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Legal Requirements for Section 501(c)(3) Hospitals

April 15, 2024

Congressional Research Service

<https://crsreports.congress.gov>

R48027



R48027

April 15, 2024

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It is estimated that approximately half of private, community hospitals are non-profit organizations, which may be eligible for federal income tax exemption as charitable organizations under § 501(c)(3) of the Internal Revenue Code (I.R.C.). To qualify for such tax-exemption, hospitals must satisfy two distinct hospital-specific tests, in addition to the general requirements applicable to all § 501(c)(3) organizations.

First, a hospital claiming charitable organization status must meet the “community benefit” standard, as described in two Internal Revenue Service (IRS) revenue rulings issued in 1969 and 1983. The community benefit standard generally asks whether the hospital promotes the health of a broad class of individuals in the community that it serves based on all relevant factors and circumstances. While the provision of free or reduced-cost care or the operation of an emergency room that is open to all are two examples of ways in which a hospital may provide a community benefit, these examples are not the only types of benefits that meet that standard. Other types of community benefits that the IRS has acknowledged include reinvesting revenues to expand facilities, improve patient care, and conduct medical training, education, and research.

Although the IRS has not specified a particular amount or percentage of community benefit that is required to qualify as a charitable § 501(c)(3) hospital, it does require such hospitals to provide annual public reports in Schedule H to Form 990 on various metrics that are related to community benefit, such as the amount of free or reduced-cost care provided, expenditures toward other community building activities, and reimbursement shortfalls from government health care programs.

Separately from the community benefit standard, § 501(r) of the I.R.C. requires § 501(c)(3) hospitals to conduct a triennial community health needs assessment, to have written financial assistance and emergency medical care policies, to limit charges for persons who qualify for financial assistance to amounts generally billed to insured patients, and to refrain from extraordinary billing and collection actions. Failure to comply with these requirements may subject a hospital to loss of its tax-exempt status, the assessment of an annual excise tax, or taxation of income derived from noncompliant hospital facilities.

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In 2022, the Centers for Medicare and Medicaid Services (CMS) reported that almost half of all Medicare-enrolled hospitals were private, non-profit organizations.¹ Such non-profit hospitals may qualify as tax-exempt charitable organizations under § 501(c)(3) of the Internal Revenue Code (I.R.C.).² In addition to exemption from corporate income taxes, tax-exempt hospitals also benefit from eligibility to receive tax-deductible donations and special bond financing.³ The requirements hospitals must meet to qualify as charitable have also been the subject of recent congressional and media attention.⁴

To be federally tax-exempt, private non-profit hospitals must meet the general requirements applicable to all § 501(c)(3) organizations.⁵ Hospitals are also subject to hospital-specific requirements arising from two separate provisions of the I.R.C. First, private non-profit hospitals must meet the “community benefit” standard, as described in multiple Revenue Rulings issued by the Internal Revenue Service (IRS), to be considered *charitable* organizations under I.R.C. § 501(c)(3). Second, such hospitals must also comply with specific requirements under I.R.C. § 501(r) added by the Patient Protection and Affordable Care Act (ACA).⁶ This report describes the regulatory and legislative development of the hospital-specific requirements imposed under both of these statutes.

Definition of “Charitable” Under Section 501(c)(3)

Section 501(c)(3) of the I.R.C. provides tax-exempt status for “charitable” organizations but does not define “charitable.”⁷ U.S. Department of the Treasury (Treasury) regulations provide that the term should be used in “its generally accepted legal sense” and provide examples, including the relief of the poor or unprivileged; the promotion of social welfare; and the advancement of

¹ U.S. DEP’T OF HEALTH AND HUMAN SERVICES, ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, OWNERSHIP OF HOSPITALS: AN ANALYSIS OF NEWLY-RELEASED FEDERAL DATA & A METHOD FOR ASSESSING COMMON OWNERS 4 (Aug. 2023), <https://aspe.hhs.gov/sites/default/files/documents/582de65f285646af741e14f82b6df1f6/hospital-ownership-data-brief.pdf>. See also, U.S. GOV’T ACCOUNTABILITY OFF., GAO-20-679, TAX ADMINISTRATION: OPPORTUNITIES EXIST TO IMPROVE OVERSIGHT OF HOSPITALS’ TAX-EXEMPT STATUS 1 (2020) (citing American Hospital Association, Fast Facts on U.S. Hospitals, 2020) (“Slightly more than half of the community hospitals in the United States are private, non-profit organizations.”).

² *Simon v. E. Ky. Welfare Rights Org.*, 426 U.S. 26, 29 (1976) (citing 26 U.S.C. § 501(c)(3), which does not mention hospitals specifically, but provides income tax-exemption for “organizations operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes”). Federal tax-exemption is distinct from non-profit organization under state law, which may impose additional requirements on non-profit hospitals. E.g., FLA. STAT. § 617.2002(2) (2024) (requiring non-profit hospitals to participate in Medicaid and provide charity care). Because this report is focused on federal requirements for tax-exemption, such state laws are beyond the scope of this report.

³ 26 U.S.C. §§ 145, 170.

⁴ See STAFF OF S. COMM. ON HEALTH, EDUCATION, LABOR, AND PENSIONS, 118TH CONG., MAJ. REP. ON EXECUTIVE CHARITY: MAJOR NON-PROFIT HOSPITALS TAKE ADVANTAGE OF TAX BREAKS AND PRIORITIZE CEO PAY OVER HELPING PATIENTS AFFORD MEDICAL CARE (Oct. 10, 2023); Jessica Silver-Greenberg & Katie Thomas, *They Were Entitled to Free Care. Hospitals Hounded Them to Pay.*, N.Y. TIMES (Sept. 24, 2022), <https://www.nytimes.com/2022/09/24/business/nonprofit-hospitals-poor-patients.html>; *Tax-Exempt Hospitals and the Community Benefit Standard: Hearing Before the H. Ways & Means Comm.*, 118th Cong. (2023).

⁵ For more information about general requirements for all § 501(c)(3) organizations, see CRS Testimony TE10090, *Growth of the Tax-Exempt Sector and the Impact on the American Political Landscape*, by Justin C. Chung (2023); and CRS Report RL33377, *Tax-Exempt Organizations Under Internal Revenue Code Section 501(c): Political Activity Restrictions*, by Justin C. Chung (2024).

⁶ Pub. L. No. 111-148, § 9007(a), 124 Stat. 855.

⁷ 26 U.S.C. § 501(c)(3).

education, religion, and science.⁸ In the absence of explicit statutory or regulatory requirements specifically applying the term “charitable” to hospitals, IRS has provided guidance principally through revenue rulings describing the criteria it uses to determine whether hospitals qualify as § 501(c)(3) charitable organizations. The IRS currently uses a “community benefit” standard to evaluate whether a hospital qualifies as a § 501(c)(3) charitable organization, which is discussed in the following section.⁹

Evolution of the “Community Benefit” Standard

The standard used by the IRS to evaluate whether a private hospital is charitable has evolved over the past seventy years, originating with a “charity care” standard that has been replaced by the current “community benefit” standard. Revenue Ruling 56-185, issued by the IRS in 1956, established the charity care standard.¹⁰ Under that ruling, to qualify as a charitable § 501(c)(3) entity, a hospital could not be operated exclusively for those who were expected and able to pay, and was required to provide, to the extent of its financial ability, free or below-cost care to patients who were unable to pay for their care.¹¹ The ruling further stated that, if a hospital expects full payment for services rendered, it cannot subsequently claim that it provided charity care merely because some patients ultimately failed to pay.¹²

In 1969, the IRS issued Revenue Ruling 69-545, which expressly eliminated the 1956 ruling’s requirement that a hospital provide free or below-cost care to qualify as a charitable § 501(c)(3) organization.¹³ Under the standard developed in Revenue Ruling 69-545, which has come to be known as the “community benefit standard,” hospitals seeking to qualify as charitable § 501(c)(3) entities are judged on whether they promote the health of a broad class of individuals in the community.¹⁴ The IRS reasoned that the promotion of health is a charitable purpose when it benefits the community as a whole, even though not all community members (such as indigent people) may benefit.¹⁵ As such, the IRS concluded that a hospital with a full-time emergency room that provided care to everyone, regardless of their ability to pay, qualified for § 501(c)(3) charitable status even though the hospital otherwise only admitted individuals who could pay for the services (by themselves, through private insurance, or through public programs such as Medicare).¹⁶

⁸ Treas. Reg. § 1.501(c)(3)-1(d)(2) (as amended in 2017).

⁹ See *Geisinger Health Plan v. Comm’r*, 985 F.2d 1210, 1214 (3rd Cir. 1993) (upholding IRS’s denial of a hospital’s application for tax-exempt status based on failure to meet the “community benefit” standard) and *St. David’s Health Care Sys. v. United States*, 349 F.3d 232, 234 (5th Cir. 2003) (reviewing IRS’s revocation of tax-exempt status following audit). Hospitals apply for tax-exempt status through the filing of Form 1023, which provides a means for a hospital to describe how its tax-exempt activities qualify as charitable. See IRS, *About Form 1023, Application for Recognition of Exemption Under Section 501(c)(3) of the Internal Revenue Code*, <https://www.irs.gov/forms-pubs/about-form-1023> (last visited Feb. 15, 2024).

¹⁰ Rev. Rul. 56-185, 1956-1 C.B. 202.

¹¹ See *id.*

¹² See *id.*

¹³ Rev. Rul. 69-545, 1969-2 C.B. 117.

¹⁴ See *id.*

¹⁵ See *id.* (citing to RESTATEMENT (SECOND) OF TRUSTS §§ 368, 372 (1959); IV SCOTT ON TRUSTS §§ 368, 372 (3d ed. 1967)).

¹⁶ *Id.* Other characteristics of the hospital that the IRS highlighted included the following: its surplus funds were used to improve patient care, expand hospital facilities, and advance medical training, education, and research; it was controlled by a board of trustees that consisted of independent civic leaders; and hospital privileges were available to all qualified physicians. See *id.*

While a significant factor in Revenue Ruling 69-545 was that the hospital operated an emergency room open to everyone, in 1983 the IRS issued Revenue Ruling 83-157, which clarified that a hospital without an emergency room may still qualify as a § 501(c)(3) entity under the community benefit standard.¹⁷ In Revenue Ruling 83-157, the IRS recognized there are circumstances in which hospitals may not need to operate emergency rooms, such as when a state agency has determined that such operation would be duplicative or when a hospital is in a specialized field (such as a cancer or eye hospital) unlikely to require emergency care.¹⁸ In these situations, a hospital may still meet the community benefit standard for § 501(c)(3) eligibility by demonstrating other evidence of hospital-provided benefits that promote the health of a broad class of persons.¹⁹ Factors that may be used as evidence of meeting the community benefit standard include a board of directors chosen from members of the community; an open medical staff policy (i.e., allowing a broad group of physicians in the community to treat patients at the hospital); treatment of patients using public programs (e.g., Medicare and Medicaid); and using surplus funds for improving patient care, facilities, equipment, and medical training, education, and research.²⁰

Following the shift to the community benefit standard in 1969, several individual and organizational plaintiffs sued, challenging the IRS's authority to eliminate the prior charity care standard.²¹ That challenge was ultimately dismissed by the Supreme Court, which held that plaintiffs lacked standing because the claimed loss of indigent access to non-emergency medical services was not traceable to the revenue ruling.²² The Court also explained that the relief sought by the plaintiffs (rescinding the community benefit standard revenue ruling) would not necessarily redress the loss of medical services for indigent populations because hospitals could independently forgo tax-exempt status.²³ Subsequently, lower courts have continued to apply the community benefit standard as described in both Revenue Rulings 69-545 and 83-157 when evaluating IRS's denials of tax-exemption for hospitals.²⁴

Schedule H to Form 990

Tax-exempt § 501(c)(3) organizations are generally required to file an annual information return (Form 990 series) with the IRS.²⁵ The form asks for information on a variety of topics, including income, expenses, assets, officers and employees, and activities related to the organization's basis for tax-exempt status. The Form 990 is generally due on the 15th day of the fifth month after the

¹⁷ Rev. Rul. 83-157, 1983-2 C.B. 94.

¹⁸ *See id.*

¹⁹ *See id.*

²⁰ *See id.*

²¹ *Simon v. E. Ky. Welfare Rights Org.*, 426 U.S. 26 (1976).

²² *Id.* at 42–43. Prior to dismissal at the Supreme Court, the appellate court had held that the IRS had permissibly interpreted the term “charitable” when issuing Revenue Ruling 69-545. *E. Ky. Welfare Rights Org. v. Simon*, 506 F.2d 1278, 1290 (D.C. Cir. 1974), vacated, 426 U.S. at 46.

²³ *Simon*, 426 U.S. at 43.

²⁴ E.g., *IHC Health Plans, Inc. v. Comm’r*, 325 F.3d 1188, 1198–99 (10th Cir. 2003); *St. David’s Health Care Sys. v. U.S.*, 349 F.3d 232, 235–36 (5th Cir. 2003); *Geisinger Health Plan v. Comm’r*, 985 F.2d 1210, 1217 (3rd Cir. 1993).

²⁵ 26 U.S.C. § 6033. There are exceptions for small entities and houses of worship, among others. *See id.* The penalty for failure to file the return is \$20 per day for each day the failure continues, which is increased to \$100 per day if the organization has annual gross receipts exceeding \$1 million in any year. *See id.* at § 6652(c)(1)(A). The maximum penalty is \$50,000 for entities exceeding \$1 million in gross receipts, and is the lesser of \$10,000 or 5% of gross receipts for all others. *See id.* The hospital’s managers may also be subject to penalty. *See id.* at § 6652(c)(1)(B).

close of an entity's tax year (May 15 for calendar-year organizations), although an entity may seek an extension.

In 2007, amid continued concerns about “whether there [were] differences between for-profit and tax-exempt hospitals,”²⁶ the IRS announced that hospitals would be required to provide additional information specific to their industry on a new Schedule H to Form 990.²⁷ The IRS drafted Schedule H to “combat the lack of transparency surrounding the activities of tax-exempt organizations that provide hospital or medical care.”²⁸ Schedule H divides the information to be reported into six parts.²⁹

Part I: Quantifying “Community Benefit”

Part I of Schedule H attempts to quantify the amount of community benefit provided by hospitals on an annual basis.³⁰ Expenses that are reportable in Part I include free care, unreimbursed Medicaid, unreimbursed costs from other means-tested government programs, community health improvement services, health professions education, subsidized health services, research, and contributions to other community groups.³¹ The IRS has not suggested a minimum level of expenditures that would be required to justify tax-exemption.

Part II: Community Building Activities

Part II quantifies the hospital's community building activities. Although the definition of “community building” may not be obvious at first glance, it is generally understood to refer to programs that are intended to have a beneficial impact upon the health of a community but that do not provide medical care. Examples of community building are housing improvements, economic development, community support, environmental improvements, leadership development, coalition building, community health improvement advocacy, and workforce development.³²

Despite the inclusion of community building metrics on the Schedule H, these numbers are still separate from the reporting of charity care and community benefit expenditures in Part I. The IRS commentary on the Schedule's final draft reflected the view that the link between community

²⁶ IRS, DRAFT FORM 990 REDESIGN PROJECT - SCHEDULE H: INSTRUCTIONS 1 (June 14, 2007) [hereinafter JUNE 14 DRAFT COMMENTS], http://www.irs.gov/pub/irs-tege/draftform990redesign_schh_instr.pdf. Schedule H was based on responses to questionnaires IRS sent to approximately 600 large hospitals regarding their billing practices, emergency room availability, compensation, and what types of community benefit they provided. See IRS, FORM 13790: COMPLIANCE CHECK QUESTIONNAIRE TAX-EXEMPT HOSPITALS, http://www.irs.gov/pub/irs-tege/exhibit_1__form13790.pdf (last visited Apr. 10, 2024). The IRS issued a final report on the compliance project, see IRS, IRS EXEMPT ORGANIZATIONS (TE/GE) HOSPITAL COMPLIANCE PROJECT FINAL REPORT, <http://www.irs.gov/pub/irs-tege/frepthospproj.pdf> (last visited Apr. 10, 2024). See also IRS FSA 01-10-030 (Feb. 5, 2001) (addressing whether a hospital's stated policies to provide health care services to the indigent are sufficient to satisfy the community benefit standard).

²⁷ Press Release, IRS Releases Final 2008 Form 990 for Tax-Exempt Organizations, Adjusts Filing Threshold to Provide Transition Relief (Dec. 20, 2007) [hereinafter Dec. 20 Draft Highlights], <https://www.irs.gov/pub/irs-news/ir-07-204.pdf>. The new Schedule H is part of a significant redesign of the entire Form 990.

²⁸ JUNE 14 DRAFT COMMENTS, *supra* note 26, at 1.

²⁹ IRS, Schedule H (Form 990): Hospitals (2023) [hereinafter Schedule H], <https://www.irs.gov/pub/irs-pdf/f990sh.pdf> (last visited Apr. 10, 2024).

³⁰ JUNE 14 DRAFT COMMENTS, *supra* note 26, at 1.

³¹ Schedule H, *supra* note 29, at Part I.

³² Schedule H, *supra* note 29, at Part II.

building and health was still tenuous and that the reporting tools in Schedule H are intended to operate, in part, as data collection methods for the IRS to discern what links exist.³³

Part III: Medicare Shortfalls and Bad Debt

Hospitals incur costs when treating all patients, including patients who are covered by Medicare. Medicare, however, may not reimburse a provider for the total cost of services received by a patient.³⁴ The difference between the Medicare reimbursement rates and the costs incurred by a hospital are called shortfalls. Schedule H includes a dedicated area in which to report Medicare shortfalls. Despite the addition of Part III, the IRS does not appear to automatically treat Medicare shortfalls as a direct measure of community benefit. Instead, hospitals are asked to “[d]escribe ... the extent to which any shortfall reported [in Part III] *should* be treated as community benefit.”³⁵

Hospitals regularly engage in billing and collection practices to recoup co-pays, deductibles, and other expenses from patients. The collection process may eventually reach a point at which it becomes apparent that a debt owed to the hospital has little or no potential of repayment. In accordance with generally accepted accounting practices, it is customary to “write off” these debts as “bad debt.”³⁶ Schedule H allows hospitals to report bad debt in Part III alongside Medicare shortfalls, but bad debt expense may not be reported on the charity care and community benefit table in Part I.³⁷ As with Medicare shortfalls, filing hospitals must explain what portion of bad debt should be considered community benefit.³⁸ The IRS comments accompanying the Schedule’s final draft indicated that it does not intend to consider any portion of bad debt a de facto community benefit, citing a lack of consensus regarding bad debt policies among hospitals.³⁹

Part IV: Management Companies and Joint Ventures

Part IV requires disclosure of any joint ventures in which a hospital participates. Part IV of Schedule H asks tax-exempt entities that operate hospitals to list the joint ventures in which they participate. Joint ventures can present challenges in the non-profit health care context for a variety of reasons. If physicians with staff privileges at the hospital also have a proprietary interest in the joint venture, referrals to that joint venture may violate federal prohibitions against self-referrals or kickbacks.⁴⁰ If directors or trustees of the hospital have a proprietary interest in that joint venture, the non-profit status of the hospital could be jeopardized by any benefit they receive as a result of their interest in the venture.⁴¹ Similarly, in *St. David’s Health Care System v.*

³³ Dec. 20 Draft Highlights, *supra* note 27, at 4.

³⁴ For further information about Medicare benefits and payments, including applicable patient cost sharing—deductibles, coinsurance—see CRS Report R40425, *Medicare Primer* (2020).

³⁵ Schedule H, *supra* note 29, at Part III (emphasis added).

³⁶ Under Medicare, hospitals may receive payments that cover a *portion* of Medicare “bad debt”—unpaid Medicare patient deductibles and coinsurance that are written off as uncollectible after reasonable collection efforts have been made. See 42 C.F.R. § 413.89(e) (2023) and 42 C.F.R. § 413.89(h).

³⁷ Schedule H, *supra* note 29, at Part III; JUNE 14 DRAFT COMMENTS, *supra* note 26, at 3.

³⁸ Schedule H, *supra* note 29, at Part III.

³⁹ Dec. 20 Draft Highlights, *supra* note 27, at 4.

⁴⁰ For a more detailed discussion of physician self-referral and federal law, see CRS Report RS22743, *Health Care Fraud and Abuse Laws Affecting Medicare and Medicaid: An Overview*, by Jennifer A. Staman.

⁴¹ Under 26 U.S.C. § 501(c)(3), the net earnings of a charitable organization may not flow to the benefit of any private shareholder or individual.

United States, the U.S. Court of Appeals for the Fifth Circuit held that a joint venture's profit motive could undermine a non-profit partner's status as a charitable organization.⁴²

Part V: Facility Information

Part V requests information about the entity's health care facilities, including questions about compliance with the ACA's requirements, discussed below. Organizations are asked, in Part V of Schedule H, to identify all hospital or medical care facilities and to indicate the types of medical services provided by each. The definition of hospital or medical care does *not* include assisted living services, vocational training for the disabled, or medical education and research.⁴³

Part VI: Supplemental Information

Part VI of Schedule H provides an area in which to provide narrative information regarding the amount of community benefit provided. The IRS stated that this area could be used to justify why some portion of Medicare shortfall or bad debt reported in other areas of the Schedule should be considered community benefit.⁴⁴ In addition, hospitals may provide details about other community benefits they provide that are not easily quantifiable.⁴⁵

Section 501(r) Requirements

During the 109th and 110th Congresses, both the House Ways & Means Committee and the Senate Finance Committee held hearings examining the benefits provided by tax-exempt hospitals and considered legislative reforms that would have required such hospitals to provide minimum amounts of charity care.⁴⁶ Although neither of these legislative proposals were ultimately enacted, in 2010, Congress enacted Section 9007 of the ACA, which added a new I.R.C. § 501(r) that imposes four additional requirements hospitals must meet to qualify for § 501(c)(3) status.⁴⁷ These requirements are in addition to such hospitals meeting the community benefit standard, as described in the previous section, although there is some overlap between the two sets of requirements. Section 501(r) requires § 501(c)(3) hospitals to meet the following requirements:

⁴² *St. David's Health Care System v. United States*, 349 F.3d 232, 237 (5th Cir. 2003).

⁴³ JUNE 14 DRAFT COMMENTS, *supra* note 26, at 8.

⁴⁴ Dec. 20 Draft Highlights, *supra* note 27, at 5.

⁴⁵ *Id.*; see also Schedule H, *supra* note 29, at Part VI (describing a hospital's open medical staff policy or community board as examples of community benefit that can be reported in this part).

⁴⁶ See H.R. 6420, Tax Exempt Hospitals Responsibility Act of 2006; Senate Finance Committee Minority Staff, *Tax-Exempt Hospitals: Discussion Draft* (2007), <https://www.finance.senate.gov/imo/media/doc/prg071907a.pdf>; *Hearing on the Tax-Exempt Hospital Sector before the H. Ways & Means Comm.*, 109th Cong. (2005); *Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals: Hearing before the S. Finance Comm.*, 109th Cong. (2006).

⁴⁷ Pub. L. No. 111-148, § 9007, 124 Stat. 855 (codified at 26 U.S.C. §§ 501(r), 4959, 6033(b)(15)). There are three possible consequences for failing to comply with the § 501(r) requirements: (1) the hospital may have its § 501(c)(3) status revoked; (2) if the IRS determines that revocation of § 501(c)(3) status is not appropriate for a hospital with multiple facilities, the hospital will be subject to tax on the income of any noncompliant facility; and (3) if the hospital fails to comply with the community health needs assessment requirement, it is subject to a \$50,000 excise tax for each taxable year the failure occurs. 26 U.S.C. §§ 501(r)(1), (2)(B), 4959; Treas. Reg. § 1.501(r)-2 (2015).

- Hospitals must conduct a “community health needs assessment” (CHNA) at least once every three years and adopt an implementation strategy to meet those needs.⁴⁸
- Hospitals must have written financial assistance and emergency medical care policies.⁴⁹
- For emergency and other medically necessary care, hospitals may not charge individuals eligible under the financial assistance policy more than the amounts generally billed for care provided to those with insurance coverage. For all other medical care, hospitals must charge such patients less than the gross charges (i.e., the full, established prices before any discounts, contractual allowances, or deductions are applied) for such care.⁵⁰
- Hospitals must make reasonable efforts to determine whether an individual is eligible for financial assistance before beginning extraordinary collection actions.⁵¹

Treasury regulations issued in 2014 and 2015 have provided further guidance on the scope and definitions used for each of the four § 501(r) requirements, which are discussed in more detail in the following sections. Additionally, Section 9006 requires the Treasury Secretary to review, at least once every three years, the community benefit activities of any tax-exempt hospital.⁵² Since the enactment of § 501(r), the IRS has also issued a handful of private letter rulings revoking the tax-exempt status of hospitals for failing to meet the new ACA requirements.⁵³ With the exception of one case in which the hospital failure was limited to adequately publicizing its CHNA (discussed in more detail below), the IRS found that these hospitals were generally not aware of their obligations under § 501(r).⁵⁴ Therefore, these cases provide little further guidance regarding these requirements.

Community Health Needs Assessment

The CHNA required under § 501(r)(3) must have been conducted by a § 501(c)(3) hospital in the current or preceding two tax years. The CHNA must also be made publicly available and be developed after considering input from persons representing the broad interests of the community, including those with public health knowledge or expertise and the views of medically underserved, low-income, and minority populations within the community. Additionally, hospitals must adopt an implementation strategy responding to the CHNA that describes how the needs identified are being met and explain why any identified needs are not being addressed.⁵⁵

Hospitals have some discretion to define the community they serve for purposes of conducting the triennial CHNA. Treasury regulations provide that a hospital may define its community based on the geographical area it serves, the characteristics of target populations (such as children,

⁴⁸ See 26 U.S.C. § 501(r)(1)(A), (3); Treas. Reg. § 1.501(r)-3 (2015).

⁴⁹ See 26 U.S.C. § 501(r)(1)(B), (4); Treas. Reg. § 1.501(r)-4 (2015).

⁵⁰ See 26 U.S.C. § 501(r)(1)(C), (5); Treas. Reg. § 1.501(r)-5 (2015).

⁵¹ See 26 U.S.C. § 501(r)(1)(D), (6); Treas. Reg. § 1.501(r)-6 (2015).

⁵² Pub. L. No. 111-148, § 9007(c), 124 Stat. 858 (2010).

⁵³ I.R.S. Priv. Ltr. Rul. 201731014 (Aug. 4, 2017); I.R.S. Priv. Ltr. Rul. 201833021 (Aug. 17, 2018); I.R.S. Priv. Ltr. Rul. 201833020 (Aug. 17, 2018). CRS also searched Westlaw for federal court cases discussing the requirements in § 501(r), but did not identify any.

⁵⁴ I.R.S. Priv. Ltr. Rul. 201833021 at 10 (Aug. 17, 2018); I.R.S. Priv. Ltr. Rul. 201833020 at 9.

⁵⁵ See 26 U.S.C. § 501(r)(1)(A), (3); Treas. Reg. § 1.501(r)-3.

women, or the elderly), and the hospital's particular functions (such as a focus on certain medical specialties or diseases).⁵⁶ A hospital's CHNA may not exclude the medically underserved, low-income, or minority populations who reside in the geographical area served by the hospital, except where those populations fall outside of the hospital's targeted populations or principal functions.⁵⁷

In 2017, the IRS revoked the tax-exempt status of a hospital that had failed to conduct a CHNA.⁵⁸ Although the hospital had conducted a CHNA, in part to qualify as a critical-access hospital under Medicare, the IRS found that the hospital had not adopted the required implementation strategy.⁵⁹ Additionally, the hospital had not satisfied the requirement to make the CHNA widely available to the public because it only offered a paper copy on request.⁶⁰

Financial Assistance Policy

Section 501(r)(4)(A) requires § 501(c)(3) hospitals to have a written financial assistance policy (FAP).⁶¹ The FAP, which must apply to all emergency and medically related care provided by the hospital, must detail the full spectrum of financial assistance provided by the hospital, ranging from discounted care to free care, and the eligibility criteria for each level.⁶²

The FAP must also describe the mechanics of how patients may apply for financial assistance, including any required documentation the patient will be asked to provide.⁶³ The FAP must also describe whether the hospital will consider a patient presumptively eligible based on prior FAP-eligibility determinations or on information received from third party sources such as means-tested public programs.⁶⁴ The FAP shall also describe how the extent of financial assistance will be calculated.⁶⁵ For example, where a hospital offers a percentage discount, the FAP shall describe the amount (such as gross charges) to which that percentage reduction will be applied.

The hospital must also widely publicize the FAP, via web sites, paper copies, and conspicuous notices on bills and in admissions areas and emergency rooms.⁶⁶ When publicizing the FAP, the hospital must also make translations available for significant populations that have limited English proficiency within the community served by the hospital.⁶⁷

Emergency Medical Care Policy

Section 501(r)(4)(B) requires a § 501(c)(3) hospital to have a written emergency medical care policy, under which the hospital shall provide emergency medical care to all individuals, without

⁵⁶ Treas. Reg. § 1.501(r)-3(b)(3).

⁵⁷ *Id.*

⁵⁸ I.R.S. Priv. Ltr. Rul. 201731014 (Aug. 4, 2017).

⁵⁹ *Id.* at 6.

⁶⁰ *Id.* at 2.

⁶¹ Additionally, CMS requires that the FAP be the basis for the amounts hospitals claim as uncompensated care costs—charity care, non-Medicare bad debts, and non-reimbursable Medicare bad debts—for purposes of calculating Medicare uncompensated care payments to hospitals.

⁶² 26 U.S.C. § 501(r)(4); Treas. Reg. § 1.501(r)-4.

⁶³ Treas. Reg. § 1.501(r)-4(b)(3).

⁶⁴ *Id.* § 1.501(r)-4(b)(1)(iii)(E).

⁶⁵ *Id.* § 1.501(r)-4(b)(2).

⁶⁶ *Id.* § 1.501(r)-4(b)(5).

⁶⁷ *Id.*

discrimination, and without regard to whether the individual qualifies under the hospital's FAP.⁶⁸ The policy must also prohibit the hospital from taking actions that would discourage a person from seeking emergency medical treatment, such as by demanding payment before providing care.⁶⁹

Many § 501(c)(3) hospitals may already have a legal obligation to provide treatment for emergency medical conditions under the Emergency Medical Treatment and Active Labor Act (EMTALA).⁷⁰ EMTALA generally requires Medicare-participating hospitals with an emergency department to provide medical screening examinations and stabilizing treatment for persons who come to the hospital's emergency department and present with an emergency medical condition.⁷¹ A hospital that is subject to EMTALA can satisfy the § 501(r) written emergency medical care policy requirement if its written policy states that it will comply with EMTALA.⁷²

Limitation on Charges

Section 501(r)(5) imposes two limits on how much a hospital may charge individuals who are FAP-eligible. For emergency and other medically necessary care, hospitals may not charge FAP-eligible individuals more than the amounts generally billed (AGB) for care provided to those with insurance coverage. For all other medical care, § 501(r) requires hospitals to charge FAP-eligible patients less than the gross charges (i.e., the full, established prices) for such care.⁷³

There are two methods for determining the AGB for a hospital. Under the “look-back” method, an AGB percentage is calculated by dividing the sum of the amounts of all its claims for emergency and other medically necessary care that have been allowed by health insurers described in paragraph (b)(3)(ii) of this section during a prior twelve-month period by the sum of the associated gross charges for those claims.⁷⁴ That AGB percentage is then applied to the gross charges to determine what amount a FAP-eligible person could be required to pay.

Alternatively, a hospital may use the “prospective” method to determine AGB using the amount Medicare or Medicaid would generally allow for the provided medical care.⁷⁵ In this method, the amount that a FAP-eligible person could be required to pay would be limited by the amount allowed under either Medicare or Medicaid.⁷⁶

Extraordinary Billing and Collection Actions

Section 501(r)(6) requires § 501(c)(3) hospitals to make reasonable efforts to determine whether an individual is eligible for financial assistance before beginning extraordinary collection actions.⁷⁷ Treasury regulations define extraordinary collection actions to include

⁶⁸ See 26 U.S.C. § 501(r)(1)(B), (4); Treas. Reg. § 1.501(r)-4.

⁶⁹ Treas. Reg. § 1.501(r)-4(c)(2).

⁷⁰ Pub. L. No. 99-272, 100 Stat. 164 (1986) (codified as 42 U.S.C. § 1395dd).

⁷¹ See CRS In Focus IF12355, *Overview of the Emergency Medical Treatment and Active Labor Act (EMTALA) and Emergency Abortion Services*, by Jennifer A. Staman (2023).

⁷² Treas. Reg. § 1.501(r)-4(c)(3).

⁷³ See 26 U.S.C. § 501(r)(1)(C), (5); Treas. Reg. § 1.501(r)-5.

⁷⁴ Treas. Reg. § 1.501(r)-5(b)(3).

⁷⁵ *Id.* § 1.501(r)-5(b)(4).

⁷⁶ *Id.*

⁷⁷ See 26 U.S.C. § 501(r)(1)(D), (6); Treas. Reg. § 1.501(r)-6.

- most sales of an individual's debt to another party such as a collection agency;
- reporting adverse information to consumer credit reporting agencies or credit bureaus;
- deferring or denying medically necessary care because of an individual's nonpayment for previously provided FAP-eligible care;
- legal or judicial process, such as placing a lien, foreclosure, seizing a bank account, filing suit, or garnishing wages.⁷⁸

The reasonable efforts a hospital must take to determine whether an individual is FAP-eligible include finding a person to be presumptively FAP-eligible based on third-party information or prior FAP-eligibility determinations, and notifying the individual of the FAP and application procedures at least thirty days before beginning any extraordinary collection action.⁷⁹ Additionally, no extraordinary collection action may be taken sooner than 120 days after the first post-discharge bill is provided to the individual.⁸⁰

Although deferring or denying medically necessary care based on past-due amounts is generally considered an extraordinary collection action, and therefore subject to the time limitations described in the previous paragraph, Treasury regulations provide an exception to this time period if the hospital provides a financial assistance application form and written notice of the FAP to the individual, and provides a deadline for submitting such application that is no earlier than thirty days from the notice and 240 days from the first post-discharge billing statement.⁸¹

Enforcement of §501(r) Requirements

Failure to satisfy any of the § 501(r) requirements above can potentially jeopardize a hospital's tax-exemption under § 501(c)(3). When deciding whether to revoke a hospital's tax-exempt status, Treasury regulations provide that IRS will consider the magnitude of the failure, any history of noncompliance, the reason for noncompliance, and remedial actions the organization has taken to correct noncompliance issues.⁸² Where a tax-exempt hospital system operates more than one facility, one of which is noncompliant, the IRS may treat the income from the noncompliant facility as taxable in lieu of revoking the entire organization's tax-exempt status for failing to comply with § 501(r).⁸³ Additionally, the IRS may levy an excise tax upon a hospital for any year in which it has failed to perform the required triennial CHNA, in the amount of \$50,000.⁸⁴

⁷⁸ 26 C.F.R. § 1.501(r)-6(b).

⁷⁹ *Id.* § 1.501(r)-6(c)(2).

⁸⁰ *Id.* § 1.501(r)-6(c)(3)(i).

⁸¹ *Id.* § 1.501(r)-6(c)(3).

⁸² Treas. Reg. § 1.501(r)-2(a) (2015). *See also* I.R.S. Priv. Ltr. Rul. 201731014 (Aug. 4, 2017) (revoking tax-exempt status after finding that failure to comply with CHNA requirements was "egregious" and that hospital lacked "the will, financial resources, [or] the staff" to comply).

⁸³ Treas. Reg. § 1.501(r)-2(d).

⁸⁴ 26 U.S.C. § 4959.

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