of medical science, are and should be regarded as charities.").

in 1992, the IRS issued guidelines emphasizing that agents applying the community benefit standard should consider all of the factors cited in the two rulings, which included the use of funds on medical research. Announcement 92-83, 1992-22 I.R.B. 59. At no point in this long history did the IRS ever suggest that it mattered *how* a hospital funded its medical research—i.e., whether through restricted grants or other means.

B. In 2008, After Seeking Public Comments on the Community Benefit Standard, the IRS Reconfirmed the Relevance of All Medical Research Regardless of Funding Source.

In 2006, the IRS began to revisit the community benefit standard. Responding to concerns that the standard was too flexible and open-ended—with, for example, no binding rules on how to measure or report community benefit activities—the IRS launched a study of nonprofit hospitals in an attempt to better understand how hospitals were meeting the standard.

As part of this "Hospital Compliance Project," the agency sent questionnaires to hundreds of hospitals asking about their community benefit activities and expenditures. That questionnaire asked nine questions about hospitals' medical research, including whether the research was funded through public or private sources. *See* IRS Exempt Organizations (TE/GE), Hospital Compliance Project, Final Report, Appendix B, *available at* http://www.irs.gov/pub/irs-tege/frepthospproj.pdf. The agency did *not* ask whether the funding was limited to specific projects (i.e., through restricted grants). *See id.*

While the Hospital Compliance Project was underway, the IRS embarked on a redesign of Form 990, the form that tax-exempt organizations must file annually. The draft redesign required nonprofit organizations to submit schedules specific to the organization's type and activities. IRS, Tax-Exempt and Government Entities Division, Exempt Organizations, Background Paper: Redesigned Draft Form 990, June 14, 2007 ("Background Paper"). One of these draft schedules, Schedule H, was exclusively for nonprofit hospitals and required them to quantify and report their community benefit expenditures.

The IRS's draft of Schedule H asked hospitals to itemize their charity care, medical research, education, and other types of community benefit expenditures. The draft schedule also included extensive instructions on how to complete the form, and called for hospitals to compute their community benefit expenditures as a percentage of their total expenses. These instructions effectively functioned as a new rule delineating the IRS's position on which activities satisfied the community benefit standard (and thus supported tax-exempt status).

The IRS recognized the importance of these (and its other) changes to Form 990. Unlike most other tax forms, Form 990 must be made publicly available, both by the IRS and the nonprofit organization. *See* IRC § 6104(b).[11] The form therefore gives the public insight into how a nonprofit organization pursues its mission and complies with tax laws. Acknowledging, then, that a redesigned Form 990 not only could add

---

[11] In addition, the nonprofit organization GuideStar USA, Inc. compiles these forms and makes them available online. *See* GuideStar Home Page, http://www.guidestar.org.

significant administrative burdens and be highly consequential to nonprofit organizations' tax status, but also could impact these organizations' public stature, the IRS solicited public comments on a draft of the new form. *See* Press Release, IRS Releases Discussion Draft of Redesigned Form 990 for Tax-Exempt Organizations, IR 2007-117 (June 14, 2007).

The IRS took particular interest in "the reporting of community benefit by hospitals in Schedule H," seeking input on this specific issue as part of its more general request for comments. Background Paper, *supra*, at 5. The public shared the agency's interest, both in Form 990 and in Schedule H in particular. The IRS received approximately 700 public comments on the draft form,[12] and more comments on Schedule H than on any other part of the draft. *See* Christopher Quay, Changes, New Schedule to Draft Redesign Form 990 Coming, Official Says, Tax Notes Today, November 19, 2007. IRS officials said publicly that many hospitals expressed concern with how the draft form solicited information on community benefits.

After considering the many comments as well as information from the ongoing Hospital Compliance Project, the IRS issued draft instructions for Schedule H in April 2008. These draft instructions included 10 pages and 8 worksheets explaining which expenditures counted as promoting the community's health and thus as a "community benefit." Of

---

[12] Internal Revenue Service, Overview of Form 990 Redesign For Tax Year 2008 (Dec. 20, 2007), *available at* http://www.irs.gov/pub/irs-tege/overview__form__990__redesign.pdf.

particular note, one of the worksheets focused on medical research activities.

This worksheet's instructions permitted hospitals to claim credit for "the cost of internally-funded research, as well as the cost of research funded by a tax-exempt or government entity"—without further regard to how the research was funded. Moreover, the IRS emphasized when issuing the draft instructions that unrestricted and restricted grants would be treated identically. *See* 2008 Schedule H (Form 990) Instructions – Draft, April 7, 2008 ("The Part I Table and Worksheets do not require that grants restricted for community benefit activities be deducted from the grantee organization's gross community benefit expenses in determining its net community benefit expenses."). As with the draft of Schedule H, the IRS solicited public comments for the draft instructions as well.

When the final instructions were issued in August 2008, the IRS reiterated even more explicitly that expenses for research funded by restricted grants count fully as community benefit expenditures. In highlighting changes from the draft instructions, the IRS explained that the final version "[c]larifies the organization may include . . . the cost of research that is funded by a tax-exempt or governmental entity . . . ." Background Paper, Changes to April Draft Instructions at 6, August 19, 2008. In addition, the final instructions to Schedule H unambiguously state that hospitals need not deduct (through "direct offsetting revenue") any "restricted or unrestricted grants or contributions that the organizations uses to provide a community benefit."

In 2009, after Schedule H had been finalized, the Hospital Compliance Project issued its final report. *See* Hospital Compliance Project, Final Report, *supra*. The report discusses medical research expenditures at length, and never suggests that such expenditures could be anything other than community benefit expenditures. The report does not even mention the question of whether research is funded by restricted or unrestricted grants.

That was not surprising. Under the instructions to Schedule H, as well as decades of prior practice, medical research funded by restricted grants counted as activity that promoted a community benefit. What would have been surprising was a suggestion to the contrary.

C. In December 2013, the IRS Changed Its Rule on Medical Research Expenditures Retroactively, Without Notice, Explanation, or Relief for Past Reliance.

At the end of 2013, with no warning and no explanation, the IRS reversed its longstanding position on restricted grants. On December 9, 2013, the IRS released a draft of Form 990 (including Schedule H) and the accompanying instructions for the 2013 tax year. Suddenly, without precedent, restricted research grants were to be treated differently by no longer being counted toward community benefit.

The draft instructions discarded the rule that had been reconfirmed after the prior notice-and-comment process, under which "direct offsetting revenue" did *not* include any "restricted or unrestricted grants or contributions that the organizations uses to provide a community benefit." Now, the instructions stated

that "direct offsetting revenue" *did* include "restricted grants or contributions that the organization uses to provide a community benefit, such as a restricted grant to provide financial assistance or fund research." In other words, hospitals could no longer claim credit for restricted grants.[13] Coming in December of the tax year at issue, this change was proposed too late for nonprofit hospitals to adjust their research and other activities so as to maintain their prior levels of community benefit expenditures.

Nor did hospitals have any meaningful opportunity to raise their concerns with the IRS. Although the IRS permitted comments on the draft form (as the IRS does with all draft forms), the agency gave no deadline for comments. And just *eleven* days after releasing the draft form, on December 20, 2013, the IRS issued a final form and instructions adopting the change, and discarding decades of precedent on the treatment of research grants. The IRS did not explain the change in the instructions or any accompanying statement, nor did the agency even highlight the change in the "What's New" section of the instructions.

Notwithstanding the IRS's apparent efforts to avoid attention, affected parties quickly noticed the change. On December 26, 2013, just 17 days after the draft was issued, the AHA, HFMA, and AAMC submitted comments expressing great concern about the draft form—not only regarding the change on restricted grants, but also on another, unrelated

---

[13] Hospitals are still able to claim credit for "unrestricted grants or contributions that the organization uses to provide a community benefit." IRS, Instructions for Schedule H (Form 990) at 3.

change. In response, the IRS promptly revised the latter change, issuing a corrected version of the instructions on January 15, 2014. The agency, however, did not even respond to the comments on the change regarding restricted grants.

As a result, for the 2013 tax year, restricted grants—for the first time in the history of the community benefit standard—will be treated differently from unrestricted grants. Buried in the revised instructions to a form, this reversal of the IRS's position was not the subject of a revenue ruling, notice-and-comment rulemaking, or any other of the more formal procedures regularly used by the IRS.

The IRS's use of an interpretive rule is a far cry from the picture Petitioners paint of such rules and their function. *See, e.g.*, Fed. Petitioners' Br. at 21 (stating that interpretive rules exist "*simply to inform* the public about the agency's own views on the meaning of relevant statutory and regulatory provisions" (emphasis added)); Private Petitioners' Br. at 51 ("[I]nterpretive rules *merely reflect* the agency's present belief concerning the meaning of the statutes and regulations administered by the agency" (emphasis added) (internal quotation marks and brackets omitted)). The IRS employs interpretive rules (which include changes to tax form instructions) to directly regulate taxpayers, including nonprofit hospitals. And when the IRS revises these rules, it is thus doing much more than "simply explaining" that it "has corrected or revised its previous legal interpretation of a regulation in some significant way," to ensure the public is not "misled" while the agency abides by a different understanding. Fed.

Petitioners' Br. at 14. The IRS is, instead, changing how tax law *operates*.[14]

Moreover, when the IRS revises an interpretive rule, it is rare that "no one has ever relied on the prior interpretation." *Id.* Nevertheless, the IRS has not hesitated to disregard such reliance and to retroactively erase a decades-old position with just days of notice, without any explanation or prior announcement. These changes affect the regulated parties directly and significantly—as, unfortunately, many nonprofit hospitals have experienced first-hand.

[14] Indeed, a hospital that disregards the IRS's view when reporting its community benefit would face the risk of penalties. *See* IRC § 6652(c)(1).

CONCLUSION

The judgment of the U.S. Court of Appeals for the D.C. Circuit should be affirmed.

Respectfully submitted,

MELINDA REID HATTON
MAUREEN MUDRON
AMERICAN HOSPITAL ASSOCIATION
Two CityCenter, Suite 700
800 10th Street, NW
Washington, D.C. 20001

FRANK TRINITY
IVY BAER
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
Suite 100
655 K Street NW
Washington, DC 20001

BETH HEIFETZ
Counsel of Record
CATHERINE E. LIVINGSTON
RAJEEV MUTTREJA
JONES DAY
51 Louisiana Avenue, NW
Washington, D.C. 20001
202.879.3939
bheifetz@jonesday.com

JAMES LANDMAN
HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION
Suite 900
1825 K Street, N.W.
Washington, D.C. 20006

October 16, 2014

Counsel for Amici Curiae

(ATTACHMENT B)

PROPOSAL: REQUIRE INTERNAL REVENUE SERVICE ADHERENCE TO THE ADMINISTRATIVE PROCEDURE ACT

ISSUE

Under the current provisions of the Internal Revenue Code (the "Code") related to the collection of information from tax-exempt organizations, the Internal Revenue Service (the "IRS") may issue and materially amend the forms and instructions it uses to collect information from tax-exempt organizations without any notice to or comment from affected organizations, even if the forms and instructions impose new and burdensome requirements.

RECOMMENDATION

Require the IRS to follow the applicable provisions of the Administrative Procedure Act ("APA") when issuing forms and instructions.

BACKGROUND

The following is a summary of the events that have precipitated this action:

- In 2010 Congress enacted the Patient Protection and Affordable Care Act ("ACA"), which imposed four additional requirements on tax-exempt hospitals that must be met in order for tax-exempt hospitals to maintain their exempt status: (1) a community health needs assessment ("CHNA") to be conducted every 3 years; (2) adoption of a written financial assistance policy; (3) limitations on the amounts a hospital charges to individuals eligible for financial assistance; and (4) limits on engaging in certain collection actions before making reasonable efforts to determine an individual's eligibility for financial assistance. The additional requirements were included in a new section 501(r) of the Code and all except one requirement were effective immediately

upon enactment, (March 23, 2010). The requirement for hospitals to conduct a CHNA was effective for tax years beginning after March 23, 2012.

- The new section 501(r) mandates the Department of the Treasury and the IRS to issue regulations and guidance as may be necessary to carry out the provisions of section 501(r).

- Without issuing proposed or temporary regulations or any other guidance, on February 23, 2011, the IRS amended the 2010 Schedule H, *Hospitals*, to Form 990, *Return of Organizations Exempt from Income Tax*, and instructions accompanying Schedule H. The revised Schedule H and instructions impose onerous reporting requirements on tax-exempt hospitals that exceed the scope of Section 501(r). Schedule H and instructions were materially amended without the IRS providing any meaningful notice to the tax-exempt hospital community or opportunity for comment. Furthermore, when issuing the revised form and instructions, the IRS neglected to follow the collection of information requirements contained in the Paperwork Reduction Act ("PRA") or the notice and comment process under the APA.

- After receiving numerous concerned responses to the revised Schedule H from the tax-exempt hospital community, on June 9, 2011, the IRS issued Notice 2011-37 advising tax-exempt hospitals that the revised portions of Schedule H related to the new section 501(r) requirements were optional for tax year 2010.

- In the meantime, the tax-exempt hospital community continued to submit comments to the IRS and offered and attempted to collaborate with the IRS to craft a more streamlined version of Schedule H that would reduce reporting burdens while, at the same time, achieving the underlying section 501(r) purposes of accountability and transparency.

- On October 14, 2011, and again on December 15, 2011, the IRS published draft 2011 Schedule H to Form 990 and instructions. The 2011 Schedule and instructions remained largely and substantively unchanged from the 2010 Schedule and instructions. Although the IRS permitted comments to be submitted with respect to the 2011 draft Schedule H and instructions, the IRS did not follow the procedure prescribed by the PRA for an agency's collection of information.

- On January 23, 2012, the IRS published the 2011 draft Schedule H and instruction in final. The Schedule and instructions were identical to the draft versions. The IRS issued final Schedule H and instructions without following the PRA-mandated process. The 2011 Schedule H and instructions did not reflect the comments that were submitted to the IRS by the tax-exempt hospital community.

- On May 9, 2012, almost four months after final Schedule H and instructions were released, the IRS published a notice in the Federal Register pursuant to the PRA requesting comments on the collection of information contained in Schedule H and instructions.

- On June 22, 2012 the IRS released a notice of proposed rulemaking ("NPRM") for three of the four requirements in section 501(r). The NPRM requested public comments and scheduled a public hearing on the proposed regulations. The NPRM followed the requirement of the PRA for collection of information. However, the NPRM stated that the APA does not apply to the proposed regulations. The proposed regulations generally reflected the content of the revised Schedule H and instructions.

- On December 5, 2012, the IRS held a public hearing on the proposed section 501(r) regulations.

- In January 2013, the IRS published 2012 Schedule H and instructions, which included modest revisions to the 2011 versions but largely ignored the comments that were submitted by the regulated community generally and in response to the notice published on May 9, 2012, and to the NPRM.

- On April 3, 2013 the IRS released a notice of proposed rulemaking ("NPRM") for the fourth requirement in section 501(r), the CHNA. The NPRM requested public comments on the proposed regulations. The NPRM followed the requirement of the PRA for collection of information. However, the NPRM stated that the APA does not apply to the proposed regulations. The proposed regulation generally reflected the content of prior informal guidance on CHNA issued in 2011 (Notice 2011-52). The NPRM also included a proposed regulation on the consequences of failing to satisfy any of the Section 501(r) requirements.

- On December 9, 2013 the IRS released a draft of Form 990 (including Schedule H) and the accompanying instructions for the 2013 tax year that suddenly, without warning, eliminated research funded by grants from government and nonprofit sources (e.g., by the National Institutes of Health (NIH)) from a hospital's calculation of the value of community benefit provided to its community. Despite the magnitude of this reversal, hospitals had no meaningful opportunity to raise their concerns with the IRS. Although the IRS *permitted* comments on the draft form (as the IRS does with all draft forms), the agency gave no deadline for comments. And just eleven days after releasing the draft form, on December 20, 2013, the IRS issued a final form and instructions adopting the change, and discarding decades of precedent on the treatment of research grants. Worse still, the IRS applied the change retroactively to all of 2013.

- On Dec. 26, 2013, just 17 days after the draft was issued, the AHA and other associations submitted comments expressing great concern about the draft form – not only regarding the change on grant funding, but also on another, unrelated change. In response, the IRS promptly revised the latter change, issuing a corrected version of the instructions on Jan. 15, 2014. The agency, however, did not even respond to the comments on the change regarding grants. As a result, for the 2013 tax year, research grants – for the first time in the history of the community benefit standard – will not be counted as community benefit.

PROPOSED AMENDMENT TO IRC

The following amendment to IRC section 6033 would rectify the IRS's lapse in process for issuing informal guidance that binds tax-exempt organizations without any formal opportunity for input from them, such as in the example outlined above. Additionally, the amendment would ensure public participation and transparency in the IRS's process for issuing new or materially amended forms to collect information from tax-exempt organizations.

Section 6033(a) is currently divided into three paragraphs. Paragraph (1), which grants the Secretary expansive authority to issue new forms, provides:

> (1) Except as provided in paragraph (3)**,** every organization exempt from taxation under section 501(a) shall file an annual return, stating specifically the items of gross income, receipts, and disbursements, and such other information for the purpose of carrying out the internal revenue laws as the Secretary may by forms or regulations prescribe, and shall keep such records, render under oath such statements, make such other returns, and comply with such rules and regulations as the Secretary may from time to time prescribe; except that, in the discretion of the Secretary, any organization described in section 401(a) may be relieved from stating in its return any information which is reported in returns filed by the employer which established such organization.

We would recommend revising the text of paragraph (1), adding a new paragraph (2), and renumbering the remaining paragraphs. The amended section 6033(a) would read:

(1) Except as provided in paragraph (4), every organization exempt from taxation under section 501(a) shall file an annual return, stating specifically the items of gross income, receipts, and disbursements, and such other information for the purpose of carrying out the internal revenue laws as the Secretary may by forms or regulations prescribe consistent with the requirements of paragraph (2), and shall keep such records, render under oath such statements, make such other returns, and comply with such rules and regulations as the Secretary may from time to time prescribe consistent with the requirements of paragraph (2); except that, in the discretion of the Secretary, any organization described in section 401(a) may be relieved from stating in its return any information which is reported in returns filed by the employer which established such organization.

(2) Notwithstanding any other provision of law, the Secretary shall comply with the provisions of sections 553 through 557 (other than subparagraphs (A) and (B) of section 553(b)) and section 706 of title 5 when prescribing forms, regulations, and rules under paragraph (1).

(3) [former paragraph (2)]

(4) [former paragraph (3)]

(b) Every organization described in section 501(c)(3) which is subject to the requirements of subsection (a) shall furnish annually information, at such time and in such manner as the Secretary may by forms or regulations prescribe, consistent with the requirements of paragraph (a)(2), setting forth-- . . . .