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MEASURING THE "CHARITABILITY" OF HOSPITALS: PUTTING MEAT ON THE BONES OF THE GRASSLEY-HATCH REQUEST

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On February 15, 2018, Senators Chuck Grassley (R-Iowa) and Orrin Hatch (R-Utah) requested specific information from the Internal Revenue Service (IRS) on its oversight activities of nonprofit hospitals. In this brief, to provide evidence well beyond what the IRS considers, I present a new tool that they and the hospitals themselves can to help assess whether a charity fully utilizes the charitable resources available to it.

On February 15, 2018, Senators Chuck Grassley (R-Iowa) and Orrin Hatch (R-Utah) requested specific information from the Internal Revenue Service (IRS) on its oversight activities of nonprofit hospitals. Skeptical about whether some or many nonprofit hospitals actually operate as charities, they sought evidence that they provide "community benefits."

To provide evidence well beyond what the IRS considers, I suggest that they and the hospitals themselves adopt a tool I developed to help assess whether a charity fully utilizes the charitable resources available to it. It turns out that a hospital can qualify for tax exemption and provide community benefits while operating more as a partnership serving its doctors, staff, and managers than as a charity. The main value of this tool, however, is not for a top-down assessment by an understaffed IRS wading through a measurement swamp, but for self-assessment of charitable operations by truly mission-driven hospitals.

This measurement tool is simply a variation on the accountant's most powerful tools: the income statement and the balance sheet. Using this tool goes beyond the traditional balancing of cash flows in and cash flows out, or of assets with liabilities, to what I call the uses and sources of those "resources" gathered to pursue the charitable activities of the hospital. Of course, it can be used by almost all charities, not just hospitals.

Think about it. If a nonprofit hospital claims to be charitable, then it implicitly or explicitly claims to be making additional, not-fully-compensated, transfers for the public good that a profit-making hospital does not make. Indigent care, health education, and disease prevention all serve the public. Where such uses of funds exist, there must be sources. Since those two must match in size, a hospital has available a way to check whether its measures of charitable activities match up with the charitable contributions of time and money that made them possible.

The two traditional ways of assessing qualification—what Henry Hansmann calls the "nondistribution [of profits] constraint" to private individuals and the tax code's requirement that tax exemption under section 501(c)(3) applies only to entities organized and operated exclusively for religious, charitable, scientific, literary, educational, and a few related purposes—have never been more than minimum bounds for propriety. In recent years, they have become increasingly unsatisfactory in fulfilling even that minimum role.

Today both charitable and noncharitable organizations can operate mainly on behalf of managers, partners, senior staff, or paid contractors and still meet a "standard" of generating no formal profit distribution for stockholders or other owners. Meanwhile, an ever-larger portion of both industries and occupations in our society engage in activities—health care a prime example—that can be provided either as a charity or a for-profit business. Those developments help explain why debates increasingly arise, as in the case of the Grassley-Hatch request, as to the "charitability" of organizations claiming to be charities.

Requiring the provision of "community benefits," a new federal requirement enacted as part of the Affordable Care Act, was an additional way to prevent a nonprofit hospital from assuming that its engagement in health care and lack of distributable profits by themselves fulfilled its charitable mission. However, meeting the bare community benefit standard itself presents two complications.

First, a nonprofit hospital should be showing that it is doing more than a profit-making hospital would be doing in the same circumstances. Suppose both the nonprofit and profit-making hospital must, by law, provide the community benefit of accepting nonpaying patients in emergency room. Then, unless the nonprofit hospital is accepting more of those patients, it hasn't shown that it is doing anything different, nor that the resources accorded it through sources such as charitable contributions have been transferred to or set aside to benefit the community. Second—and here's why also looking to sources, not just uses, of funds becomes so important—the hospital should be trying to self-assess that it provides as much community benefit as its resources allow. Proving that it does somewhat more than a comparable profit-making hospital isn't much of a test at all if the charitable hospital has significant nonprofit assets.

What are the potential sources of funds to support this charitable output? Nongovernment sources can be divided broadly into two major categories of contributions: financial or real capital and volunteer labor. These often come in more complicated forms than outright charitable contributions. Many, but not all nonprofits, have both volunteers and workers who accept below-market compensation. This labor cost saving is a source of charitable resources. People may pay extra fees as an indirect way of contributing to the hospital, another source of charitable resources. Without going into detail, most of these sources of funds are tax-favored either as charitable contributions or untaxed labor services transferred freely or at below-market cost.

In the simplest case, if a charity has no charitable assets yielding a return, no current charitable contributions, and no volunteers, while asserting that it must pay everyone in the organization market wages, then it has no sources of charitable funds to provide additional community benefit.

Contributions of cash, labor, time, work at below-market wages, and other gifts need not be spent concurrently with when they are received. An equity buildup of plant and equipment worth $1 billion in a nonprofit hospital, held on behalf of the community, essentially represents an endowment accumulated through past charitable contributions of money and time. For example, the early labor contributions of religious orders who led in the establishment of many nonprofit hospitals have compounded over the years, even if today only a few religious are engaged with those hospitals.

Let's now work through a simple example of two hospitals which both qualify as charities and provide community benefits. Yet one removes, and the other adds, to the flow of community benefits that its charitable sources make possible.

Suppose Hospital A has no current contributors of volunteer time and no staff who work at below-market wages. Suppose additionally that it has one asset – equity in real estate – worth $1 billion, that has accrued over time through past charitable efforts and contributions. At a 5-percent real rate of return, the rental saving from the real estate provides a flow of $50 million not available to competitive for-profit hospitals, which must pay the return from built-up equity to their equity owners. Suppose Hospital A also receives $5 million in charitable contributions that year.

If Hospital A provides $45 million in indigent care and free educational services over and above that typically provided by a profit-making hospital, it might assert that it provided $45 million in community benefit, and that's true enough. But a careful use of the accounting tool I suggest would show it that it has yet to account for a $10 million

discrepancy between sources and uses of charitable resources available to it ($55 million of resources from the $50 million rental savings and $5 million charitable contributions minus the $45 million of community benefits provided). Hospital A might discover that it didn't add that differential to charitable reserves, but too freely accepted doctors' charges and salary demands of its staff, allowing them literally to withdraw charitable resources of $10 million that was supposed to benefit the community.

If this is the case, Hospital A's current workers, staff, and contractors provided a net *negative* contribution of $10 million, effectively channeling some of the benefits from past and current contributors owed to the community to themselves. Technically, a charity is not allowed to pay excessive compensation, but that is almost impossible to prove and unlikely to be discovered even by a mission-driven hospital without engaging in this type of exercise. And in this case, Hospital A really is providing fewer community benefits than could be supported by its charitable resources.

Suppose Hospital B similarly yields a return on its equity in real estate of $50 million and raises $5 million in charitable contributions over the course of the year. Suppose further that when Hospital B calculates the community benefits it provides in the form of indigent care and free educational services (again, over and above that typically provided by a profit-making institution), they add up to $65 million. In this example, an initial accounting shows a surplus of charitable uses over charitable resources of $10 million ($65 million community benefits provided minus $55 million charitable resources). When Hospital B reexamines its charitable ledger, it might conclude that the difference was made up by staff acting as net contributors by working at pay levels below market.

The IRS would likely conclude that both hospitals qualified as charities and provided substantial community benefits, but only the second one was truly fulfilling its charitable mission.

A more lengthy discussion of this tool can be found here, here, and here. Frances Hill provides a related discussion on diversion of charitable resources.

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