Nos. 13-1041, 13-1052

IN THE

Supreme Court of the United States

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

v.

MORTGAGE BANKERS ASSOCIATION,
Respondent.

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

v.

MORTGAGE BANKERS ASSOCIATION,
Respondent.

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

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

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STATEMENT OF INTEREST[1]

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

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

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

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

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

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

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

INTRODUCTION AND SUMMARY OF THE ARGUMENT

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

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

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

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

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

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

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

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

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

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

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

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

ARGUMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

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

Respectfully submitted,

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