

**WRITTEN STATEMENT OF MARK W. EVERSON  
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BEFORE THE COMMITTEE ON WAYS AND MEANS  
UNITED STATES HOUSE OF REPRESENTATIVES  
A REVIEW OF THE TAX-EXEMPT HOSPITAL SECTOR  
MAY 26, 2005**

Mr. Chairman, Congressman Rangel, distinguished members of the Committee: Thank you for the opportunity to discuss tax-exempt hospitals and health care organizations, and the IRS administration of this area.

Tax-exempt hospitals and health care organizations are an important and highly visible element of the tax-exempt community. According to Statistics of Income (SOI) data for 2001, the most recent available, this sector consists of approximately 7,000 entities. It includes hospitals, clinics, other health care providers, cooperative health service organizations, and medical research organizations. Over half these organizations are traditional hospitals. That year, this sector controlled approximately \$490 billion in assets and received over \$500 billion in gross receipts. In terms of assets, it is the largest element within the universe of tax-exempt entities.

The country rightfully takes pride in its system of tax-exempt hospitals and health care organizations. This sector employs the talents of millions of dedicated professionals, staff and volunteers who conscientiously, and with great dedication and skill, provide life-saving medical and rehabilitative care, train medical professionals, educate the public about health and medical issues, and conduct ground-breaking research. Their contributions and importance to the country cannot be overstated.

My remarks will focus on the law applicable to tax-exempt hospitals and health care organizations, and on the Internal Revenue Service's coverage of this area. As I outline the law and our work in this area, what should become clear is that we at the IRS are now faced with a health care industry in which it is increasingly difficult to differentiate for-profit from non-profit health care providers. Our agents at work in this industry encounter dauntingly complex corporate tax issues. These derive from the use of multiple inter-related entities and a complex web of service and other contractual relationships. We regularly find ourselves engulfed in paper as we attempt to discern whether those in control of a particular non-profit health care provider are acting more as investors for their own account or as stewards of charitable assets.

**General Discussion of the Internal Revenue Service's Regulation of the Non-Profit Sector**

Before beginning a specific discussion of the health care sector, I would like briefly to place health care within the context of our overall regulation of tax-exempt organizations. I believe that the overwhelming majority of charitable organizations do their utmost to comply fully with the letter and spirit of the tax

law. But we are now at an important juncture. Simply stated, there are increasing indications that the twin cancers of technical manipulation and outright abuse that we saw develop in the profit-making segments of the economy are now spreading to pockets of the non-profit sector.

We can see that abuse is increasingly present in the tax-exempt sector, and we must work to address it. We will act vigorously, for to do otherwise is to risk the loss of the faith and support that the public has always given to the charitable community. And if that is lost, the bountiful vitality of the American charitable sector will wither.

That is why the IRS Strategic Plan for 2005 – 2009 recognizes the significance of the tax-exempt sector as a whole for tax administration. The IRS Strategic Plan sets out four key objectives designed to enhance tax law enforcement over the next five years. One of them directly addresses the charitable sector:

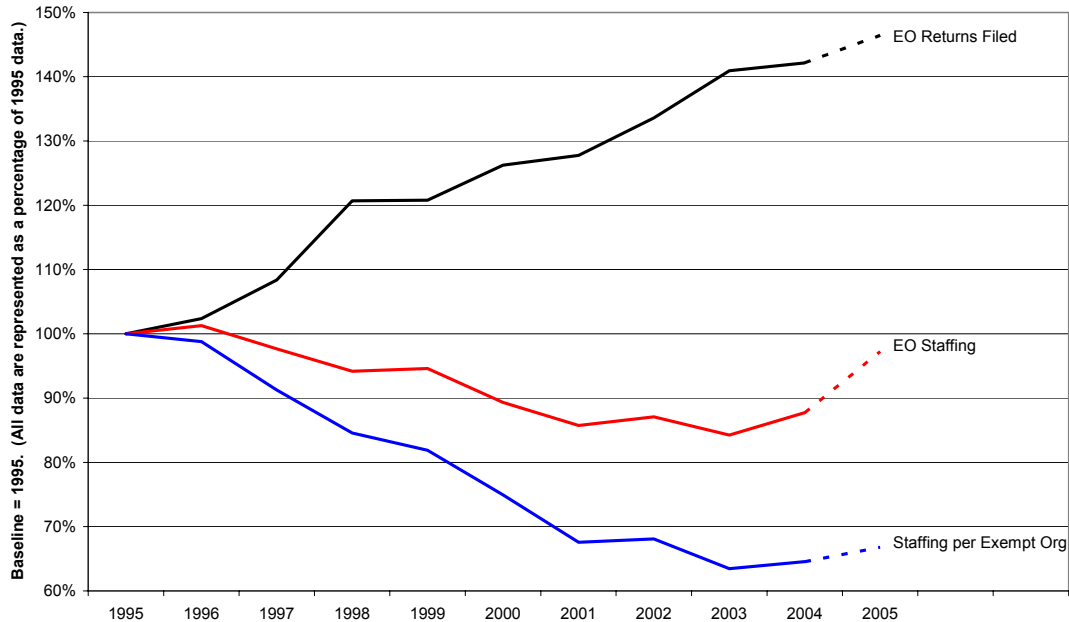
Deter abuse within tax-exempt and governmental entities and misuse of such entities by third parties for tax avoidance and other unintended purposes.

Despite the importance of the tax-exempt sector, and its unique set of challenges, our enforcement budget did not keep up with the sector's growth. From 1995 through 2003, the number of exempt organization returns filed increased 40 percent, yet IRS staffing of the exempt organizations function steadily declined.

The chart below shows that we have begun to turn this around. Using 1995 as a benchmark, the chart shows the percentage increase in exempt organization returns filed, together with the percentage changes in staffing and staffing per exempt organization, on a year-by-year basis. Although our staffing devoted to exempt organizations has declined, we are reversing this trend.

### Exempt Organizations Staffing and Workload Trends

Revised 3/21/05



This reversal reflects the priority we have given to the charitable sector. Although the IRS budget as a whole increased only one-half percent in FY 2005, the Exempt Organizations budget increased 13.8 percent, and the Exempt Organizations examination budget increased 21 percent.

In FY 04, we added 70 new agents to conduct exempt organizations examinations, as well as additional employees to begin implementing our plans for a more flexible approach to enforcement. This year's budget supports additional staffing to continue our plans. We established two new offices to enhance our ability to identify and resolve compliance issues. The first, our new EO Compliance Unit, will help us interact with a larger number of exempt organizations by reviewing Forms 990, corresponding with organizations to resolve inconsistencies and errors, and conducting correspondence audits. The second new office, the Financial Investigations Unit, will focus on in-depth analysis of our most complex and significant cases to identify civil tax issues as well as potential fraud and terrorist-financing referrals, and will serve as a strike force when we need to move quickly.

These units will be aided by two new groups and additional staffing. The first group is the Data Analysis Unit, established in 2004, which uses combinations of data to better select cases for examination. A second newly-funded group will identify and follow up with selected Form 990 filers in the first years of their operations, bridging the gap between what an applicant organization tells us when it applies for exemption and how it actually operates. In addition, I have

reallocated resources to our Exempt Organizations function to enable it to hire 69 additional compliance employees.

### **The Law Governing Tax Exemption for Hospitals and Health Care Organizations**

#### **Overview: Current Exemption Requirements -- the Current Community Benefit Standard.**

The current standard for exemption of a hospital, known as the “community benefit standard,” was first set forth in 1969 in Revenue Ruling 69-545, 1969-2 C.B. 117. The factors considered in Rev. Rul. 69-545 to determine whether a hospital met the community benefit standard were the following:

- (a) The governing body of the hospital is composed of members of the community (as opposed to financially interested individuals);
- (b) Medical staff privileges in the hospital are available to all qualified physicians in the area, consistent with the size and nature of the facilities;
- (c) The hospital operates a full-time emergency room open to all regardless of ability to pay;
- (d) The hospital otherwise admits as patients those able to pay for care, either themselves or through third-party payers such as private health insurance or government programs such as Medicare and Medicaid; and
- (e) The hospital’s excess funds are generally applied to expansion and replacement of existing facilities and equipment, amortization of indebtedness, improvement in patient care, and medical training, education, and research.

In addition to meeting the community benefit standard, hospitals must meet the general requirements for exemption under section 501(c)(3), including the prohibitions on inurement and substantial private benefit.

#### **History and Discussion of Tax Exemption for Hospitals.**

Despite the significance of hospitals and health care organizations in the tax-exempt sector, neither the Code nor the underlying regulations explicitly provides for the exemption from federal income tax of non-profit hospitals.

Nevertheless, we have long recognized that non-profit hospitals can qualify for exemption as organizations described in section 501(c)(3) of the Code. Before 1969, the IRS viewed the term “charitable” in the limited sense of providing relief to the poor. Accordingly, in 1956, the first published position of the IRS regarding hospitals recognized them as charitable organizations provided they accepted patients without regard for their ability to pay, to the extent of the hospital's financial ability. Rev. Rul. 56-185, 1956-1 C.B. 202.

Three years later, in 1959, the IRS determined that the term “charitable” in section 501(c)(3) should be interpreted in its generally accepted legal sense and not limited to relief of the poor. Treas. Reg. section 1.501(c)(3)-1(d)(2). Although the regulation expanded the concept of charitable, it did not explicitly provide that promotion of health is a charitable purpose even though promotion of health was and is considered charitable under common law. Then, in 1965, Medicare and Medicaid were established. At the time, many believed these government programs would eliminate the need for indigent care.

Meanwhile, the “financial ability standard” set forth in the 1956 revenue ruling was being criticized for its imprecise standards concerning the extent to which a hospital must accept patients unable to pay in order to retain exempt status. An example of such criticism is that expressed in 1969 at Congressional hearings (see H.R. Rep. No. 43, 91<sup>st</sup> Cong., 1<sup>st</sup> Sess. Pt. 1 at 43 (1969)). These factors led the IRS to study the hospital industry and develop a new standard: the community benefit standard, set forth in Rev. Rul. 69-545, and outlined above. Under this standard, hospitals would no longer be required to provide a specific level of care to the poor in order to qualify for tax exemption, but instead must demonstrate that they benefit the community sufficiently.

In Rev. Rul. 69-545, the IRS recognized that the promotion of health is considered to be a charitable purpose under the common law of charity. Promotion of health is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from activities does not include all members of the community, provided that the class is not so small that its relief is not of benefit to the community. Therefore, in order to qualify as an organization described in section 501(c)(3), a hospital must demonstrate that it provides benefits to a class of persons that is broad enough to benefit the community and it must show that it is operated to serve a public rather than a private interest.

Rev. Rul. 69-545 presents a snapshot of the hospital industry as it existed in 1969. At that time, most for-profit hospitals were owned and operated by physicians as an adjunct to their private practice. Therefore, the particular facts illustrating the difference between the exempt hospital and the for-profit hospital are based upon this model.

The ruling was challenged by a group of private citizens who argued that the IRS should continue to require hospitals to provide free care to those unable to pay in order to qualify for tax exemption under section 501(c)(3). While the district court agreed with the plaintiffs' assertion that the ruling was an improper reversal of

long-standing policy, the District of Columbia Circuit Court reversed that decision. It held that the definition of charity was not limited to the relief of poverty and the IRS was authorized to modify the requirements for tax exemption for non-profit hospitals. The Supreme Court subsequently vacated the Circuit Court's decision on jurisdictional grounds for plaintiff's lack of standing. Eastern Kentucky Welfare Rights Organization v. Simon, 370 F. Supp. 325 (D.D.C. 1973), rev'd, 506 F.2d 1278 (D.C. Cir. 1974), vacated on other grounds, 426 U.S. 26 (1976).

While the Supreme Court's decision on standing to sue effectively precluded litigation seeking a return to the financial ability standard as the sole method by which a non-profit hospital may qualify as a tax-exempt organization, the decision has not meant that the financial ability standard has no relevance. It was not repealed when the community benefit standard was adopted. Rev. Rul. 69-545 did not revoke Rev. Rul. 56-185; it merely modified it. While a hospital is no longer required to operate to the extent of its financial ability for those not able to pay, doing so is a major factor indicating that the hospital is operated for the benefit of the community.

Rev. Rul. 69-545 was modified in 1983 with respect to the operation of an emergency room as a factor. In Rev. Rul. 83-157, 1983-2 C.B. 94, a hospital that did not operate an emergency room because the appropriate governmental health agency had determined that this would be unnecessary and duplicative could qualify for exemption by showing that it operated to benefit the community through other factors. Similarly, specialized hospitals, such as eye hospitals and cancer hospitals, treating conditions that are unlikely to require emergency treatment can qualify for exemption without operating an emergency room based on similar, significant factors demonstrating community benefit.

Thus, other factors that demonstrate that the hospital is operating for the benefit of the community may also be considered. Some factors that may be considered are whether the hospital conducts medical training or research activities, engages in activities to educate the public regarding health care matters, or provides types of health care services not otherwise available to the community.

The courts have adopted the Rev. Rul. 69-545 community benefit standard and applied it to determine whether other types of health care organizations qualify for exemption from tax. In Sound Health Association v. Commissioner, 71 T.C. 158 (1978), acq., 1981-2 C.B. 2, the Tax Court used that test in deciding if a health maintenance organization qualified for exemption. Similarly, the community benefit standard was applied in Geisinger Health Plan v. Commissioner, 985 F.2d 1210 (3rd Cir., 1993), rev'g 62 T.C.M. 1656 (1991).

Since the issuance of Rev. Rul. 69-545, there have been a number of changes in the health care industry that have affected the application of the community benefit standard. Under the Medicare and Medicaid programs, hospitals were reimbursed for medical care of the elderly and poor. The availability of this reimbursement was a major factor in the rise of for-profit hospital chains. Thus, the typical model of the for-profit hospital is no longer the physician owned facility operated as an adjunct to

a private practice. It has become the investor owned hospital systems. Additionally, hospitals that participate in Medicare and have an emergency room are required to treat any patient in an emergency condition (not just those covered by Medicare or Medicaid), regardless of ability to pay. Furthermore, to achieve cost containment, Medicare and other insurance providers have changed their reimbursement methodologies. With these changes in the health care industry, certain factors specifically discussed in Rev. Rul. 69-545 appear less relevant in distinguishing tax-exempt hospitals from their for-profit counterparts. Having an open medical staff, participating in Medicare and Medicaid, and treating all emergency patients without regard to ability to pay are now common features of tax-exempt and for-profit hospitals rather than distinguishing factors.

Nonetheless, the community benefit standard continues to be the basis for determining tax exemption for hospitals and health care organizations. More and more, the IRS looks to the independent board exercising its fiduciary duty to operate for the benefit of the community to differentiate the tax-exempt hospital from a for-profit operation. This approach was illustrated in the IRS rulings on integrated delivery systems and joint ventures.

In the 1990's a number of hospital systems were acquiring physician practices to integrate the delivery of hospital and physician services so that one organization could negotiate and bill for all of the services rather than having the hospital and physician services negotiated for and billed separately. Frequently, the acquired physician practice would be established as a separate clinic within the hospital system seeking exempt status under section 501(c)(3). In reviewing these applications, we were concerned about the role the physicians from the acquired practice played in the newly created exempt clinic, and whether the clinic had an independent community board based on the Rev. Rul. 69-545 community benefit standard. As part of our review of these types of cases, we developed a sample conflict of interest policy. Adopting a conflict of interest policy would establish a set of procedures to follow to help avoid the possibility that those in a position of authority, such as a director, officer, or manager, may receive an inappropriate benefit and would help preserve the independence of the community board. While not a requirement for exemption of health care organizations, we routinely encourage health care organizations to adopt such a policy.

Similarly, when developing guidance concerning hospital joint ventures, the independent community board factor was of critical importance when applying the community benefit standard of Rev. Rul. 69-545. In Rev. Rul. 98-15, 1998-1 C.B. 718, an organization that contributed all of its hospital operating assets to a joint venture continued to qualify for exemption when the governing documents of the joint venture required the joint venture to operate for the benefit of the community and to give charitable purposes priority over profit maximization and the community members appointed to the governing board of the joint venture by the organization had voting control over major decisions thereby ensuring that the organization's participation in the joint venture furthered the organization's charitable purposes.

## **Administrative Treatment of Hospitals and Health Care Organizations by the Internal Revenue Service**

### General Overview.

The Internal Revenue Service's oversight of the hospital and health care organizations sector employs two programs: the determination letter process based on the organization's structure and proposed activities, and the examination process based on the organization's actual operations.

### Determination Letter Process.

Like most other charitable organizations, hospitals and health care organizations are required to apply for tax exemption by an application. In FY 2004, we processed over 87,000 applications from organizations seeking recognition of exemption under section 501(c)(3).

When we receive an application, it is assigned for screening by specialists to determine whether it can be closed without further review because it presents matters that can be resolved based on established precedent and without further development. Cases that cannot be processed under our screening procedures are assigned for additional review and development. Due to their complexity, hospitals generally require additional development.

Over the last ten years, we processed, on average, between 100 to 150 exemption applications per year filed by organizations that are classified as hospitals, which includes hospitals, clinics, medical research organizations, and cooperative hospital service organizations. In FY 2004, we processed about 115 exemptions for these types of organizations. This includes both newly established hospitals as well as clinics formed by hospital systems that reorganize or that purchase medical practices.

To qualify for exemption, hospitals must provide information detailing their proposed operations, governance, and finances. In addition, hospitals must complete a specialized hospital schedule to Form 1023. In October, 2004, we undertook a major effort to overhaul Form 1023, *Application for Recognition of Exemption Under Section 501(c)(3) of the Internal Revenue Code*, to make it easier to comprehend and to allow us to identify exemption issues. For example, the hospital schedule now asks whether the hospital has adopted a conflict of interest policy consistent with a sample policy that is provided. If not, the schedule pointedly asks how the hospital will avoid the possibility of conflict of interest for those in a position of authority absent adoption of a policy. Other key questions include disclosures about joint ventures and other exemption issues based on the community benefit standard. There are specific questions concerning charity care.

In 2004, we issued a training document to assist our agents in processing exemption applications filed by hospitals entitled *Health Care Provider Reference*



*Guide.* The guide provides a roadmap for agents to make sure that a hospital is organized and operated to promote health care consistent with exemption standards. This material is available on our internet site so that the interested public is also provided with information about how to comply as a tax-exempt hospital.

### Review of Hospital Operations—Annual Reporting and the Examination Program

Hospitals and health care organizations have long comprised a part of the Exempt Organizations examination program, reflecting the significance of the health care industry in the tax-exempt sector.

These organizations, like most other types of tax-exempt entities must file annually a Form 990 that outlines their activities, revenues, expenses, balance sheet, certain compensation information related to key employees, officers and contractors, contributor information and certain other information. The Form 990, with the exception of certain contributor information, is publicly available. In addition, if the organization receives more than \$1,000 in unrelated business income, it must file a Form 990T (Unrelated Business Income Tax Return). Electronic filing is now available for the Forms 990, 990EZ and 990PF. For 2005 returns, certain tax-exempt entities (*viz.*, those with over \$100 million in assets and that file 250 or more returns with us) will be required to file the Form 990 electronically. The asset level that triggers this requirement will be lower in future years. The Form 990 is under revision. As part of this revision, there will be a new schedule for hospitals that reflects the above-described 1023 schedule. Thus, hospitals will be asked how they meet the community benefit standard and its constituent components, including charity care.

While we expect improvements in light of the recent increase in resources and modified business practices outlined above, our coverage in the area of hospitals has not been robust. From FY 1995 through the first half of FY 2005, we examined over 375 health care organizations (out of a population of around 7,000), including both hospitals and related organizations or parts of hospital systems. There are two reasons for this level of coverage. The first is the overall lack of available examination resources. The second is that many of these entities were examined as part of our large case Team Examination Program (TEP). Comprehensive TEP examinations of large, complex organizations, which include related entities, are, by their nature, exceptionally resource intensive because they involve teams of agents looking at a wide variety of issues. Of the 375 plus examinations, many were included as part of 79 TEP audits of health care organizations or systems, including their myriad related entities.

In our TEP program, we examine large organizations on a team basis, reviewing numerous issues. As part of those audits we review whether the organization meets the community benefit standard, as well as other exemption issues such as compensation and inurement, and tax issues, including unrelated business income tax, allocations of income and expenses among related entities, taxable

subsidiary taxation, joint venture income, employment tax, retirement plan issues and numerous other issues.

In more than one quarter of our TEP health care cases we found tax exemption issues. In these cases we can revoke the tax status of the organization. We have done so in only a few instances because traditionally we attempt to get a tax-exempt organization back on the right track. (We have generally reserved revocation for cases in which we believe the organization is incapable of furthering exempt purposes in the future.) We attempt to resolve exemption issues with the taxpayer short of revocation, often through the use of a closing agreement. Almost half of the health care TEP cases ended in this fashion.

The range of issues is even broader in our recent examinations, reflecting the changes in the health care industry that have resulted in ever more complex arrangements. For example, examinations of organizations engaged in whole-hospital joint ventures with for-profit partners present not only difficult exemption issues requiring analysis of the degree of control retained by the tax-exempt partner, but also issues of allocation of income and losses between the tax-exempt and for-profit entity, and other partnership flow-through issues. Other examinations raise the issue whether the organization is barred from exemption because it is primarily engaged in providing commercial-type insurance within the meaning of section 501(m). We also continue to see a variety of compensation arrangements that include components, such as deferred compensation, loan forgiveness, and non-accountable expense plans, that raise excess benefit or inurement issues.

### **IRS Focus Areas for Discussion of Reforms -- Unresolved Issues**

The tax-exempt world and, in particular, the non-profit health care industry have changed. We have indicated that the tax-exempt sector has increased in size and complexity. This growth impacts our ability to regulate, creates other pressures within the sector and has exacerbated the decline in our enforcement presence as our staffing available for examinations declined in the late 1990s.

In addition, the tax-exempt sector has not been immune from recent trends toward lax corporate practices. Like their for-profit brethren, many charitable boards appear to be lax in certain areas. In addition, we are increasingly seeing the importation of corporate practices and operating methods into the tax-exempt sector.

These factors have created opportunities for noncompliance. We believe that with the additional staff and new business processes underway, we are re-establishing meaningful oversight in this area. However, notwithstanding our revitalized and refocused program, we believe there are several areas that should be included as part of any discussion of reform in the tax-exempt sector, including any reforms in the area of hospitals and other health care

organizations. We believe that any discussion of reforms should include the following questions.

Have changes in practice or the industry created gaps in the statutory or regulatory framework?

There has been huge growth in the tax-exempt sector, but much less change in the law governing those organizations that qualify for tax-exempt status. Since 1969 there has been only limited Congressional review of the rules relating to tax-exempt organizations.

As we regulate various parts of the tax-exempt community, compliance in some areas becomes difficult to administer where industry practice, or the industry itself, changes, but the rules remain constant decade after decade. As individual organizations and industries grew, the skyline changed with more organizations entertaining complex business structures and transactions. The transformation of health care providers, and increased merger activity in the health care sector in the 1980s and 1990s, is the prime example of this kind of change. The health care industry grew up in a different time, with different funding sources and competitive factors, and now has evolved into something substantially different from what it was. Yet the law remains largely unchanged.

Some have argued that it is time for a more thorough review. We welcome that suggestion, both in general with respect to the law of charities and other nonprofits, and more specifically with respect to hospitals and health care organizations. A key question here is whether there are additional bright-line tests that might be available to aid the public in complying with the law, and the IRS in administering it. Often in health care issues, the IRS is left with difficult and fact-intensive administrative challenges. For example, as indicated, some exempt providers have entered into joint ventures with for-profit organizations, sometimes placing their entire health care operation in the venture and transforming themselves into what is effectively a tax-exempt holding company with a charitable grant-making function. Although this is not impermissible, we insist that the charitable entity ensure that the charitable purposes of the venture are not sacrificed for the sake of maximizing profits. This is an example of how the health care industry has changed. To determine control requires our agents and courts to parse through reams of contracts, data and state law. This is a far cry from the industry as it existed in 1969.

This is not to say that the IRS believes the community benefit standard should be modified, but simply that many years have passed since 1969. The community benefit standard is a reasonable interpretation, within the current language of the statute, which speaks only to charitable purposes. The standard reflected, and still reflects, the economic rationale for tax exemption and allows for a variety of mechanisms by which a hospital may attain exemption. In a constantly changing health care market, this flexibility in approach may be exactly what is needed.

### Does the IRS have the flexibility to respond appropriately to compliance issues?

We believe a discussion about reform should address whether we have the proper range of tools to enforce compliance in a measured way. In many areas of our jurisdiction, our remedial tools are not effective. Often our only recourse is revocation of tax-exemption, a “remedy” that may work a disproportionate hardship on innocent charitable beneficiaries. Moreover, even where we have an intermediate sanction, it may not work as intended. Thus, as seen in the examination process described above, we are left with many resolutions short of revocation that are nonetheless imperfect.

There are two examples in this area. First, under section 4958, certain compensation arrangements may be found to be excessive. In some cases, however, the amounts considered permissible under section 4958 may be viewed by some as too high. The second example concerns our ability to police expenditures and grants. In our attempts to ensure that exempt organization funds are not diverted to improper purposes, including terrorism, we do not have tools comparable to those applicable to private foundations to sanction public charities that fail to monitor their grants and expenditures.

### Should more be done to promote transparency?

Transparency is a lynchpin of compliance within the tax-exempt sector. “Transparency” refers to the ability of outsiders -- donors, the press, interested members of the public -- to review data concerning the finances and operations of a tax-exempt organization. By creating a means by which the public may review and monitor the activities of tax-exempt organizations, we promote compliance, help preserve the integrity of the tax system, and help maintain public confidence in the charitable sector. To achieve these goals, we began in the mid-to-late 1990s to image Forms 990, the annual information returns filed by many tax-exempt organizations. Prior to 2005, the IRS only imaged returns of organizations described in section 501(c)(3). Beginning this year, we are imaging all Forms 990. We put this information on CDs, and provide it to members of the public, including a number of watchdog groups that monitor charitable organizations. These groups post the information to their websites, where it is available to the press and to the public. This process has resulted in increased press and public scrutiny of the tax-exempt sector, which we believe is highly desirable. It also has increased the ability of the IRS and state regulators to access Form 990 data, because they are more readily available.

However, there are legitimate questions about whether to further enhance transparency, and if so, how to proceed. For example, limitations exist on our ability to communicate with state charity officials, and these prevent us from fully leveraging the relationship and jurisdiction we share with them. Further, there are segments of the community that we are unable to track, including several categories of legal non-filers (for example, those exempt organizations that are not required to file a Form 990, such as churches and organizations with less

than \$25,000 in gross receipts). Our master-file is replete with errors concerning these organizations.

Finally, one of our key transparency initiatives is the establishment of electronic filing for Forms 990 and 990-PF. The recent interim report by the Panel on the Nonprofit Sector supports requiring electronic filing for all returns for nonprofits. As indicated, we have issued temporary regulations requiring such filing for certain groups. While this will markedly advance the ability of the Service, the states, and the public to access Form 990 data in real time, our ability to require e-filing is limited at present by statutory restrictions that prevent us from mandating electronic filing for any organization that files fewer than 250 returns. The Administration's 2006 Budget proposal echoes this concern. The Administration's proposal would lower the current 250-return minimum for mandatory electronic filing, but would maintain the minimum at a level high enough to avoid imposing undue burden on taxpayers.

#### Does the IRS have the resources it needs to do the job?

While this is a topic worthy of discussion, I have outlined what we have done to expand our resources in the tax-exempt area. I believe we have done a credible job of recognizing the task before us and preparing to meet that challenge. To continue this work, I ask the Committee to support the Administration's 2006 budget proposal, which calls for an 8 percent increase in our enforcement budget. If the Congress approves the request, the amount we plan to dedicate to the tax-exempt area would be used to combat abusive promotions involving tax-exempt entities, to start examinations quickly when we detect a risk, and to increase vigilance against the misdirection of exempt organizations' assets for illegal activities or private gain.

#### **Conclusion**

We welcome the Committee's review of the law of charities and other nonprofits, including the law of tax-exempt hospitals and health care organizations. We are ready to assist the Committee in this endeavor.