

# The State of Charity Care in the United States: Holding Nonprofit Hospitals Accountable for Their Tax Exemptions

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*Charity care, or the provision of free or reduced-cost medical services to low-income and uninsured patients, has long served as a critical safety net in the United States health care system. However, the provision of charity care by nonprofit hospitals has failed to keep pace with their soaring revenues. As a result, nonprofit hospitals across the country have come under scrutiny for failing to provide adequate levels of charity care to justify their large tax exemptions.*

*This Note examines the connection between charity care and tax-exempt status, with a close focus on federal tax developments that have arguably weakened the connection between nonprofit hospitals' traditional charitable functions and their current operations. Unlike the prior financial ability standard, the current community benefit standard does not adequately incentivize nonprofit hospitals to provide charity care. Even the additional requirements placed on nonprofit hospitals by the Affordable Care Act have had very little measurable impact on nonprofit hospitals' charity care spending. The passage of the One Big Beautiful Bill Act will only intensify the need for charity care across the nation, putting pressure on the legal framework for nonprofit hospitals' tax exemptions.*

*This Note concludes by examining the recently proposed Holding Nonprofit Hospitals Accountable Act, which is a step in the right direction but is unlikely to substantially increase charity care provision even if enacted. To hold nonprofit hospitals accountable to their communities, Congress should look to the example of states that have enacted minimum requirements for charity care, like Texas.*

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Tax-exempt hospitals don't have many measures of accountability for their special status. The law hasn't given them much direction, and so they've defined standards for themselves . . . . The Government Accountability Office and others, including the former IRS commissioner, have said for a long time that there is often no discernible difference between the operations of taxable and tax-exempt hospitals.

— Senator Chuck Grassley<sup>1</sup>

## Introduction

A health system in the Midwest withholds medical care from patients who have \$4,500 or more of unpaid debt.<sup>2</sup> A busy university hospital in Manhattan has emergency room nurses redirecting homeless patients to a public hospital that primarily serves the poor, while reserving a special room in its emergency department for V.I.P.s.<sup>3</sup> Another hospital system is frustrated that it is losing hundreds of millions of dollars providing free health

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1. Press Release, Chuck Grassley, United States Senator for Iowa, Grassley's Provisions for Tax-Exempt Hospital Accountability Included in New Health Care Law (Mar. 24, 2010), <https://www.grassley.senate.gov/news/news-releases/grassleys-provisions-tax-exempt-hospital-accountability-included-new-health-care> [https://perma.cc/JX4C-AH7A]. Since January 2025, Senator Grassley has served as the President pro tempore of the Senate. *President Pro Tempore*, Chuck Grassley, United States Senator for Iowa, <https://www.grassley.senate.gov/about/president-pro-tempore> [https://perma.cc/HV6Z-QQA5].

2. Sarah Kliff & Jessica Silver-Greenberg, *This Nonprofit Health System Cuts Off Patients with Medical Debt*, N.Y. TIMES (June 7, 2023), <https://www.nytimes.com/2023/06/01/business/allina-health-hospital-debt.html> [https://perma.cc/R2Y8-A2JP].

3. Sarah Kliff & Jessica Silver-Greenberg, *'Major Trustee, Please Prioritize': How NYU's E.R. Favors the Rich*, N.Y. TIMES (Dec. 22, 2022), <https://www.nytimes.com/2022/12/22/health/nyu-langone-emergency-room-vip.html> [https://perma.cc/ZB9J-G5BN].

care to patients, so it trains its employees to push payment plans on patients and only offers financial assistance as a last resort.<sup>4</sup> What do all three of these institutions have in common?

They are all nonprofits. Nonprofit hospitals make up 58% of the community hospitals in the United States today,<sup>5</sup> but they are relatively modern inventions. Historically, hospitals were established by religious orders to provide inexpensive health care to the poor, while wealthier patients paid doctors to treat them in their own homes.<sup>6</sup> Providence, the hospital system that instructed employees to withhold financial assistance from needy patients, had its humble beginnings in 1856 as St. Joseph, a single-room hospital with four beds that charged patients \$1 a day; patients typically paid in goods, not cash.<sup>7</sup> These nineteenth-century hospitals are a perfect illustration of the *quid pro quo* rationale underlying tax exemptions for nonprofit hospitals.<sup>8</sup> In exchange for tax relief, nonprofit hospitals were expected to serve the indigent by providing “charity care” (free or reduced-cost medical care) to the extent of their financial ability.<sup>9</sup>

Today’s nonprofit hospitals little resemble their nineteenth-century predecessors, yet they still receive significant tax breaks under current law. Mandatory Medicare filings from 2021 show that nonprofit hospitals received \$37.4 billion in tax benefits.<sup>10</sup> At the same time, the Lown Institute estimates that the “fair share deficit”—the gap between how much nonprofit hospitals spend on financial assistance and community investment and their

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4. Jessica Silver-Greenberg & Katie Thomas, *They Were Entitled to Free Care. Hospitals Hounded Them to Pay.*, N.Y. TIMES (Dec. 15, 2022), <https://www.nytimes.com/2022/09/24/business/nonprofit-hospitals-poor-patients.html> [<https://perma.cc/4DNS-S3TM>].

5. Jamie Godwin, Zachary Levinson & Scott Hulver, *The Estimated Value of Tax Exemption for Nonprofit Hospitals Was About \$28 Billion in 2020*, KFF (Mar. 14, 2023), <https://www.kff.org/health-costs/issue-brief/the-estimated-value-of-tax-exemption-for-nonprofit-hospitals-was-about-28-billion-in-2020/> [<https://perma.cc/W7F4-QTHF>].

6. Silver-Greenberg & Thomas, *supra* note 4.

7. *Id.*

8. *See also* Fam. Tr. of Mass., Inc. v. United States, 892 F. Supp. 2d 149, 155 (D.D.C. 2012) (“The public-benefit requirement highlights the *quid pro quo* nature of tax exemptions: the public is willing to relieve an organization from the burden of taxation in exchange for the public benefit it provides, because ‘[f]or every dollar that a man contributes to these public charities, educational, scientific, or otherwise, the public gets 100 percent.’” (alterations in original) (first quoting IHC Health Plans, Inc. v. Comm’r, 325 F.3d 1188, 1195 (10th Cir. 2003) (citation omitted)) (then quoting Bob Jones Univ. v. United States, 461 U.S. 574, 590 (1983) (citation omitted))).

9. *Cf.* EDWARD C. LIU, CONG. RSCH. SERV., R48027, LEGAL REQUIREMENTS FOR SECTION 501(C)(3) HOSPITALS 2 (2024) (explaining that from 1956 to 1969, the IRS formally required nonprofit hospitals to provide free or below-cost care to indigent patients to the extent of their financial ability).

10. *U.S. Nonprofit Hospitals Received More than \$37 Billion in Total Tax Benefits in 2021*, JOHNS HOPKINS BLOOMBERG SCH. OF PUB. HEALTH (Sep. 26, 2024), <https://publichealth.jhu.edu/2024/us-nonprofit-hospitals-received-more-than-37-billion-in-total-tax-benefits-in-2021> [<https://perma.cc/M6BW-VBF8>].

tax breaks—was \$25.7 billion for 2021.<sup>11</sup> While the American Hospital Association has criticized the Lown Institute’s methodology for estimating the fair share deficit,<sup>12</sup> similar studies show that many nonprofit hospitals’ estimated tax exemptions outstrip their charity care costs.<sup>13</sup> Moreover, charity care spending has actually *decreased* at top hospitals like the Cleveland Clinic and UCLA Medical Center even as their revenues have grown in recent years due in part to Affordable Care Act (ACA) coverage expansion.<sup>14</sup> While charity care is not the only way that a nonprofit hospital can provide community benefits,<sup>15</sup> proponents of a minimum charity care requirement at the federal level argue that there is a growing need for charity care given Americans’ rising medical debt and the unaffordability of health care generally.<sup>16</sup>

Though nonprofit hospitals have come under increasing scrutiny over their tax-exempt status over the past decade,<sup>17</sup> 2024 saw an unprecedented wave of governmental action. The Internal Revenue Service (the “IRS”) announced audits of thirty-five nonprofit hospitals, with a focus on whether they are providing sufficient community benefits to warrant their tax-exempt

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11. *Fair Share Spending: 2024 Results*, LOWN INST., <https://lownhospitalsindex.org/hospital-fair-share-spending-2024/> [<https://perma.cc/3AAT-84A8>].

12. Rick Pollack, *There Is Nothing ‘Fair’ about the Lown Institute’s ‘Fair Share’ Report*, AM. HOSP. ASS’N (Mar. 25, 2024, at 6:56 PM), <https://www.aha.org/news/blog/2024-03-25-there-nothing-fair-about-lown-institutes-fair-share-report> [<https://perma.cc/UQ3L-P8NS>] (arguing that the report “selectively rel[ies] on isolated data to paint a negative picture about the hospital field”).

13. See, e.g., Godwin, Levinson & Hulver, *supra* note 5 (estimating that nonprofit hospitals received \$28.1 billion from tax exemptions in 2021 while incurring only \$16 billion in charity-care costs); STATE OF MINN. OFF. OF THE LEGIS. AUDITOR, COMMUNITY BENEFIT EXPENDITURES AT NONPROFIT HOSPITALS 39 (2025) (finding that many nonprofit hospitals in Minnesota had a fair share deficit under a limited definition of community benefit that focuses on financial assistance and community investment).

14. Dan Diamond, *How Hospitals Got Richer Off Obamacare*, POLITICO (July 17, 2017, at 5:00 AM ET), <https://www.politico.com/interactives/2017/obamacare-non-profit-hospital-taxes/> [<https://perma.cc/VUN7-UJBU>]; Derek Jenkins & Vivian Ho, *Nonprofit Hospitals: Profits and Cash Reserves Grow, Charity Care Does Not*, 42 HEALTH AFFS. 866, 868–69 (2023); Shelby Olin, Kelsey Owsley, Charles Stoecker & Tatiane Santos, Long-Term Impact of Medicaid Expansion on Not-for-Profit 7–8 (Jan. 29, 2026) (unpublished manuscript) (available in PMC).

15. *Congress Must Uphold Nonprofit Hospitals’ Tax-Exempt Status*, ASS’N OF AM. MED. COLLS. (Dec. 3, 2024), <https://www.aamc.org/about-us/aamc-leads/congress-must-uphold-nonprofit-hospitals-tax-exempt-status> [<https://perma.cc/HN7L-AKM7>] (explaining that research, training, and critical clinical services are important community benefits that nonprofit hospitals contribute beyond charity care).

16. See, e.g., Zachary Levinson, Scott Hulver & Tricia Neuman, *Hospital Charity Care: How It Works and Why It Matters*, KFF (Nov. 3, 2022), <https://www.kff.org/health-costs/hospital-charity-care-how-it-works-and-why-it-matters/> [<https://perma.cc/7K27-XYXN>] (pointing out the lack of minimum charity care standards despite high medical debt and health care costs).

17. Seth Horvath, April Schweitzer & Grace Connelly, *Trends in Charity-Care Legislation and Litigation*, NIXON PEABODY LLP (Sep. 28, 2023), <https://www.nixonpeabody.com/insights/alerts/2023/09/28/trends-in-charity-care-legislation-and-litigation> [<https://perma.cc/MC6N-KUXE>].

status.<sup>18</sup> Nine members of Congress and two Senators sent letters to the IRS urging stricter enforcement of tax exemption requirements and a new guidance letter on charity care standards moving forward.<sup>19</sup>

With calls for change intensifying, it is important to evaluate existing federal tax exemption laws to understand current requirements for tax-exempt hospitals and assess where changes, stricter enforcement, or both might occur. This Note proceeds in three Parts. Part I examines federal tax laws governing tax-exempt status, starting with § 501(c)(3) of the Internal Revenue Code (the “IRC”), which applies to tax-exempt organizations generally. Part I then moves to the specific requirements for hospitals implemented through the IRS’s community benefit standard and § 501(r) of the IRC, which was enacted by the ACA. Part II considers the role of the IRS in shaping the future of the community benefit standard and § 501(r). Finally, Part III addresses the Holding Nonprofit Hospitals Accountable Act that was introduced in the House of Representatives in 2023. It argues that Congress should do more to ensure that nonprofit hospitals provide community benefits to the extent of their tax benefits.

## I. Background on Federal Tax Exemption Provisions

### A. *A Brief History and the Financial Ability Standard*

Tax exemptions for charitable organizations have existed for as long as the federal income tax has existed.<sup>20</sup> The Wilson-Gorman Tariff Act of 1894 established the first non-wartime federal income tax and provided an exemption for “corporations, companies, or associations organized and conducted solely for charitable, religious, or educational purposes.”<sup>21</sup> Today’s tax code contains the same exemption provision at 26 U.S.C. § 501(c)(3), with some expansion of the categories for exemption.<sup>22</sup> Currently, § 501(c)(3) provides tax exemptions for “[c]orporations, and any

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18. Tamar Rosenberg & Emma Arroyo, *IRS Audits & Ongoing Scrutiny of Nonprofit Hospitals – Key Background & Action Steps*, SHEPPARD MULLIN LLP: HEALTHCARE L. BLOG (Aug. 13, 2024), <https://www.sheppardhealthlaw.com/2024/08/articles/irs/irs-audits-ongoing-scrutiny-of-nonprofit-hospitals-key-background-action-steps/> [https://perma.cc/F54Z-QFF7].

19. Letter from Representative Nydia M. Velázquez et al. to Daniel Werfel, Comm’r, IRS, and Janet Yellen, Secretary, U.S. Dep’t of Treas. (Apr. 4, 2024) [hereinafter Velázquez Letter]; Letter from Elizabeth Warren & Chuck Grassley, U.S. Senators, to Daniel Werfel, Comm’r, IRS, at 2–4 (Nov. 19, 2024) [hereinafter Warren & Grassley Letter].

20. IRS, EXEMPT ORGANIZATIONS CONTINUING PROFESSIONAL EDUCATION: THE CONCEPT OF CHARITY (1980) [hereinafter THE CONCEPT OF CHARITY].

21. Wilson-Gorman Tariff Act of 1894, ch. 349, § 32, 28 Stat. 509, 556; THE CONCEPT OF CHARITY, *supra* note 20.

22. THE CONCEPT OF CHARITY, *supra* note 20 (“So far as the term “charitable” is concerned, there has been no extensive change through a series of revenue acts from the Tariff Act of 1913 to the present IRC 501(c)(3), although additional privileges, requirements, and categories have been added.”).

community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes.”<sup>23</sup> While § 501(c)(3) has never specifically identified hospitals as tax-exempt entities, they are usually covered under the provision for “charitable” purposes.<sup>24</sup>

What it means to be “charitable” for federal income tax purposes has evolved and expanded over time.<sup>25</sup> The original meaning of “charitable” aligned with its ordinary and popular meaning of providing relief for the poor and distressed.<sup>26</sup> While Congress did not define “charitable,”<sup>27</sup> early Treasury Regulations from the 1920s explained that “[c]orporations organized and operated exclusively for charitable purposes comprise, in general, organizations for the relief of the poor.”<sup>28</sup> This language remained unchanged until 1956, when the IRS issued new proposed regulations (the “1956 Proposed Regulations”) that recognized “organizations for the relief of poverty, distress, or other conditions of similar public concern” as charitable organizations.<sup>29</sup> While the 1956 Proposed Regulations would have slightly expanded the class of charitable persons to be served, they remained substantively aligned with the ordinary and popular meaning of “charitable.”

This meaning of “charitable” was used again later that year in Revenue Ruling 56-185, which established the financial ability standard as one of four requirements that hospitals would have to meet to qualify for tax-exempt status.<sup>30</sup> Under the financial ability standard, a hospital “must be operated to the extent of its financial ability for those not able to pay for the services rendered” and “must not . . . refuse to accept patients in need of hospital care who cannot pay for such services.”<sup>31</sup> Though Revenue Ruling 56-185 did not provide specific illustrations of hospitals that met the “financial ability” standard,<sup>32</sup> the IRS later stated in private letter rulings that hospitals providing free care to fewer than 5% of patients would not qualify for tax-exempt status.<sup>33</sup> Aside from the financial ability standard, tax-exempt

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23. 26 U.S.C. § 501(c)(3).

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

25. THE CONCEPT OF CHARITY, *supra* note 20.

26. *Id.*; STAFF OF JOINT COMM. ON TAX’N, 109TH CONG., HISTORICAL DEVELOPMENT AND PRESENT LAW OF THE FEDERAL TAX EXEMPTION FOR CHARITIES AND OTHER TAX-EXEMPT ORGANIZATIONS 7 (Comm. Print 2005).

27. LIU, *supra* note 9, at 1.

28. Treas. Reg. 65, art. 517 (implementing the Revenue Act of 1924, 43 Stat. 282); Treas. Reg. 69, art. 517 (implementing the Revenue Act of 1926, 44 Stat. 40).

29. THE CONCEPT OF CHARITY, *supra* note 20 (quoting Prop. Treas. Reg. § 1.501(c)(3)-1(b), 21 Fed. Reg. 460, 464 (Jan. 21, 1956)).

30. Rev. Rul. 56-185, 1956-1 C.B. 203–04.

31. *Id.* at 203.

32. *See id.* (providing guidelines only).

33. PEARL RICHARDSON, CONG. BUDGET OFF., HEALTH CARE TRENDS AND THE TAX TREATMENT OF HEALTH CARE INSTITUTIONS 15 (1994).

hospitals also had to meet the following three requirements: (1) incorporating as a nonprofit charitable organization, (2) refraining from restricting facility usage to a select group of physicians, and (3) preventing net earnings from inuring directly or indirectly to the benefit of any private shareholder or individual (also known as “the prohibition against inurement”).<sup>34</sup>

While the latter requirements remain good law,<sup>35</sup> the financial ability standard proved short-lived for two major reasons. First, the IRS shifted its interpretation of “charitable” away from the ordinary and popular meaning and towards a broader legal sense.<sup>36</sup> It also withdrew the 1956 Proposed Regulations and issued new § 501(c)(3) regulations just three years later (the “1959 Regulations”).<sup>37</sup> The 1959 Regulations, which remain in effect today, begin by explicitly stating that the term “charitable” as used in § 501(c)(3) should be read in its “generally accepted legal sense” as opposed to the ordinary and popular meaning.<sup>38</sup> The regulation urges a broad construction of the term “charitable,” which is “not to be construed as limited by the separate enumeration in section 501(c)(3) of other tax-exempt purposes which may fall within the broad outlines of charity as developed by judicial decisions.”<sup>39</sup> It continues by giving a lengthy list of possible charitable purposes with “relief of the poor” as only one of many possibilities.<sup>40</sup> This general shift away from the ordinary and popular meaning of “charitable” was motivated largely by changes in society: As one court observed, “[n]ew discoveries in science, new fields and opportunities for human action, the differing condition, character, and wants of communities change and enlarge the scope of charity.”<sup>41</sup> Moreover, broadening the scope of tax exemption

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34. Rev. Rul. 56-185, 1956-1 C.B. 203; *see also* IRS, EXEMPT ORGANIZATIONS CONTINUING PROFESSIONAL EDUCATION: OVERVIEW OF INUREMENT/PRIVATE BENEFIT ISSUES IN IRC 501(c)(3) (1990) (describing the third requirement as the “prohibition against inurement”).

35. *See Charitable Hospitals - General Requirements for Tax-Exemption under Section 501(c)(3)*, IRS, <https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3> [<https://perma.cc/5NMC-ZN43>] [hereinafter *Charitable Hospitals*] (listing the requirements for tax exemption under current law).

36. THE CONCEPT OF CHARITY, *supra* note 20.

37. *Id.*

38. Treas. Reg. § 1.501(c)(3)-1(d)(2) (1959).

39. *Id.*

40. *Id.* The other enumerated charitable purposes are:

advancement of religion; advancement of education or science; erection or maintenance of public buildings, monuments, or works; lessening of the burdens of Government; and promotion of social welfare by organizations designed to accomplish any of the above purposes, or (i) to lessen neighborhood tensions; (ii) to eliminate prejudice and discrimination; (iii) to defend human and civil rights secured by law; or (iv) to combat community deterioration and juvenile delinquency.

*Id.*

41. *Todd v. Citizens' Gas Co. of Indianapolis*, 46 F.2d 855, 865 (7th Cir. 1931).

allowed the government to indirectly promote activities that were socially desirable, rather than merely “obvious social needs.”<sup>42</sup>

The second major reason the financial ability standard did not survive was due to aggressive hospital lobbying for reconsideration of exemption standards. When Medicare and Medicaid came into existence in the 1960s, millions of people suddenly had health insurance to cover their medical expenses.<sup>43</sup> With the rise of these government health insurance programs, along with private medical insurance becoming more common, some scholars even thought there would no longer be a need for hospitals to provide free or reduced-cost care by the 1970s.<sup>44</sup> In response to this perceived existential threat, nonprofit hospitals began arguing for new exemption standards that would “*broaden* the financial ability standard to take into account hospital expenditures beyond charity care.”<sup>45</sup> One such proposal by the American Hospital Association would have amended the language of § 501(c)(3) to include hospitals as an independent basis for exemption.<sup>46</sup> Notably, this amendment would have legislatively codified the prohibition against private inurement from Revenue Ruling 56-185, but not the financial ability standard.<sup>47</sup> Though this amendment was never passed,<sup>48</sup> the IRS ultimately replaced the financial ability standard with the community benefit standard, which remains in effect today.<sup>49</sup>

#### B. *Hospitals’ Current Operational Test: The Community Benefit Standard*

The IRS uses the community benefit standard to determine whether a nonprofit hospital is “organized and operated exclusively” for charitable purposes under § 501(c)(3).<sup>50</sup> To understand the role of this standard, it is necessary to understand the two tests that underlie it: the organizational test

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42. THE CONCEPT OF CHARITY, *supra* note 20.

43. Silver-Greenberg & Thomas, *supra* note 4.

44. See, e.g., ANNE R. SOMERS, HOSPITAL REGULATION: THE DILEMMA OF PUBLIC POLICY 41 (1969) (“Thanks to Medicare, Medicaid, and numerous other public and private mechanisms for financing care for the indigent and medically indigent, in a few years free hospital care will approach the vanishing point.”).

45. Jessica Berg, *Putting the Community Back into the “Community Benefit” Standard*, 44 GA. L. REV. 375, 396 (2010) (emphasis in original); see also *The Tax-Exempt Hospital Sector: Hearing Before the Comm. on Ways and Means*, 109th Cong. 87 (2005) (statement of John Colombo, Professor, Univ. of Ill. Coll. of L.) (noting that exempt hospitals began pushing the IRS for more flexible exemption standards in the wake of Medicare and Medicaid).

46. Douglas M. Mancino & Gerald R. Peters, *Tax Challenges Facing Non-Profit Hospitals*, 14 WHITTIER L. REV. 219, 226 (1993).

47. *Id.*

48. *Id.*

49. *Charitable Hospitals*, *supra* note 35.

50. 26 U.S.C. § 501(c)(3); *Charitable Hospitals*, *supra* note 35.

and the operational test, which were added in the 1959 Regulations.<sup>51</sup> These tests apply to all tax-exempt entities and are still used today.<sup>52</sup> The organizational test looks to whether the organization's articles of organization "(A) [l]imit the purposes of such organization to one or more exempt purposes; and (B) [d]o not expressly empower the organization to engage, otherwise than as an insubstantial part of its activities, in activities which in themselves are not in furtherance of one or more exempt purposes."<sup>53</sup> The operational test clarifies that an organization is treated as "*operated exclusively* for one or more exempt purposes only if it engages primarily in activities which accomplish" its exempt purpose, and it disqualifies organizations that engage in certain prohibited conduct.<sup>54</sup> While failure to meet the organizational test is one possible reason why an organization might be denied tax-exempt status, the vast majority of denials from 2014 through 2017 (535 out of 588 available private letter rulings) cited failure to meet the operational test as a reason for denial.<sup>55</sup>

As applied to nonprofit hospitals, the operational test requires that they engage primarily in activities that accomplish a charitable purpose. To prove that they meet this test, nonprofit hospitals must meet the community benefit standard.<sup>56</sup> The essence of the community benefit standard is that hospitals must operate in a way that promotes the health of a broad class of people within their community.<sup>57</sup> This standard was implemented by the IRS in Revenue Ruling 69-545, which eliminated the financial ability standard previously set out in Revenue Ruling 56-185.<sup>58</sup> Revenue Ruling 69-545 identified the following six factors as demonstrating community benefit: (1) operating an emergency room open to all, regardless of ability to pay; (2) maintaining a board of directors drawn from the community; (3) maintaining an open medical staff policy; (4) providing hospital care for all patients able to pay, including those who pay their bills through public programs such as Medicaid and Medicare; (5) using surplus funds to improve facilities, equipment, and patient care; and (6) using surplus funds to advance

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51. IRS, EXEMPT ORGANIZATIONS CONTINUING PROFESSIONAL EDUCATION: THE ORGANIZATIONAL TEST UNDER IRC 501(C)(3) (1985).

52. *Charitable Hospitals*, *supra* note 35.

53. Treas. Reg. § 1.501(c)(3)-1(b)(1)(i) (2017).

54. *Id.* § 1.501(c)(3)-1(c)(1) (emphasis in original). In addition to assessing the nexus between the organization's operations and its exempt purposes, the operational test prohibits private inurement and substantial political activity. *Id.* § 1.501(c)(3)-1(c)(2)-(3).

55. Terri Lynn Helge, *Rejecting Charity: Why the IRS Denies Tax Exemption to 501(c)(3) Applicants*, 14 PITT. TAX REV. 1, 31 (2016).

56. JANET E. GITTERMAN & MARVIN FRIEDLANDER, IRS, EXEMPT ORGANIZATIONS CONTINUING PROFESSIONAL EDUCATION: HEALTH CARE PROVIDER REFERENCE GUIDE 9 (2004).

57. See Rev. Rul. 69-545, 1969-2 C.B. 117-18 ("The promotion of health . . . is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole . . . provided that the class is not so small that its relief is not of benefit to the community.").

58. *Id.* at 118-19.

medical training, education, and research.<sup>59</sup> In determining whether a nonprofit hospital meets the community benefit standard, no factor is dispositive; the IRS will “weigh all of the relevant facts and circumstances.”<sup>60</sup>

To illustrate the community benefit standard, Revenue Ruling 69-545 applies the six factors to Hospital A, which meets the community benefit standard, and Hospital B, which does not.<sup>61</sup> First, Hospital A operates a full-time emergency room and does not deny treatment to anyone requiring emergency care, whereas Hospital B maintains an emergency room on a relatively inactive basis and primarily for the convenience of the staff doctors’ patients.<sup>62</sup> Second, Hospital A has a board of trustees composed of prominent citizens in the community, whereas Hospital B has a board of trustees composed of the five doctors who originally owned the hospital (“the original five doctors”), their accountant, and their lawyer.<sup>63</sup> Third, Hospital A makes medical staff privileges available to all qualified local physicians, whereas Hospital B has a medical committee comprised of the original five doctors, who control the selection and admission of other doctors to the medical staff such that many qualified doctors have been rejected.<sup>64</sup> Fourth, Hospital A accepts Medicare patients in addition to patients with private health insurance, whereas Hospital B “ordinarily limit[s] admissions to those who can pay the cost of the services rendered.”<sup>65</sup> As for the final two factors, while Revenue Ruling 69-545 does not discuss how Hospital B uses its surplus funds, it explicitly notes that Hospital A is not precluded from tax exemption by ending each year with more in operating receipts than costs.<sup>66</sup> Rather, by funneling its excess funds into improving existing facilities and equipment and improving patient care through medical training, education, and research, Hospital A furthers its exempt purpose of promoting health in the community.<sup>67</sup>

When listed in this way, the relevant facts and circumstances do support Hospital A’s tax exemption under the community benefit standard. However, Hospital A likely would not have qualified under the previous financial ability standard. Factor four, which considers whether the hospital provides care to all patients *able to pay* (including those on government-sponsored

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59. *Id.* at 118; JESSICA LUCAS-JUDY, U.S. GOV’T ACCOUNTABILITY OFF., GAO-23-106777, TAX ADMINISTRATION: IRS OVERSIGHT OF HOSPITALS’ TAX-EXEMPT STATUS 4–5 (2023) [hereinafter 2023 GAO Report].

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

61. *Id.* at 117–18.

62. *Id.* at 117.

63. *Id.*

64. In fact, during the first five years of Hospital B’s operations, only four other doctors were granted staff privileges at the hospital. *Id.*

65. *Id.*

66. *Id.* at 118.

67. *Id.*

health insurance), allows the hospital to turn away indigent patients with nonemergent health care needs. As explained in the revenue ruling, Hospital A “ordinarily limits admissions to those who can pay the cost of their hospitalization, either themselves, or through private health insurance, or with the aid of public programs such as Medicare.”<sup>68</sup> Any patients “who cannot meet the financial requirements for admission are ordinarily referred to another hospital in the community that does serve indigent patients.”<sup>69</sup> This is a far cry from the original financial ability standard, which stated that a tax-exempt hospital “must not, however, refuse to accept patients in need of hospital care who cannot pay for such services.”<sup>70</sup> Furthermore, Hospital A likely does not meet the 5% threshold to show that it operates to the extent of its financial ability for patients who are unable to pay for the services rendered.<sup>71</sup> The fact that Hospital A still qualifies for tax exemption shows that the community benefit standard not only broadened the relevant considerations for qualifying for tax-exempt status but also effectively eliminated the financial ability standard.

Revenue Ruling 69-545 is a seminal ruling that exemplifies how tax law drives and is driven by health care policy.<sup>72</sup> Policymakers during the 1960s lived during a time when health planning “formed a major theme of American health policy,” and advocates of national health insurance hoped it would help lead to universal coverage.<sup>73</sup> While the promotion of health was a charitable purpose in English common law, its basis for tax exemption independent of relief for the poor is a relatively recent phenomenon shaped by public discourse around the role that hospitals would and should play in a rapidly changing society.<sup>74</sup> Some predictions that justified the community benefit standard, such as the ever-expanding and increasingly complex nature of the health care field, were borne out.<sup>75</sup> Other predictions, such as the overly

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68. *Id.* at 117.

69. *Id.*

70. Rev. Rul. 56-185, 1956-1 C.B. 203.

71. RICHARDSON, *supra* note 33, at 15 (noting that the IRS has “ruled that private hospitals that provided free treatment for less than 5 percent of their patients were not qualified for tax exemption”); Rev. Rul. 69-545, 1969-2 C.B. 117 (“Patients who cannot meet the financial requirements for admission [to Hospital A] are *ordinarily* referred to another hospital in the community that does serve indigent patients.” (emphasis added)).

72. See Sara Rosenbaum, *The Legal Framework for Hospital Emergency Care*, in EMERGENCY CARE AND THE PUBLIC’S HEALTH 181, 186–88 (Jesse M. Pines et al. eds., 2014) (explaining that the 1969 revenue ruling was the second “major federal precursor policy” to the Emergency Medical Treatment and Labor Act (EMTALA), which made the provision of emergency care mandatory for Medicare participating hospitals).

73. Evan M. Melhado, *Health Planning in the United States and the Decline of Public-Interest Policymaking*, 84 MILBANK Q. 359, 359–60 (2006).

74. See THE CONCEPT OF CHARITY, *supra* note 20 (describing various social, political, and legislative changes that drove the IRS to revise its definition of charitable in the 1950s and ’60s).

75. *Id.*

optimistic projections that Medicare and Medicaid would lead to universal health care coverage in the United States, have not.<sup>76</sup> Revenue Ruling 69-545 has been criticized on the grounds that it “operates as unwise health policy by perpetuating and enlarging the gulf between the health care available to the rich and that available to the poor” and has helped create today’s “payment-focused hospital system.”<sup>77</sup>

This gap between the haves and the have-nots will widen due to the One Big Beautiful Bill Act (the “Big Beautiful Bill”), enacted on July 4, 2025, which is almost certain to increase the demand for charity care while simultaneously decreasing nonprofit hospitals’ financial ability to provide such care.<sup>78</sup> The Big Beautiful Bill is projected to cause roughly 15 million people to lose health coverage and become uninsured by 2034, mostly due to Medicaid and ACA marketplace cuts.<sup>79</sup> Around 7.8 million, or more than half of those affected by the Big Beautiful Bill, will lose access to Medicaid through a variety of mechanisms.<sup>80</sup> These mechanisms include new community engagement requirements to qualify for coverage, more frequent eligibility redetermination, and loss of Medicaid eligibility for qualified immigrants who are humanitarian entrants.<sup>81</sup> Around 4.2 million, or nearly a third of those affected, will lose ACA marketplace coverage because the Big Beautiful Bill allows the enhanced premium tax credits (PTCs) that support the marketplace to sunset after 2025.<sup>82</sup> These enhanced PTCs were first enacted in 2021 and encouraged roughly 9.6 million people to enroll in the ACA marketplace by lowering the average annual premium by an estimated

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76. Rainer WG Guessner, *Why Does Universal Health Coverage Not Exist in the United States? A Physician’s Perspective*, MATHEWS J. CASE REPS., Oct. 2023, at 1, 3–4.

77. Patrick Maseo, *IRS Rule Changes Helped Create a Payment-Focused Hospital System*, STAT (Mar. 5, 2019) (quoting Marilyn G. Rose, *The Internal Revenue Service’s “Contribution” to the Health Problems of the Poor*, 21 CATH. UNIV. L. REV. 35, 43 (1971)), <https://www.statnews.com/2019/03/05/irs-rule-changes-payment-driven-hospital-system/> [<https://perma.cc/CS7Q-8HQR>].

78. “OBBBA” Poses Long-Term Challenges for U.S. Not-For-Profit Hospitals, FITCH RATINGS (July 10, 2025, at 5:01 PM ET), <https://www.fitchratings.com/research/us-public-finance/obbba-poses-long-term-challenges-for-us-not-for-profit-hospitals-10-07-2025> [<https://perma.cc/FC2T-88UU>] [hereinafter “OBBBA” Poses Long-Term Challenges]; *By the Numbers: Harmful Republican Megabill Will Take Health Coverage Away from Millions of People and Raise Families’ Costs*, CTR. ON BUDGET & POL’Y PRIORITIES (Aug. 27, 2025), <https://www.cbpp.org/research/health/by-the-numbers-republican-reconciliation-law-will-take-health-coverage-away-from> [<https://perma.cc/P4G3-2NPV>].

79. *By the Numbers*, *supra* note 78.

80. Letter from Phillip L. Swagel, Dir., Cong. Budget Off., to Ron Wyden, Richard E. Neal and Frank Pallone, Jr., Members of Congress, at 3, 6–8 (June 4, 2025).

81. One Big Beautiful Bill Act, Pub. L. No. 119-21, §§ 71107, 71109, 71119, 139 Stat. 72, 295, 297, 306–07 (2025); Letter from Phillip L. Swagel, *supra* note 80, at 6–7.

82. Letter from Phillip L. Swagel, *supra* note 80, at 3–4.

\$700.<sup>83</sup> As more patients lose Medicaid or ACA marketplace coverage, hospitals will experience squeezes on their cash flows, which will ultimately degrade their ability to serve uninsured patients.<sup>84</sup> Given that the most dramatic cuts have been made to Medicaid, hospitals with higher exposure to Medicaid patients or in states that have aggressively expanded Medicaid eligibility will likely be most vulnerable to these financial pressures.<sup>85</sup>

With the demand for charity care only projected to increase, discourse over whether to reform the community benefit standard will likely intensify. Defenders of the community benefit standard argue that different communities have different needs, so a flexible standard allows hospitals to demonstrate that they provide community benefits through various tailored means.<sup>86</sup> For instance, a hospital in a remote rural area may be the only hospital for hundreds of miles, so its very existence is the primary benefit to the community.<sup>87</sup> Further, certain types of hospitals like university hospitals arguably provide specialized community benefits through medical research or education. For example, even though the University of Chicago Medical Center provided only \$24.1 million in charity care in 2023, it invested \$48 million in medical research and \$4.1 million in medical education.<sup>88</sup>

On the other hand, critics point to the lack of substantive updates to the community benefit standard, despite mistaken assumptions leading to its adoption and changing circumstances in the medical sector. Although the community benefit standard offers hospitals more flexibility to invest in their communities, the fact that the standard has not changed significantly since 1969 means that it is not as responsive to present-day communities as it could be.<sup>89</sup> As the United States Government Accountability Office (the “GAO”) indicated in its most recent report on nonprofit hospitals, various developments in the health care field have perhaps made Revenue Ruling 69-545’s factors “a less useful gauge for measuring community benefit than they once were.”<sup>90</sup> In 1986, Congress passed EMTALA, which requires Medicare-participating hospitals to provide emergency treatment to all

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83. Gideon Lukens & Elizabeth Zhang, *Premium Tax Credit Improvements Must Be Extended to Prevent Steep Rise in Health Care Costs*, CTR. ON BUDGET & POL’Y PRIORITIES (Nov. 14, 2024), <https://www.cbpp.org/research/health/premium-tax-credit-improvements-must-be-extended-to-prevent-steep-rise-in-health> [<https://perma.cc/9S22-MET9>].

84. “*OBBBA*” Poses Long-Term Challenges, *supra* note 78.

85. *Id.*

86. 2023 GAO Report, *supra* note 59, at 7.

87. *Id.*

88. 2023 *Annual Community Benefit Report*, UCHICAGO MED., <https://community.uchicagomedicine.org/2023/community-investment.html> [<https://perma.cc/G3BC-KJ6W>].

89. While the IRS clarified in 1983 that hospitals were not required to operate an emergency room open to the general public to qualify for tax-exempt status, the factors themselves have not changed. Rev. Rul. 83-157, 1983-2 C.B. 94-95.

90. 2023 GAO Report, *supra* note 59, at 7.

patients, regardless of their ability to pay.<sup>91</sup> As well, it is a given today that most (if not all) hospitals maintain an open medical staff and accept patients on Medicare and Medicaid.<sup>92</sup> Despite these significant changes in the health care landscape, the community benefit standard has not been revised significantly since 1969, making it a ripe area for legislative reform.

C. *Section 501(r): The New Patient Protection and Affordable Care Act Requirements*

To increase charity care and decrease aggressive collection practices, in 2010 Congress added new statutory requirements for nonprofit hospitals in the Affordable Care Act, codified at 26 U.S.C. § 501(r).<sup>93</sup> Section 501(r) was intended to help ensure that nonprofit hospitals meet the community benefit standard, but lax enforcement of the provision has made it an increasing area of scrutiny for lawmakers.

Section 501(r) was proposed by Senator Chuck Grassley, who has investigated nonprofit hospital reform since at least 2005.<sup>94</sup> In relation to § 501(r)'s purpose, Senator Grassley explained: "The provisions take steps to differentiate tax-exempt hospitals from for-profit hospitals and provide further transparency about tax-exempt hospitals' fulfilling their charitable mission. Congress, the IRS, and the public will now have additional tools and information to ensure that charitable hospitals act charitably."<sup>95</sup>

Section 501(r) imposes four additional requirements on top of the operational test discussed above for nonprofit hospitals seeking tax-exempt status: (1) conducting a triennial community health needs assessment, (2) writing and publicizing a financial assistance policy, (3) refraining from gross billing charges, and (4) refraining from extraordinary collection actions before the hospital has made reasonable efforts to determine whether patients are eligible for financial assistance.<sup>96</sup> On paper, § 501(r) should have resulted in increased charity care spending because of the financial assistance policy requirement. In addition, the requirement to determine whether patients are eligible for financial assistance *before* making extraordinary collection efforts should have prevented predatory billing practices like Providence's "detailed playbook for wringing money out of patients."<sup>97</sup>

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91. *Id.*

92. *Id.*

93. 26 U.S.C. § 501(r); Velázquez Letter, *supra* note 19.

94. Christopher J. Armstrong, Nicole M. Elliott & Lisa Hawke, *Senate Finance Committee Begins Review of Nonprofit Hospitals*, HOLLAND & KNIGHT (Feb. 25, 2019), <https://www.hklaw.com/en/insights/publications/2019/02/senate-finance-committee-begins-review-of-nonprofi> [<https://perma.cc/W3YZ-ML4J>].

95. Press Release, Chuck Grassley, *supra* note 1.

96. 26 U.S.C. § 501(r)(3)–(6).

97. Silver-Greenberg & Thomas, *supra* note 4.

In practice, however, this has not been the case,<sup>98</sup> mostly since § 501(r)'s enforcement mechanism is lacking. The final regulations under § 501(r), which apply to taxable years after December 29, 2015,<sup>99</sup> inherently give the IRS significant leeway in whether and how to punish noncompliant nonprofit hospitals. For example, the regulations provide that minor omissions and errors do not constitute a § 501(r) violation as long as they were inadvertent or due to reasonable cause, and the hospital is proactive in correcting them in a reasonably prompt manner after discovery.<sup>100</sup> Further, even if the omission or error is not minor, the regulations provide that it “shall be excused” if corrected and disclosed, and if the hospital’s failure to meet a § 501(r) requirement “is neither willful nor egregious.”<sup>101</sup>

While revocation of § 501(c)(3) status is a possible consequence of failure to comply with § 501(r),<sup>102</sup> the IRS has resorted to that punishment in fewer than five instances.<sup>103</sup> A hospital would need to behave egregiously or willfully to lose its § 501(c)(3) status through § 501(r) noncompliance. For example, two of the hospitals that have lost § 501(c)(3) status due to violation of § 501(r) completely failed to meet any § 501(r) requirement.<sup>104</sup> In another instance, a private letter ruling found that the nonprofit hospital’s failure to comply was “egregious” and that it lacked “the will, the financial resources, [or] the staff” to comply.<sup>105</sup>

Most tellingly, the IRS has only revoked § 501(c)(3) status due to § 501(r) noncompliance for dual-status hospitals. A dual-status hospital is a governmental hospital that is tax-exempt under both § 501(c)(3) and § 115 of the Internal Revenue Code.<sup>106</sup> Thus, even if a dual-status hospital’s § 501(c)(3) status is revoked, it is still eligible for federal income tax

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98. See, e.g., *Senate Committee Report on Non-Profit Hospitals Recommends Minimum Requirements for Meeting Community Benefit Standard*, ERNST & YOUNG (Oct. 16, 2023), <https://taxnews.ey.com/news/2023-1721-senate-committee-report-on-non-profit-hospitals-recommends-minimum-requirements-for-meeting-community-benefit-standard> [https://perma.cc/QT8N-J7LK] (citing a study that found “average charity care spending by tax-exempt hospitals dropped from \$6.7m to \$6.4m between 2012 and 2019, while their average cash balance held in reserve increased from about \$133m to more than \$224m”).

99. *IRS Finalizes Regulations Under Section 501(r)*, FAEGRE DRINKER (Jan. 21, 2015), <https://www.faegredrinker.com/en/insights/publications/2015/1/irs-finalizes-regulations-under-section-501r> [https://perma.cc/3G5P-SAE9].

100. Treas. Reg. § 1.501(r)-2(b) (2015).

101. *Id.* § 1.501(r)-2(c).

102. *Id.* § 1.501(r)-2(a).

103. LIU, *supra* note 9, at 7.

104. See I.R.S. Priv. Ltr. Rul. 201833021 (Aug. 17, 2018) (finding that the entity was not in compliance with § 501(r) and was not even aware of its obligation to comply); I.R.S. Priv. Ltr. Rul. 201833020 (Aug. 17, 2018) (same).

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

106. Andrew D. Kloeckner, *Governmental Hospitals and Section 501(r) Compliance*, BAIRD HOLM LLP (Mar. 29, 2013), <https://www.bairdholm.com/blog/governmental-hospitals-and-section-501r-compliance/> [https://perma.cc/E8P6-QGJ9].

exemption under § 115 due to its status as a governmental hospital.<sup>107</sup> As such, the hospitals that have lost § 501(c)(3) status due to noncompliance with § 501(r) did not litigate the issue.<sup>108</sup> In fact, the two dual-status hospitals were even “agreeable” to the IRS terminating their § 501(c)(3) status since they did not derive additional tax benefits from being a § 501(c)(3) organization.<sup>109</sup> Because these dual-status hospitals are unrepresentative of § 501(c)(3) hospitals generally, it is unclear that the IRS would take such drastic action in other contexts.

## II. Recent Pressures on the IRS and Legal Predictions

However, increased political pressure on the IRS in the last two years has nonprofit hospitals wary that the federal tax exemption requirements will either be reformed or be subject to stricter enforcement. In early 2023, the GAO’s Director of Strategic Issues testified before a House subcommittee on the ways in which the IRS’s enforcement of the community benefit standard was lacking.<sup>110</sup> Later that year, a bipartisan group of four senators, including Senator Grassley, wrote a letter to the IRS asking how its 2024 audit plan would “improve oversight of hospitals’ tax-exempt status.”<sup>111</sup> In 2024, lawmakers put even more pressure on the IRS with a letter in April from the House of Representatives and in November from the Senate.<sup>112</sup> These developments suggest major changes on the horizon for both the community benefit standard and § 501(r).

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107. *Id.*

108. At the time of the Congressional Research Service’s report on § 501(c)(3) hospitals in April 2024, there were zero Westlaw cases discussing § 501(r). LIU, *supra* note 9, at 7 n.53. A cursory Westlaw search as of February 2026 reveals two cases that cite § 501(r). The earlier of the two cases merely references § 501(r) as an example of a statute that specifically provides for two words as alternatives, but the case itself did not litigate § 501(r) noncompliance. *Mayo Clinic v. United States*, 412 F. Supp. 3d 1038, 1049 (D. Minn. 2019). The more recent case does indirectly concern § 501(r) noncompliance, though the issue was whether the hospital violated Oregon laws on fair debt collection and financial assistance policies, which expand on the requirements of § 501(r)—not whether the hospital’s conduct was egregious enough to threaten its tax-exempt status. *Reiger v. St. Charles Health Sys., Inc.*, 2025 WL 1676534, at \*1–4 (D. Or. June 13, 2025).

109. *See, e.g.*, I.R.S. Priv. Ltr. Rul. 201833021 (“The entity’s CEO stated they were agreeable to termination of the 501(c)(3) status since they were not aware for [sic] its existence, nor was a tangible benefit being derived from the status. The entity was established as [a] governmental hospital and has been operating as such.”); I.R.S. Priv. Ltr. Rul. 201829017 (July 20, 2018) (stating the same).

110. 2023 GAO Report, *supra* note 59, at 11–12.

111. Letter from Elizabeth Warren, Raphael Warnock, Bill Cassidy & Chuck Grassley, U.S. Senators, to Daniel Werfel, Comm’r, IRS and Edward T. Killen, Comm’r, IRS, Tax Exempt and Gov’t Entities Div., at 4–5 (Aug. 7, 2023).

112. *See* Velázquez Letter, *supra* note 19 (urging the IRS “to ensure accountability for nonprofit hospitals”); Warren & Grassley Letter, *supra* note 19, at 2 (requesting that the IRS “strengthen and enforce regulations” pertaining to nonprofit hospitals).

A. *The Future of the Community Benefit Standard*

There has been pressure on the IRS to reinstate the financial ability standard from Revenue Ruling 56-185. On April 4, 2024, nine members of Congress wrote to the Department of Treasury and the IRS recommending a new revenue ruling “clarifying that nonprofit hospitals are expected to provide charity care commensurate with their financial resources.”<sup>113</sup> On November 19, 2024, Senators Elizabeth Warren and Chuck Grassley similarly called for a return to the financial ability standard but went further in asking that the IRS also “issue guidance on when charity care is appropriate, *e.g.*, when hospitals should assume that patients are unable to pay.”<sup>114</sup>

Though it is within the IRS’s power to reinstate the financial ability standard, some of the language of Revenue Ruling 56-185 would need clarification. The financial ability standard was criticized for being imprecise and ambiguous.<sup>115</sup> To qualify for tax-exempt status under the previous financial ability standard, a nonprofit hospital:

must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay. It is normal for hospitals to charge those able to pay for services rendered in order to meet the operating expenses of the institution, without denying medical care or treatment to others unable to pay. The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may furnish services at reduced rates which are below cost, and thereby render charity in that manner. It may also set aside earnings which it uses for improvements and additions to hospital facilities. It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services.<sup>116</sup>

Unlike some state legislation that requires hospitals to devote a certain percentage of revenue to charity care,<sup>117</sup> the financial ability standard is not a bright-line rule. While individual taxpayers could request private letter rulings to clarify if they provided adequate charity care to qualify for tax

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113. Velázquez Letter, *supra* note 19.

114. Warren & Grassley Letter, *supra* note 19, at 4 (alterations in original).

115. *The Tax-Exempt Hospital Sector: Hearing Before the Comm. on Ways and Means*, 109th Cong. 12 (2005) (statement of Mark Everson, Comm’r, IRS); H.R. Rep. No. 91-413, pt. 1, at 43 (1969) (“Such obligations to serve those who cannot pay are indefinite under existing law and existing interpretations of the law.”).

116. Rev. Rul. 56-185, 1956-1 C.B. 203.

117. *E.g.*, TEX. HEALTH & SAFETY CODE ANN. § 311.045(b)(1)(C) (West 2025).

exemption,<sup>118</sup> Revenue Ruling 56-185 never provided an explicit benchmark for how to determine the amount of charity care a hospital was “financially able” to provide. Indeed, it states that a relatively low charity record “is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability.”<sup>119</sup> Revenue Ruling 56-185 creates further ambiguity by suggesting that setting aside earnings for improvements and additions to hospital facilities would be taken into consideration when applying the financial ability standard.<sup>120</sup> Improving hospital facilities is considered a separate factor under the community benefit standard,<sup>121</sup> which raises the question of how the financial ability standard would apply to hospitals that have high overall community benefit spending but low charity care spending.

Still, despite these uncertainties around the financial ability standard, it is not hard to see why several members of Congress have pressured the IRS to reinstate it. Reinstating the financial ability standard is within the IRS’s authority to issue guidance, and the IRS would be able to update and clarify the standard for the twenty-first century. Further, administrative agencies can generally act faster than legislative bodies.<sup>122</sup> Though it is rare for the IRS to reinstate a previous revenue ruling, there is precedent for it. For example, the IRS issued Revenue Ruling 83-111 in 1983, which revoked Revenue Ruling 77-475.<sup>123</sup> However, due to “tremendous public criticism and expected Congressional action,” the IRS reinstated and modified Revenue Ruling 77-475 as Revenue Ruling 84-58 the following year.<sup>124</sup>

Given the public and political pressure on the IRS in recent years, it seems likely that a new revenue ruling is on the horizon for nonprofit hospitals. Most likely, the financial ability standard will make a return in some form, though it is possible the IRS may treat it as just one factor—or even the predominating factor among many—in assessing community benefit, rather than eliminating the community benefit standard entirely. A modified community benefit standard in this form would preserve the

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118. See, e.g., RICHARDSON, *supra* note 33, at 15 (noting that the IRS ruled in several instances that private hospitals that provided free treatment to less than 5% of their patients did not satisfy the financial ability standard).

119. Rev. Rul. 56-185, 1956-1 C.B. 203.

120. *Id.*

121. See Rev. Rul. 69-545, 1969-2 C.B. 118 (finding that Hospital A is furthering its charitable purpose by using its surplus funds to expand its facilities).

122. Mark Richardson, *Delegation and Deference in the Administrative State: The Fate of Chevron Deference*, GOV’T AFFS. INST. (June 24, 2024), <https://gai.georgetown.edu/delegation-and-deference-in-the-administrative-state-the-fate-of-chevron-deference/> [<https://perma.cc/98Z8-D2Z4>].

123. I.R.S. Field Serv. Advice Mem. for Dist. Counsel 199911001, at 3 n.4 (Nov. 10, 1998).

124. *Id.*

flexibility afforded to nonprofit hospitals, while also emphasizing the importance of charity care.

*B. The Future of Section 501(r)*

Though the IRS has historically been lax in enforcing § 501(r), recent developments indicate that the IRS is looking at § 501(r) compliance more closely moving forward.<sup>125</sup> On March 18, 2024, the IRS's Tax-Exempt and Government Entities Division updated its compliance strategies to include a focus on compliance with the ACA and examining whether tax-exempt hospitals are meeting their statutory obligations under § 501(c)(3), including the community benefit standard, and § 501(r).<sup>126</sup> Not even a month later, nine members of Congress wrote a letter to the IRS urging it to “strengthen and enforce the regulations for nonprofit hospitals under Section 501(r)” by taking the following five actions:

- (1) Ensuring that financial assistance policies are more accessible to eligible patients and that the financial assistance application is not overly burdensome;
- (2) Prohibiting hospitals from billing inflated “gross charges” to any patients;
- (3) Banning the most harmful collections actions, such as wage garnishment or the denial of necessary medical care due to outstanding bills;
- (4) Strengthening the requirements for nonprofit hospitals to make “reasonable efforts” to determine financial assistance eligibility prior to pursuing collection actions; and
- (5) Increasing enforcement activities, such as audits and/or the loss of tax-exempt status, so that nonprofit hospitals are held accountable for practices that threaten the wellbeing of their patients.<sup>127</sup>

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125. See Lauren West, *Complying with ACA Tax-Exempt Hospital Requirements*, TAX ADVISOR (July 31, 2025), <https://www.thetaxadviser.com/issues/2025/jul/complying-with-aca-tax-exempt-hospital-requirements/> [<https://perma.cc/N6GL-8PFR>] (listing recent developments that suggest the IRS's renewed interest in regulating tax-exempt hospitals).

126. Michael Kuczynski, Lisa M. Schultes & Toni Ruo, *Examining Community Benefit: The IRS' Shifting Standards for Tax-Exempt Hospitals*, POLSINELLI (Apr. 1, 2024), <https://www.polsinelli.com/publications/examining-community-benefit-the-irs-shifting-standards-for-tax-exempt-hospitals> [<https://perma.cc/38KA-HX98>] (citing *Tax-Exempt & Government Entities: Compliance Program and Priorities*, IRS, <https://www.irs.gov/government-entities/tax-exempt-government-entities-compliance-program-and-priorities> [<https://perma.cc/D7WJ-CFL9>]).

127. Velázquez Letter, *supra* note 19.

By that summer, the IRS had announced that it was auditing thirty-five tax-exempt hospitals.<sup>128</sup> While the IRS did not specify which hospitals were under audit due to taxpayer confidentiality and disclosure laws,<sup>129</sup> the agency seems to be targeting hospitals that “reported low community benefit percentages on their IRS Form 990.”<sup>130</sup> Alongside the audits, the IRS is expected to issue new guidance on the application of § 501(r) regulations,<sup>131</sup> though reductions in the IRS workforce may cause delays or unexpected audit closures.<sup>132</sup>

As final regulations under § 501(r) were only issued within the last decade, there may simply not be enough precedent to predict the exact form the new guidance will take. At its core, however, § 501(r)’s problem is one of enforcement rather than ambiguity. In contrast to the community benefit standard, which has inherent ambiguities, the IRS “can easily verify whether the legal requirements in [the ACA] are met” because the metrics are clear and objective.<sup>133</sup> As such, nonprofit hospitals can expect different short-term developments concerning § 501(r), with the focus being more on enforcement rather than reform.

In preparation for enhanced § 501(r) scrutiny, many tax advisors have already urged hospitals to be proactive and make sure that they are in compliance with § 501(r).<sup>134</sup> For example, one audit, tax, and consulting firm recommends that nonprofit hospitals watch for five warning signs of § 501(r) noncompliance: (1) “[t]he [financial assistance policy] is not accessible on

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128. Rosenberg & Arroyo, *supra* note 18.

129. Owen Racer, *Nonprofit Hospitals’ Community Benefits Come Under IRS Scrutiny*, BLOOMBERG LAW NEWS (July 8, 2024), <https://www.bloomberglaw.com/bloomberglawnews/daily-tax-report/XBK328A4000000> [<https://perma.cc/J5EW-DAU3>].

130. Rosenberg & Arroyo, *supra* note 18. Tax-exempt hospitals must file Form 990, Schedule H annually to demonstrate compliance with § 501(r). Amy Ciminello & Alyssa Kent, *Increased Focus on IRC 501(r) Compliance: Is Your Hospital Prepared?*, PLANTE MORAN (July 2, 2024), <https://www.plantemoran.com/explore-our-thinking/insight/2024/07/increased-focus-on-irc-501r-compliance-is-your-hospital-prepared> [<https://perma.cc/4D3M-ZWV4>].

131. See Warren & Grassley Letter, *supra* note 19, at 2 (mentioning that the IRS has announced it will issue guidance on § 501(r)); AVIVA ARON-DINE, DANNY WERFEL & MARJORIE A. ROLLINSON, DEP’T OF THE TREASURY, 2024-2025 PRIORITY GUIDANCE PLAN 1, 8 (Oct. 3, 2024), <https://www.irs.gov/pub/irs-counsel/2024-2025-priority-guidance-plan-initial-version.pdf> [<https://perma.cc/82TC-FX3L>] (listing “[g]uidance illustrating the application of the regulations under §501(r)” as one of the Treasury Department’s priorities through June 2025).

132. West, *supra* note 125.

133. 2023 GAO Report, *supra* note 59, at 11, 13 (explaining that hospitals must answer a series of yes or no questions for each of the four ACA requirements in their Form 990, Schedule H).

134. See, e.g., *Latest Congressional Call to Strengthen Tax-Exempt Hospital Regulations and Enforcement Coincides with Increased Examinations of Tax-Exempt Hospitals*, ERNST & YOUNG (May 15, 2024), <https://taxnews.ey.com/news/2024-0980-latest-congressional-call-to-strengthen-tax-exempt-hospital-regulations-and-enforcement-coincides-with-increased-examinations-of-tax-exempt-hospitals> [<https://perma.cc/XEN2-69QB>] (advising exempt hospitals to ensure they have adequate documentation of their community benefit expenses and to closely review their reporting procedures).

the hospital’s website;” (2) “[f]inancial assistance signage or invoice language has changed over time;” (3) “the hospital has been contacted by a watchdog organization regarding its financial assistance policy;” (4) the number of “[d]ays outstanding for patient account[s] receivable has decreased,” suggesting the hospital is overly aggressive with billing; and (5) “[p]ersonnel responsible for IRC Section 501(r) compliance have changed.”<sup>135</sup> As the situation is still developing, it makes sense for nonprofit hospitals to tread carefully regarding § 501(r) for the time being and learn from the 2024 and forthcoming audits.

### III. Recently Proposed and Enacted Legislation

As discussed, the community benefit standard is ripe for reform, and it is within the IRS’s power to issue a new revenue ruling reimplementing the financial ability standard. Nevertheless, congressional intervention may be needed to fully address the concerns that the Lown Institute and others have expressed regarding the fair share deficit. Unlike Congress, the IRS “does not have authority to define specific types of services and activities that a hospital must undertake to qualify for a tax exemption.”<sup>136</sup>

Perhaps that lack of authority is why the community benefit standard has not provided the desired level of clarity: The same arguments about imprecise standards that were levied against the 1956 financial ability standard have also recurred in the context of the community benefit standard.<sup>137</sup> Hypothetically, because of the looseness of the community benefit standard, a hospital could maintain its tax exemption under current law by “operating an emergency room open to all and accepting patients on Medicare or Medicaid, which are common among hospitals, while spending little to no money on charity care or other community benefit activities.”<sup>138</sup>

Due to these ambiguities, the GAO recommended in both its 2020 and 2023 reports that Congress pass legislation “specify[ing] services and activities Congress believes would provide sufficient community benefits.”<sup>139</sup> One reform that would accomplish this objective is a federal

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135. Mallory Fairless, Janice Smith & Will Smith, *5 Signs Section 501(r) Compliance Needs a Checkup*, CROWE (Feb. 15, 2024), <https://www.crowe.com/insights/tax-news-highlights/5-signs-section-501r-compliance-needs-a-checkup> [<https://perma.cc/TVD7-AY8H>].

136. 2023 GAO Report, *supra* note 59, at 7.

137. *See id.* (“Representatives of tax-exempt hospitals told us that current law and the community benefit standard offer hospitals needed flexibility in demonstrating community benefits. . . . However, that lack of clarity also creates challenges for IRS in administering tax law.”).

138. *Id.*

139. *Id.* at 8; U.S. GOV’T ACCOUNTABILITY OFF., GAO-20-679, TAX ADMINISTRATION: OPPORTUNITIES EXIST TO IMPROVE OVERSIGHT OF HOSPITALS’ TAX-EXEMPT STATUS 27 (2020) (“Congress should consider specifying in the IRC what services and activities it considers sufficient community benefit.”).

minimum charity care requirement. Such legislation would impact the provision of charity care in the many states that lack state-specific charity care minimums or other requirements.<sup>140</sup> On a national scale, increasing nonprofit hospitals' average charity care expenditures would provide billions of dollars more in lifesaving charity care.<sup>141</sup>

In fact, there have been previous congressional attempts to increase national charity care levels by tying charity care minimums to nonprofit hospitals' tax-exempt status. In 2007, the Senate Finance Committee recommended that "a nonprofit hospital should provide charity care and community benefits equal to at least 5% of hospital operating expenses or revenue (whichever is greater)."<sup>142</sup> In 2009, the Senate Finance Committee planned to include the 5% minimum charity care threshold as a requirement for tax exemption in a broader health care reform proposal submitted by Senators Max Baucus and Chuck Grassley, but the requirement was ultimately scrapped after opposition by nonprofit hospitals.<sup>143</sup>

The current Congress has not proposed legislation to implement a minimum charity care requirement,<sup>144</sup> though a proposed bill seeks to codify a modified form of the IRS's community benefit standard.<sup>145</sup> The Holding

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140. For an overview of state legislation regulating hospitals' provision of charity care and other financial assistance, see generally ANDREA BOPP STARK & JENIFER BOSCO, NAT'L CONSUMER L. CTR., AN OUNCE OF PREVENTION: A REVIEW OF HOSPITAL FINANCIAL ASSISTANCE POLICIES IN THE STATES (2021), [https://www.nclc.org/wp-content/uploads/2022/09/Rpt\\_Ounce\\_of\\_Prevention.pdf](https://www.nclc.org/wp-content/uploads/2022/09/Rpt_Ounce_of_Prevention.pdf) [<https://perma.cc/5BH7-KWKL>]; Maanasa Kona & Vrudhi Raimugia, *State Protections Against Medical Debt: A Look At Policies Across the U.S. in 2025*, COMMONWEALTH FUND (July 16, 2025), <https://www.commonwealthfund.org/publications/fund-reports/2025/jul/state-protections-against-medical-debt-look-policies-across-us> [<https://perma.cc/52ZF-VK2F>].

141. See, e.g., Wade Rathke, *Predatory Practices of Nonprofit Hospitals*, CHIEF ORGANIZER BLOG (Sep. 27, 2022), <https://chieforganizer.org/2022/09/27/predatory-practices-of-nonprofit-hospitals/> [<https://perma.cc/T722-CBF5>] (concluding that "another billion dollars in lifesaving charity care would be provided in just the three-state area [consisting of Louisiana, Texas, and Arkansas] that we researched, if all of the hospitals hit the average for charity care.").

142. Kristine Principe, E. Kathleen Adams, Jenifer Maynard & Edmund R. Becker, *The Impact of the Individual Mandate and Internal Revenue Service Form 990 Schedule H on Community Benefits from Nonprofit Hospitals*, 102 AM. J. PUB. HEALTH 229, 231 (2012).

143. *Nonprofits Unhappy with Health Care Proposals*, NONPROFIT ADVOCATE (Bricker & Eckler LLP, Columbus, Ohio), Sep. 2009, at 2, <https://www.lexology.com/library/detail.aspx?g=c6e96912-c34e-4ad3-a0ff-de3bc99898bf> [<https://perma.cc/4XCB-LYCY>].

144. However, the current Congress is actively soliciting and considering policy proposals to impose additional hospital-specific requirements for tax exemption. Most recently, on September 16, 2025, the House Subcommittee on Oversight held a hearing focused on the definition of community benefit. Dr. Christopher Whaley, one of the witnesses at the hearing, provided written testimony that recommended establishing "defined standards for financial assistance and benefits to the community health sector," such as "minimum levels of charity care based on tax-exemption value." *Virtue Signaling vs. Vital Services: Where Tax-Exempt Hospitals Are Spending Your Tax Dollars: Hearing Before the Subcomm. on Oversight of the H. Comm. on Ways and Means*, 119th Cong. 10 (2025) (statement of Christopher M. Whaley, Assoc. Dir., Ctr. for Advancing Health Pol'y through Rsch., Brown Univ. Sch. of Pub. Health).

145. Holding Nonprofit Hospitals Accountable Act, H.R. 3019, 119th Cong. (2025).

Nonprofit Hospitals Accountable Act was first introduced in the previous Congress in April 2023 by Representative Victoria Spartz<sup>146</sup> and reintroduced in the current Congress in April 2025 with the same provisions.<sup>147</sup> In Representative Spartz’s words, the Act responds to concerns that nonprofit hospitals provide levels of charity care “significantly less than government and for-profit hospitals” and “ensures that nonprofit hospitals spend 100% of the value of their tax exemptions each year on policies directly improving the affordability and accessibility of care.”<sup>148</sup> The proposed Act would revise § 501(r) to incorporate the community benefit standard as an additional statutory requirement for nonprofit hospitals to qualify for tax exemption.<sup>149</sup> However, this community benefit standard is not a mere codification of the IRS’s standard from Revenue Ruling 69-545, but rather seeks to redefine community benefit in certain key ways. The text for the proposed community benefit standard reads:

(A) IN GENERAL.—A hospital organization meets the requirements of this paragraph if such organization—

(i) has a board of directors drawn from the community in which such organization is located,

(ii) both—

(I) treats patients who pay their bills through public programs, including under the Medicare program under title XVIII of the Social Security Act or under the Medicaid program under title XIX of such Act, and

(II) does not limit the number of such patients served at any clinical site owned or controlled by such organization, and

(iii) spends an amount which meets or exceeds the expenditure threshold for the taxable year on any combination of—

(I) training, education, or research designed to improve patient care,

(II) improvements to facilities and equipment except as provided in subparagraph (C), and

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146. Holding Nonprofit Hospitals Accountable Act, H.R. 2859, 118th Cong. (2023).

147. As of February 2026, there have been no new actions taken on the Holding Nonprofit Hospitals Accountable Act. See H.R. 3019 - Holding Nonprofit Hospitals Accountable Act, <https://www.congress.gov/bill/119th-congress/house-bill/3019/all-actions> [<https://perma.cc/H6QB-SPGC>] (listing actions taken on the bill).

148. *Member Day: Hearing Before the H. Comm. on Ways and Means*, 118th Cong. 103 (2023) (statement of Rep. Victoria Spartz, Member, H.R.).

149. Holding Nonprofit Hospitals Accountable Act, H.R. 3019, 119th Cong. § 2(a)(1) (2025).

(III) free or discounted care pursuant to a financial assistance policy.<sup>150</sup>

Though the proposed community benefit standard retains the six “factors” from Revenue Ruling 69-545, the factors have been turned into a three-pronged list of requirements that a hospital must (1) have a board of directors drawn from the community, (2) accept Medicare and Medicaid patients without limit, and (3) meet a certain “expenditure threshold” through a combination of research, improvements to facilities, and charity care. The bill defines the expenditure threshold as “100 percent of the value of the Federal, State, and local tax exemptions of the hospital organization for the taxable year.”<sup>151</sup> Additionally, the provision on facility improvements cross-references subparagraph (C),<sup>152</sup> which imposes two quantitative limitations on which facility improvements will count towards the expenditure threshold. First, facility improvements can only count towards 50% of the expenditure threshold at most.<sup>153</sup> Second, no “expenditures for the acquisition of a physician practice, hospital, ambulatory surgical center, or any other care delivery organization” can count towards the expenditure threshold.<sup>154</sup>

The Holding Nonprofit Hospitals Act reflects a growing trend among bipartisan legislators “to move toward a more quantitative standard to determine a hospital’s tax-exempt status.”<sup>155</sup> As some health care analysts have noted, the use of quantitative standards, like mandatory minimums for community benefit spending, would be a major shift from existing policy and could have negative ramifications.<sup>156</sup> However, this proposed bill is a step in

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150. *Id.* § 2(a)(3).

151. *Id.*

152. *Id.*

153. *Id.*

154. *Id.*

155. Kuczynski, Schultes & Ruo, *supra* note 126.

156. Rebekuh Eley, Michael Haas & Danny Schmidt, *Proposed Legislation Scrutinizes Community Benefit Standards for Tax-Exempt Hospitals*, HEALTHCARE BUS. TODAY (May 10, 2025), <https://www.healthcarebusinessstoday.com/proposed-legislation-scrutinizes-community-benefit-standards-for-tax-exempt-hospitals/> [<https://perma.cc/R7RB-J3B8>] (“further stress for some tax-exempt hospitals”); Michael Haas & Danny Schmidt, *Risk of Losing Tax-Exempt Status Could Be Disruption for Many Nonprofit Hospitals*, REAL ECON. BLOG (June 2, 2023), <https://realeconomy.rsmus.com/risk-of-losing-tax-exempt-status-could-be-disruption-for-many-nonprofit-hospitals/> [<https://perma.cc/MLM8-X8ZA>] (possible further consolidation or hospital closures). However, these health care analysts do not address the extent to which hospitals could shift resources from other forms of community benefit spending to charity care, if their tax exemption depended on meeting a minimum level of charity care. See Emily Gee & Thomas Waldorp, *Policies to Hold Nonprofit Hospitals Accountable*, Center for American Progress (Oct. 18, 2022), <https://www.americanprogress.org/article/policies-to-hold-nonprofit-hospitals-accountable/> (explaining that hospitals benefitting from ACA expanded coverage “have chosen to dedicate resources to causes other than offsetting patient costs, even though millions of Americans remain uninsured and underinsured.”).

the right direction for holding nonprofit hospitals accountable.<sup>157</sup> Studies of community benefit reporting indicate that the level of community benefits provided by nonprofit hospitals depends on the definitions used.<sup>158</sup> By defining the expenditure threshold with respect to exemptions, the bill would require hospitals to eliminate their fair share deficits to retain nonprofit status. Also, the bright-line rules on facility improvements address the ambiguity from Revenue Ruling 56-185 concerning the extent to which facility improvements would affect a nonprofit hospital's financial ability to render charity care.

However, while the Holding Nonprofit Hospitals Act seeks to expand charity care eligibility,<sup>159</sup> it does not go far enough in addressing concerns about the amount of charity care that hospitals provide. True, the proposed bill reintroduces charity care into the definition of community benefit when it identifies "free or discounted care" as a component of the expenditure threshold calculation.<sup>160</sup> However, it does not prescribe a minimum level for such care. That is, some hospitals could conceivably reach the expenditure threshold almost entirely through research and improvements to facilities, as "any combination" of spending would allow the hospital to reach the 100% threshold, subject to the 50% limit on facility improvements.<sup>161</sup> While nonprofit hospitals would still need to provide some level of charity care to stay compliant with the § 501(r) requirement for a financial assistance policy, lax enforcement of § 501(r) and the lack of a minimum threshold in the newly proposed bill mean that there is minimal incentive for hospitals to increase their charity care spending. This is particularly problematic because charity care is the community benefit measure that shows the most variation in

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157. See, e.g., PETER J. PITTS & JERRY ROGERS, CTR. FOR MED. PUB. INT., UNMASKING THE REAL COST DRIVERS IN U.S. HEALTHCARE: A CRITICAL EXAMINATION OF HOSPITAL PRICING AND POLICY REFORM 4 (2025), [https://mr.cdn.ignitecdn.com/client\\_assets/cmpiorg/media/attachments/6855/7213/052f/de7e/626b/1692/68557213052fde7e626b1692.pdf?1750430227](https://mr.cdn.ignitecdn.com/client_assets/cmpiorg/media/attachments/6855/7213/052f/de7e/626b/1692/68557213052fde7e626b1692.pdf?1750430227) [<https://perma.cc/27PV-5YQP>] (identifying the Holding Nonprofit Hospitals Accountable Act as a proposed reform that would address hospital inefficiencies in addressing the needs of their communities). Peter J. Pitts is the president and co-founder of the Center for Medicine in the Public Interest, and he has publicly advocated for the Holding Nonprofit Hospitals Accountable Act in interviews. E.g., *Weekend Interview: Peter Pitts Believes Nonprofit Hospitals Need More Oversight*, FED. NEWSWIRE (July 11, 2025), <https://thefederalnewswire.com/stories/673963707-weekend-interview-peter-pitts-believes-nonprofit-hospitals-need-more-oversight> [<https://perma.cc/K2FA-JZM5>].

158. Hossein Zare & Gerard Anderson, The Significance of Definitions in Determining the Level of Community Benefits for Nonprofit Hospitals, 103 THE MILBANK QUARTERLY 809, 824–25 (2025).

159. Eley et al., *supra* note 156.

160. H.R. 3019 § 2(a)(3).

161. *Id.*

distribution across hospitals.<sup>162</sup> When deciding between charity care spending or continued medical education, hospital decisionmakers may be less motivated to allocate towards charity care spending because other community benefit measures would provide more direct benefit to the hospital.<sup>163</sup>

To properly address concerns about charity care expenditures, Congress should prescribe a minimum threshold. The effectiveness of a minimum threshold can be demonstrated through state legislative attempts. In 1993, Texas became the first state to adopt legislation requiring a minimum amount of charity care to qualify for state tax exemption.<sup>164</sup> While many states have since passed laws establishing some form of community benefit requirement for nonprofit hospitals, few specify a *minimum* community benefit requirement for tax exemption.<sup>165</sup> As one of only five states to have a minimum requirement, Texas currently has “one of the most stringent charity care laws in the nation.”<sup>166</sup> While there remain five Texas nonprofit hospitals that provide less charity care than the national average as of 2019, Texas nonprofit hospitals as a whole have generally exceeded expectations.<sup>167</sup> On average, Texas nonprofit hospitals “provid[e] net charity care amounting to 8.1% of expenses,” which is “significantly higher than the national average of 2.4%.”<sup>168</sup> In 2022 alone, Texas nonprofit hospitals provided \$2.4 billion in unreimbursed charity care and 32% more charity care than required by state law.<sup>169</sup> More recent statistics from 2024 show that Texas is one of only five states where most hospitals have a fair share surplus, meaning that

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162. Hossein Zare, Matthew Eisenberg & Gerard Anderson, *Charity Care and Community Benefit in Non-Profit Hospitals: Definition and Requirements*, INQUIRY: J. HEALTH CARE ORG., PROVISION, AND FIN., Jan.–Dec. 2021, at 1, 5.

163. *See id.* (“For example, providing continuing medical education to staff will benefit the hospital if the staff remains in the hospital.”).

164. Frances A. Kennedy et al., *Do Non-Profit Hospitals Provide More Charity Care When Faced with a Mandatory Minimum Standard? Evidence from Texas*, 29 J. ACCT. & PUB. POL’Y 242, 243 (2010).

165. *See Community Benefit State Law Profiles Comparison*, HILLTOP INST., <https://www.hilltopinstitute.org/our-work/hospital-community-benefit/hcbp-state-comparison/> [<https://perma.cc/TX3S-WAXJ>] (indicating only five states with a minimum community benefit requirement, including Texas).

166. *Charity Care and Community Benefit*, TEX. HOSP. ASS’N, <https://www.tha.org/issues/charity-care-and-community-benefit/> [<https://perma.cc/XG35-RFGX>].

167. Derek Jenkins, *Nonprofit Hospitals and Medical Debt in Texas*, RICE UNIV.: BAKER INST. FOR PUB. POL’Y (Oct. 31, 2024), <https://www.bakerinstitute.org/research/nonprofit-hospitals-and-medical-debt-texas> [<https://perma.cc/R6NC-XJHE>].

168. *Id.* (based on 2019 tax filings)

169. Joey Berlin, *The Texas Standard: Champions of Charity Care*, TEX. HOSP. ASS’N (Oct. 9, 2024), <https://www.tha.org/blog/the-texas-standard-champions-of-charity-care/> [<https://perma.cc/8PES-BVXJ>].

community benefit spending exceeded the value of the hospital's tax exemption.<sup>170</sup>

Given the success of the Texas model, it would be worthwhile to consider the framework of the Texas charity care statute and how it has incentivized nonprofit hospitals to provide more charity care. In light of the Big Beautiful Bill's health care cuts, Texas is also a particularly interesting case study because it is one of the ten states that have not expanded Medicaid eligibility,<sup>171</sup> and it has unique health care needs due to its large immigrant population.<sup>172</sup>

Per the language of the statute, Texas nonprofit hospitals may meet the community benefit and charity care requirements in one of the following three ways:

- (A) charity care and government-sponsored indigent health care are provided at a level which is reasonable in relation to the community needs, as determined through the community needs assessment, the available resources of the hospital or hospital system, and the tax-exempt benefits received by the hospital or hospital system;
- (B) charity care and government-sponsored indigent health care are provided in an amount equal to at least 100 percent of the hospital's or hospital system's tax-exempt benefits, excluding federal income tax; or
- (C) charity care and community benefits are provided in a combined amount equal to at least five percent of the hospital's or hospital system's net patient revenue, provided that charity care and government-sponsored indigent health care are provided in an amount equal to at least four percent of net patient revenue.<sup>173</sup>

Even though the language of the statute refers to these three ways as "standards,"<sup>174</sup> only the first is standard-like in the way that the community benefit standard is. By contrast, the other two ways that nonprofit hospitals

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170. *Fair Share Spending: 2024 Results*, *supra* note 11.

171. *Status of State Medicaid Expansion Decisions*, KFF (Sep. 29, 2025), <https://www.kff.org/status-of-state-medicaid-expansion-decisions/> [<https://perma.cc/YM7M-F5KY>].

172. See ANNE DUNKELBERG, CTR. FOR PUB. POL'Y PRIORITIES, IMMIGRANTS' ACCESS TO HEALTH CARE IN TEXAS: AN UPDATED LANDSCAPE (2016), [https://web.archive.org/web/20250615123742/https://everytexan.org/images/HW\\_2016\\_ImmigrantsAccess\\_FullReport.pdf](https://web.archive.org/web/20250615123742/https://everytexan.org/images/HW_2016_ImmigrantsAccess_FullReport.pdf) [<https://perma.cc/M75C-BGTX>] (explaining that Texas's "large immigrant population faces all the same barriers to [health] care as U.S. citizens, plus an additional complex list of exclusions").

173. TEX. HEALTH & SAFETY CODE ANN., § 311.045(b)(1) (West 2025).

174. *Id.*

might qualify for the tax exemption are more objective measures. Provision B, which allows an exemption if the hospital's state tax benefits are fully converted into charity care, is suitable for hospitals with large indigent communities. This is especially helpful for Texans without health insurance; Texas has the lowest rate of health insurance coverage in the nation, with 21.7% of Texas adults lacking health insurance in 2023.<sup>175</sup>

On the other hand, even if certain hospitals may not provide as much charity care per se, there remains another objective measure for qualifying for tax exemption through Provision C. Unlike Provision B, which focuses solely on charity care, Provision C looks at the combined charity care and community benefits provided by the hospital. Hospitals may provide other community benefits in meeting the overall 5% net patient revenue threshold, but at minimum 4% of this combined amount must consist of charity care. While critics may argue that setting a charity care minimum actually encourages more affluent hospitals to decrease their level of charity care spending,<sup>176</sup> the 4% minimum charity care requirement at least ensures a stable amount of charity care is provided from year to year. Moreover, it offers hospitals the flexibility to qualify for tax exemption in more than one way, and the metrics are objective so there is less uncertainty on the hospital's end about whether they meet the requirements. This perceived objectivity is desirable because it results in more buy-in from the medical community.<sup>177</sup>

Finally, returning to Provision A, this is more akin to the totality of the circumstances approach that the IRS takes to determine if hospitals qualify for federal tax exemption under the community benefit standard.<sup>178</sup> Even if a nonprofit hospital fails to receive state tax exemptions because it does not meet either Provisions B or C, it may still qualify so long as it provides "reasonable" levels of charity care. In practice, most Texas hospitals do not need Provision A to receive their tax exemption. In fact, in 2023 (the most recent year where data by hospital is available), most of the 127 nonprofit hospitals in Texas elected to meet their tax exemption requirements through

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175. *New Census Data: Texas Has Worst Uninsured Rate in US*, COVER TEX. NOW (Sep. 12, 2024), <https://covertexasnow.org/posts/2024/9/12/new-census-data-texas-has-worst-uninsured-rate-in-us> [<https://perma.cc/M4Q4-2NGJ>].

176. See Kennedy et al., *supra* note 164, at 243 (finding that Texas's minimum charity care law may "cause decreased spending at more affluent hospitals, which were initially spending above the benchmark").

177. See *The Tax-Exempt Hospital Sector: Hearing Before the H. Comm. on Ways and Means*, 109th Cong. 99 (2005) (statement of John Thomas, Senior Vice President and Gen. Couns., Baylor Health Care Sys.) ("Baylor has found the Texas community benefit law to be a fair and helpful measure to ensure nonprofit hospitals in the communities we serve are meeting, at a minimum, the required level of community benefits and charity care.").

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

Provision C.<sup>179</sup> And, as a whole, Texas nonprofit hospitals exceeded the minimum charity care requirement in Provision C by \$2.8 billion, or 139%.<sup>180</sup>

Texas's charity care law shows why Congress's proposed Holding Nonprofit Hospitals Accountable Act does not sufficiently incentivize hospitals to make greater charity care contributions. Provision B bears some similarities to the provision addressing the expenditure threshold in the Holding Nonprofit Hospitals Act, but Provision B is far stricter because the 100% threshold can only be met through charity care or government-sponsored indigent health care. Therefore, most nonprofit hospitals in Texas do not qualify for their exemption through Provision B, but rather through Provision C, which prescribes that charity care spending equal, at minimum, 4% of net revenue.<sup>181</sup> Prior to the Texas legislation, 20% of nonprofit hospitals did not meet even this 4% minimum.<sup>182</sup> However, the underperforming hospitals in question quickly increased their charity care spending to comply with Provision C.<sup>183</sup> In other words, Texas nonprofit hospitals overwhelmingly prefer a "standard" that is more objective than the reasonableness standard in Provision A, but also more flexible than the 100% threshold in Provision B.

The Holding Nonprofit Hospitals Accountable Act provides a clearer and more enforceable definition of community benefit than Revenue Ruling 69-545, but the "expenditure threshold" that it establishes for nonprofit hospitals is not nearly stringent enough. While the expenditure threshold is defined to equal nonprofit hospitals' tax exemptions, similar to Provision B, it is far more lax in allowing nonprofit hospitals to meet the expenditure threshold through a combination of research, improvements to facilities, and charity care. Moreover, the Holding Nonprofit Hospitals Accountable Act lacks any minimum charity care requirement that would incentivize underperforming hospitals to increase their charity care spending. Therefore, even if the federal bill is enacted, it is unlikely to increase nonprofit hospitals' charity care contributions in the way that the Texas legislation did. While the Holding Nonprofit Hospitals Accountable Act is a step in the right direction in reaffirming charity care as a factor in the community benefit analysis, it ultimately does not go far enough to hold nonprofit hospitals accountable.

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179. *Charity Care and Community Benefit in Texas: Frequently Asked Questions*, TEX. HOSP. ASS'N (Mar. 2025), <https://www.tha.org/wp-content/uploads/2025/03/Charity-care-FAQ-Mar-2025-FINAL.pdf> [<https://perma.cc/BWZ9-983Q>].

180. *Id.*

181. *Id.*

182. Kennedy et al., *supra* note 164, at 253.

183. *Id.*

### Conclusion

The current state of the law on the federal tax exemption for nonprofit hospitals is hazy. While there have been changes in federal tax exemption requirements through § 501(r), which imposes additional requirements, the community benefit standard has remained relatively stagnant. The IRS is poised to change that by reimplementing the financial ability standard or by creating a new community benefit standard, as some researchers have proposed. There is growing pressure from both the public and lawmakers on the IRS, so it would not be surprising if it issues a new revenue ruling to address the community benefit standard.

However, guidance from the IRS may not be enough. As an enforcement agency, the IRS does not have the authority to set bright-line rules in the way that legislative bodies can. Adopting a charity care minimum would be a drastic departure from current federal law and would likely happen in the distant future, if at all. While the proposed Holding Nonprofit Hospitals Accountable Act would codify charity care as a factor in maintaining tax exemption, it fails to specify a minimum level of charity care that nonprofit hospitals must provide. The Act, even if enacted, does not go far enough to meaningfully affect change.

Though reform of the community benefit standard in the foreseeable future is unlikely to incorporate a charity care minimum, such a requirement would help to ensure that tax-exempt hospitals are providing adequate benefit to their communities. At the state level, there is evidence that such legislation improves charity care outcomes by smoothing out disparities in charity care provided and improving access to charity statewide. At the national level, billions of dollars in lifesaving charity care could be provided by bringing up hospitals' average charity care expenditures. To improve the availability and accessibility of charity care throughout the nation, Congress should look to states like Texas that have implemented charity care minimums.