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LEVERAGING TAX-EXEMPT STATUS OF HOSPITALS

Lawrence E. Singer, M.H.S.A., J.D.*

INTRODUCTION

We live in a money-driven society. Consumerism is rampant, with seemingly little end to Americans' desires to spend money.¹ Our entertainment now echoes this theme, with leading television shows including *Who Wants to Be a Millionaire*² and *Deal or No Deal*.³ The motion picture industry was an early harbinger of this driving economic force in American culture, with films such as *Wall Street*⁴ and *Boiler Room*.⁵ A slogan from the 1996 movie *Jerry McGuire*⁶ perhaps best sums up one of the key attributes of American culture: "Show me the money."⁷

Our health care system is no different. Although we may like to reflect fondly upon the historically quaint notion of not-for-profit health care as continuing the era of voluntary, locally owned hospitals, the reality is that health care is big business.⁸ It has to be. The insatiable demands imposed upon health care institutions for new technology, services, and accoutrements (non-private

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¹ *Trillion-Dollar Kids*, THE ECONOMIST, Nov. 30, 2006, available at http://www.economist.com/business/displaystory.cfm?story_id=8355035 (last accessed Sept. 17, 2007).

² *Who Wants to Be a Millionaire* (ABC Television Broadcast).

³ *Deal or No Deal* (NBC Television Broadcast).

⁴ WALL STREET (American Films 1987).

⁵ BOILER ROOM (New Line Cinema 2000).

⁶ JERRY MCGUIRE (Gracie Films 1996).

⁷ *Id.*

⁸ JONATHAN COHN, SICK 149 (2007). "Once the hospital had overstocked Popsicles so that young patients could always have them; the new management eliminated such frivolities. As a former executive ruefully conceded later, 'You can't run a \$200 million operation on nostalgia.'" For a thorough history of health care in the United States, and the rise of the medical industrial-complex, see PAUL STARR, THE TRANSFORMATION OF AMERICAN MEDICINE (1982).

room, anyone?) impose significant financial pressures on hospitals to respond to “community need.”⁹

All of this costs money—lots of it. In 2006, \$2.164 trillion¹⁰ was spent on health care in the United States, approximately \$7,110 per person.¹¹ Of this, 30%,¹² or \$650 billion, was spent on hospital care. Eighty percent of these dollars went to nonprofit, tax-exempt institutions.¹³ Indeed, these pressures have driven a significant consolidation within the hospital industry, with a large number of hospitals now part of regional and national health care systems.¹⁴

As large as these dollars are, however, they seemingly are not enough. More than 9% of hospital revenue nationally arises from the Medicaid program,¹⁵ a notoriously “low and slow” payor.¹⁶ Statistics indicate that Medicaid pays approximately 50% of cost,¹⁷ causing hospitals to lose 50 cents on each dollar of care provided.¹⁸ Medicare, too, especially in certain service lines, can reimburse below cost.¹⁹ Further, private insurance, which used to be the “gold standard” for coverage and reimbursement, is waning in the wake of consumer-directed health care.²⁰

Latest statistics indicate that 46 million individuals lack insurance coverage; according to one source, by 2013 some 56 million Americans will be without coverage.²¹ For most of these people, hospital treatment means that

⁹ See COHN, *supra* note 8, at 215-31; see also *Healthcare Market Place: Hospital Spending Drives Health Costs Up 7.2%*, DAILY HEALTH REP., Sept. 27, 2001, at http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&dr_id=7154 (last accessed Sept. 17, 2007).

¹⁰ CALIFORNIA HEALTHCARE FOUNDATION, SNAPSHOT HEALTH CARE COSTS 101-02 (2006), available at <http://www.chcf.org/documents/insurance/healthcarecosts06.pdf> (last accessed Sept. 17, 2007) [hereinafter SNAPSHOT].

¹¹ *Id.* at 4.

¹² *Id.* at 5.

¹³ Eileen Salinsky, *What Have You Done for Me Lately? Assessing Hospital Community Benefit*, 821 NAT'L HEALTH POL'Y FORUM 2 (Apr. 19, 2007), available at www.nhpf.org (last accessed Sept. 17, 2007).

¹⁴ Of the 4,936 community hospitals in the United States, 2,716 of those hospitals are in a system. American Hospital Association, *Statistics and Studies*, at <http://www.aha.org/aha/resource-center/Statistics-and-Studies/fast-facts.html> (last accessed Sept. 17, 2007).

¹⁵ SNAPSHOT, *supra* note 10, at 11.

¹⁶ See Mark Taylor, *Hospitals Play Hardball*, MODERN HEALTHCARE, May 26, 2003, at 4; see also Neil S. Calman et al., *Symposium Bridging the Racial Divide in Healthcare: Eliminating Racial and Ethnic Disparities in Health Status*, 9 J. HEALTH CARE L. & POL'Y 105, 113 (2005).

¹⁷ Lawrence Singer, *Gloria Jean Ate Catfood Tonight: Justice and the Social Compact for Health Care in America*, 36 LOY. U. CHI. L.J. 613, 615 (2005).

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ See COHN, *supra* note 8, at 220-22.

²¹ *Id.* at 218-19. “The number of persons lacking coverage for some period during the year is much larger than the number uninsured at a particular point in time. Some estimate that roughly 64 million nonelderly Americans or 26% of the nonelderly population were uninsured for at least part of 2001.” See also Economic Research Initiative on the Uninsured, *How Many Are Uninsured? Different Data Offer Different Dimensions*, RESEARCH HIGHLIGHT No. 6, Aug. 2004 (Economic Research Initiative on the Uninsured, Ann Arbor, MI), available at <http://eriu.sph.umich.edu/pdf/highlight-fastfacts.pdf> (last accessed Sept. 17, 2007).

care will be provided for free or at a greatly reduced payment rate.²² The ability of charitable hospitals to generate the excess funds necessary to cover these costs is growing increasingly limited, as reimbursement tightens, expenses rise, and free or reduced cost care demand increases.

The crescendo of these competing forces is where tax-exempt hospitals find themselves today. Not surprisingly, exempt hospitals have adjusted their business practices to survive in the environment created for them.²³ Executive compensation has risen to attract and retain sophisticated executives to the field.²⁴ Best business practices, including rigorous financial, purchasing, and staffing methodologies, have been adopted, driving bottom line thinking. Clearly, a convergence in business practices has occurred between exempt organizations and their proprietary brethren.

For Congress, state legislatures, and the judiciary,²⁵ the question raised is whether the industry environment and the resulting changes it has spawned obviate the need for tax-exempt hospitals. Stated another way, might it be the case that differences between exempt and for-profit hospitals—if any—are so small as to no longer merit granting tax-exempt status to hospitals?²⁶

²² COHN, *supra* note 8, at 142; *see id.* at 155-57, 162 (for allegations that hospitals' aggressive collections and insistence on charge master rates means that many times uninsured patients pay "top shelf" rates); *see also* Provena Covenant Med. Center and Provena Hosps. v. Department of Rev. of the State of Illinois, No. 2006-MR-597 (Sangamon County, Ill., filed Mar. 9, 2007).

²³ *See* COHN, *supra* note 8, at 148-51. The advent of the prospective payment system has drastically changed the environment of hospital payment.

Beginning October 1, 1983, Medicare replaced the cost-based reimbursement system for short-term, acute care inpatient hospital services with the Inpatient Prospective Payment System (IPPS). The primary objective of this change was to create incentives for hospitals to operate efficiently and minimize unnecessary costs. Under IPPS, hospitals are reimbursed a predetermined amount; in other words, hospitals are paid a prospective payment rate per-discharge (the IPPS payment) for most inpatient cases, regardless of the costs incurred by the hospital in rendering services to the patient. This prospective payment approach represents a drastic departure from the previous cost-based reimbursement system. Unlike retrospective cost-based reimbursement, IPPS essentially places the hospital at risk for managing resource consumption. If a hospital's actual costs exceed the IPPS payment, then the hospital must absorb the loss.

Brent R. Rawlings & Hugh E. Aaron, *The Effect of Hospital Charges on Outlier Payments Under Medicare's Inpatient Prospective Payment System: Prudent Financial Management or Illegal Conduct?*, 14 ANNALS HEALTH L. 267, 270 (2005).

²⁴ David J. Felicio, *Executive Compensation in Nonprofit Healthcare Providers*, American Health Lawyers Association Annual Meeting (June 2007) (presentation on file with author).

²⁵ The proper role of the judiciary in policy making may be debatable, but it is real. Contrast the majority view of the health care environment with that of the dissent in *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265 (Utah 1985) (Stewart, J., dissenting).

²⁶ Of course, this demands a market-specific inquiry.

Any comparison among [institutions] must consider the hospital's location and the mix of hospitals in the market, because both affect the provision of subsidized care. Even controlling for these factors, it is unclear how to interpret differences in the levels of charity care provision by ownership type. For example, for-profits may offer less subsidized care than not-for-profits

I believe that the need for charitable hospitals has not lessened and suggest in this article that tax-exempt, charitable, mission-driven hospitals are more needed than ever. I agree that the environment has radically shifted since the legal tests upon which exemption rests were developed, but argue that a broad base community benefit test is superior to a limited focus on charity care as the *sine qua non* of tax-exempt status.

I. HISTORICAL DEVELOPMENT OF FEDERAL AND STATE TAX EXEMPTION

A. Federal

Federal law has long recognized that hospitals fulfill a charitable purpose worthy of encouragement through the granting of tax-exempt status.²⁷ Through this status, hospitals that meet certain requirements are free from paying federal income tax, able to access the bond market on a tax-free basis, and able to solicit donations from individuals who, in turn, will enjoy a tax deduction for their gift.²⁸ As discussed below, federal tax exemption can also position the hospital to receive state exemption recognition.²⁹

Federal tax exemption for hospitals dates back to the adoption of the first tax code in 1913.³⁰ Prior to that time, of course, the charitable nature of hospitals had long been recognized by the communities served and state legislatures.³¹ Through the adoption of Section 501(c)(3) of the Internal Revenue Code,³² organizations serving a religious, charitable, scientific, and/or

because they face less demand, but they may choose to locate in places where they are unlikely to face demand.

Jill R. Horwitz, *Why We Need the Independent Sector: The Behavior, Law and Ethics of Not-for-Profit Hospitals*, 50 UCLA L. REV. 1345, 1355 (2003).

²⁷ 26 U.S.C. § 501(c)(3) (2000); see also Shelley A. Sackett, *Conversion of Not-for-Profit Health Care Providers: A Proposal for Federal Guidelines on Mandated Charitable Foundations*, 10 STAN. L. & POL'Y REV. 247, 248 (1999).

Their predecessors were almshouses, which sheltered the ill, homeless and poor until their deaths. Gradually, citizens recognized the need to provide medical treatment to the poor, and established public hospitals. A two-tiered system of medical care developed, including private, 'fee-for-service' care for those who could afford it and a voluntary public system funded by taxes and private contributions for those less-well off.

Id.

²⁸ Salinsky, *supra* note 13, at 3-6.

²⁹ Jack Burns, *Are Nonprofit Hospitals Really Charitable?: Taking the Question to the State and Local Level*, 29 J. CORP. L. 665, 669-70 (2004).

³⁰ Jardon McGregor, *The Community Benefit Standard for Non-profit Hospitals: Which Community, and for Whose Benefit?*, 23 J. CONTEMP. HEALTH L. & POL'Y 302, 306 (2007). That law exempted nonprofit charities from income taxes and allowed deductions for charitable donations.

³¹ *Id.* at 305-06.

³² IRC § 501(c)(3). No stand-alone category automatically conferring tax-exempt status exists for health care organizations. Rather, health care organizations "achieve that status by qualifying as 'charitable' organizations under the Internal Revenue Code." See McGregor, *supra* note 30, at 312.

educational purpose, and not running afoul of certain prohibitions of private benefit, inurement, and lobbying parameters, were recognized as tax exempt.³³

The first formal guidance regarding hospitals' exemption worthiness did not come from the Internal Revenue Service (Service) until 1956.³⁴ There, in Revenue Ruling 56-185, the Service reasoned that to satisfy Section 501(c)(3), hospitals were required to operate—to the extent of their financial ability to do so—for the benefit of those unable to pay.³⁵ The Ruling distinguished between charity care and bad debt and encouraged hospitals to clearly identify when charity care would be provided.³⁶

In 1969, the Service revisited its stance.³⁷ Believing that the introduction of Medicare and Medicaid would largely obviate the need for charity care—but recognizing that even without a substantial provision of charity care hospitals fulfilled a charitable purpose—the Service redefined exemption requirements.³⁸ Revenue Ruling 69-545 took the position that hospitals could satisfy Section 501(c)(3) by fulfilling a broad “community benefit” standard.³⁹ Criteria required to be satisfied under this Ruling include

³³ IRC § 501(c)(3). A nonprofit entity must meet both the organizational and operational tests to satisfy the exclusivity requirement of Section 501(c)(3). The organizational test requires the charter to be limited to one or more exempt purposes and not to empower the organization to engage, other than as an insubstantial part of its activities, in activities not in furtherance of an exempt purpose, and requires the assets to be dedicated to exempt purposes. *See* Treas. Reg. § 1.501(c)(3)-1(b). The operational test requires that the organization primarily engage in activities directed toward accomplishment of its exempt purpose. If more than an insubstantial part of its activities is not in furtherance of its exempt purpose or if the net earnings of the organization inure to private individuals, the organization will fail the operation test. *See id.* § 1.501(c)(3)-1(c)(1).

³⁴ Rev. Rul. 56-185, 1956-1 C.B. 202.

³⁵ *Id.* The ruling provided that a charitable hospital's net earnings must not inure directly or indirectly to the benefit of any private shareholder or individual, a requirement that repeated the statutory prohibition on private inurement and private benefit.

³⁶ *Id.*

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. Furthermore, if it operates with the expectation of full payment from all those to whom it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered.

Id.

³⁷ Rev. Rul. 69-545, 1969-2 C.B. 117.

³⁸ Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307, 320-21 (1991).

³⁹ *Id.* “In this particular ruling, the IRS stressed that the promotion of health for the general benefit of the community has long been recognized as a charitable purpose under the common law of charitable trusts.”

governance by a community board, an open emergency room and medical staff, and arms length transactions between the hospital and its medical staff members.⁴⁰ The provision of charity care remained important, but the Ruling recognized that the hospital could secure payment for its services; merely making hospital services “available” to serve those unable to pay was, itself, a community benefit.⁴¹

In 1983, the open emergency room requirement was relaxed,⁴² as the Service recognized that community needs should dictate whether the hospital should offer emergency services. If a state or local agency determined that these services were adequately provided by another medical institution in the community, then they need not be provided by the applying institution for it to be considered tax-exempt.⁴³

B. State

State constitutions have long recognized that certain organizations and the properties they use should be free from taxation. In the Illinois constitution, for example, Article IX, Section 6 allows the General Assembly to exempt from taxation property used exclusively for charitable purposes.⁴⁴ Utah’s similar provision dates to 1895 (amended in 1982)⁴⁵ and Pennsylvania’s to 1875 (amended in 1997).⁴⁶ Pursuant to these laws, hospitals are relieved from state income and sales tax, as well as property tax.⁴⁷

Historically, state approaches to determining satisfaction of their tax-exemption requirements have, for all practical purposes, involved minimal policing, with states granting state exemption whenever the organization receives federal tax exemption.⁴⁸ Not until the landmark Utah Supreme Court case *Utah County v. Intermountain Health Care, Inc. (IHC)*⁴⁹ did any state seriously examine whether a hospital was satisfying state charity requirements.⁵⁰

⁴⁰ Rev. Rul. 69-545.

⁴¹ McGregor, *supra* note 30, at 315-16. “At its broadest definition, community benefit ‘includes such services as the provision of health education and screening services to specific vulnerable populations within a community, as well as activities that benefit the greater public good, such as education for medical professionals and medical research.’” *Id.* at 317.

⁴² Hall & Colombo, *supra* note 38, at 321.

⁴³ Rev. Rul. 83-157, 1983-2 C.B. 94-95.

⁴⁴ ILL. CONST. art. IX, § 6.

⁴⁵ UT. CONST. art. XIII, § 3.

⁴⁶ PA. CONST. art. VIII, § 2(a)(v).

⁴⁷ See 210 ILL. COMP. STAT. 76/10-20 (2003); UTAH CODE ANN. 26-18-302 (1993); 72 PA. STAT. ANN. § 5020-204(a)(3) (West, Westlaw through Act 2007-41); see also Coalition for Nonprofit Health Care, *State Law Approaches to Ensuring the Social Accountability of Nonprofit Health Care Organizations*, available at http://www.communityhlth.org/communityhlth/files/files_resource/Community%20Benefit/CNHC_CommBeneReport.pdf (last accessed Sept. 17, 2007) [hereinafter Coalition].

⁴⁸ See Burns, *supra* note 29, at 679-83.

⁴⁹ 709 P.2d 265 (1985).

⁵⁰ *Id.* at 272. The Utah Supreme Court refused to allow arguments that the tax exemption evolves along with the nonprofit hospital’s function. Rather, it examined the validity of that tradition within the context

In *IHC*, Utah County moved to remove the property tax exemption of two hospitals operated by IHC, itself a ministry of the Church of Jesus Christ of Latter-day Saints.⁵¹ One hospital had been started by the Church; the other was leased by Intermountain.⁵² After an extensive discussion of the contemporary hospital operating environment, the court held that, for an institution's property to be tax exempt, the institution must make a "gift" to the community or fulfill a need that government would have had to meet but for the institution.⁵³

The court posited a six-factor test that Utah hospitals would need to satisfy to secure property tax exemption.⁵⁴ Among these factors were the provision of free care, the receipt of significant donations from the community, and the absence of any profit from operations.⁵⁵ Finding satisfaction of many of the six factors lacking, the court ruled the hospital property should not be exempt.⁵⁶

Shortly thereafter challenges arose in several other states. In Pennsylvania, the property tax exemption of an enterprise created by the state's hospitals to enhance quality of care was challenged in *Hospital Utilization Project (HUP) v. Commonwealth of Pennsylvania*, with the Pennsylvania Supreme Court finding the property not exempt because the organization did not advance a charitable purpose or donate or render gratuitously any of its

of the contemporary social and economic atmosphere of the health care industry. The court noted that the economic environment in which modern hospitals function was critical to its analysis. A central point was the recognition of the diminishing distinction between nonprofit and for-profit hospitals.

⁵¹ *Id.* at 267.

⁵² *Id.* at 266.

⁵³ *Id.* at 278-79.

⁵⁴ *Id.* at 265. Given the complexities of institutional organization, financing, and impact on modern community life, there are a number of factors to be weighed in determining whether a particular institution is using its property "exclusively for . . . charitable purposes." UTAH CONST. art. XIII, § 2 (1895, amended 1982). This six-factor standard has been adapted from the test articulated by the Minnesota Supreme Court in *North Star Research Institute v. County of Hennepin*, 236 N.W.2d 754, 757 (Minn. 1975).

These factors are whether: (1) the stated purpose of the entity is to provide a significant service to others without immediate expectation of material reward; (2) the entity is supported, and to what extent, by donations and gifts; (3) the recipients of the "charity" are required to pay for the assistance received, in whole or in part; (4) the income received from all sources (gifts, donations, and payment from recipients) produces a "profit" to the entity in the sense that the income exceeds operating and long-term maintenance expenses; (5) the beneficiaries of the "charity" are restricted or unrestricted and, if restricted, whether the restriction bears a reasonable relationship to the entity's charitable objectives; and (6) dividends or some other form of financial benefit, or assets upon dissolution, are available to private interests, and whether the entity is organized and operated so that any commercial activities are subordinate or incidental to charitable ones. "These factors provide, we believe, useful guidelines for our analysis of whether a charitable purpose or gift exists in any particular case. We emphasize that each case must be decided on its own facts, and the foregoing factors are not all of equal significance, nor must an institution always qualify under all six before it will be eligible for an exemption." *Id.*

⁵⁵ *Utah County*, 709 P.2d at 278.

⁵⁶ *Id.* at 278-79.

services, its beneficiaries were not legitimate objects of charity, and it did not demonstrate that it operated entirely free from a private profit motive.⁵⁷ As a result of the *HUP* decision, ultimately 175 of Pennsylvania's 220 hospitals found their exemption challenged by local taxing authorities.⁵⁸

A challenge in Vermont led that state's supreme court to rule in the hospital's favor, largely upholding adoption of a broad exemption standard.⁵⁹ The Vermont Supreme Court relied on the tradition of tax exemption in upholding the property tax exemption of the plaintiff in this case.⁶⁰ The court held that an "open door policy" was sufficient for Medical Center Hospital to qualify as a "charitable organization," stating: "[I]t is unreasonable to suggest that because modern medical institutions no longer operate in precisely the same manner as they did many years ago, they should lose their traditional tax-exempt status. We recognize, as have other jurisdictions, that the definition of 'charitable organization' need not be locked into the past."⁶¹ Similar favorable results for hospitals were obtained in Missouri⁶² and California.⁶³

Although various states immediately following this flurry of activity in Utah, Pennsylvania, and Vermont sought to reexamine tax-exemption standards, little resulted from these initiatives. For all practical purposes, until the last few years tax exemption fell from the legislative and enforcement radar screens.

II. RENEWED INTEREST IN TAX EXEMPTION

A variety of factors have coalesced to launch tax exemption to the forefront of the policy agenda. Renewed consideration of the plight of the uninsured, coupled with the growing ranks of this population, cause advocates to look for sources of free or reduced-cost care.⁶⁴ Attention to the significant

⁵⁷ *Hospital Utilization Project v. Commonwealth of Pennsylvania*, 487 A.2d 1306, 1316-17 (1985); see also Jerry Wagner, *Community Service Foundation, Inc. v. Bucks County Board of Assessment and Revision of Taxes: The Commonwealth Court Redefines Relieving Government Burden as a Qualification for Tax Exempt Status*, 6 WIDENER J. PUB. L. 929, 936-40 (1997).

⁵⁸ Alice A. Noble et al., *Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives*, 26 J.L. MED. & ETHICS 116, 121 (1998).

⁵⁹ *Medical Center Hosp. of Vermont v. City of Burlington*, 566 A.2d 1352 (Vt. 1989).

⁶⁰ *Id.* at 1359-60.

⁶¹ *Id.* at 1356, 1360.

⁶² *Rideout Hosp. Found. v. L.A. County*, 10 Cal. Rptr. 2d 141 (Cal. App. 1992); see also Noble, *supra* note 58, at 122-23.

⁶³ *Jackson County v. State Tax Comm'n*, 521 S.W.2d 378 (Mo. 1975).

⁶⁴ KEITH ANDERSON & GEORGE GEVAS, *THE TAX STATUS OF NOT FOR PROFIT HOSPITALS UNDER SIEGE & THE FINANCIAL IMPLICATIONS OF RECENT ATTACKS: A WHITE PAPER PRESENTATION BY NATIONAL CITY* 1-5 (2006), available at <https://www.drinkerbiddle.com/files/Publication/3798d6f1-868f-4950-9b2e-0a98767c99cc/Presentation/PublicationAttachment/188499da-64f6-45dd-a800-1335d664ca97/HC-NationalCityWhitePaper.pdf> (last accessed Sept. 17, 2007).

dollars flowing to nonprofit hospitals and the business and compensation practices they have adopted encouraged attorneys general, state legislatures, Congress, and advocacy groups to hone in on the charitable nature of health care, questioning whether there is a disconnect between stated charitable attributes, methods of operation, and compliance with federal and state law.⁶⁵

A. Recent Federal Efforts

Within the past several years, the amount of attention paid at the federal level to tax-exemption issues has been unprecedented.⁶⁶ So, too, has been the variety of avenues this attention has taken.

Congressional initiatives began in earnest in 2004.⁶⁷ In June of that year, the House Ways and Means Oversight Subcommittee held hearings focusing on the sufficiency of charity care as a justification for exemption.⁶⁸ These preliminary hearings were followed by further hearings in the two succeeding years: in 2005 by the full Ways and Means Committee,⁶⁹ and, in 2006, by the Senate Finance Committee.⁷⁰ The latter, headed at the time by Senator Charles Grassley (R-Iowa), was preceded by a detailed written inquiry to 10 of the larger health care systems in the United States.⁷¹ The 46-part questionnaire ran the full gamut of exempt hospital business practices, including type and amount of charity care, collection procedures, community relations, joint venture activities, and executive compensation practices.⁷²

Not surprisingly, the Service strengthened its focus on exempt organizations during this same period. In 1996, the Service was granted intermediate sanction authority by Congress, putting a significant enforcement arrow in the Service's quiver.⁷³ Prior to this grant, the only recourse available to the Service upon its discovering abuse by an exempt organization was to remove the exemption, a penalty so severe that it was rarely exercised. Intermediate sanctions authorize the imposition of monetary penalties on certain recipients of

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ Nancy M. Kane, *Tax-Exempt Hospitals: What Is Their Charitable Responsibility and How Should It Be Defined and Reported?*, 51 ST. LOUIS U.L.J. 459, 460 (2007).

⁶⁸ Charles Grassley, Memorandum to Reporters and Editors from U.S. Senate Committee on Finance on Non-profit Hospital Responses to Finance Committee (Sept. 12, 2006), available at <http://www.senate.gov/~finance/press/Gpress/2005/prg091206.pdf> (last accessed Sept. 17, 2007).

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² *Id.*

⁷³ IRC § 4958 (1996); see also Alliance for Advancing Non Profit Health Care, *What Is the Right Pay for a Nonprofit Executive*, Summer 2005, at <http://www.nonprofithealthcare.org/documentView.asp?docid=156&sid> (last accessed Sept. 17, 2007).

“excess benefits,”⁷⁴ as well as on the organization managers who authorized the benefit.⁷⁵ Intermediate sanctions are now the Service’s preferred enforcement mechanism, but revocation is still an authorized remedy in certain situations.⁷⁶

In July of 2004, the Service introduced the “Tax Exempt Compensation Enforcement Project.”⁷⁷ The Project is designed to identify and halt “excessive” compensation to executives of exempt organizations.⁷⁸ Audits of nearly 2,000 exempt organizations will have been undertaken under this Project.⁷⁹

Also in 2004, the Service significantly expanded its internal capabilities to investigate and analyze data from exempt organizations.⁸⁰ The Exempt Organizations Compliance Unit⁸¹ is intended to improve the information reported by organizations on their annual reports to the Service (the Form 990)⁸² and to enhance compliance with this reporting requirement.⁸³ The Data Analysis Unit’s focus is to assist Service staff in setting priority areas of focus and designing audit work plans.⁸⁴

More recently, in early 2007, the Service issued its analysis of compensation paid to executives and directors of exempt organizations.⁸⁵ Of the organizations queried, 15% were selected for audit; of these, 25 received

⁷⁴ Roger C. Siske & Pamela Baker, *Tax Exempt Organization Compensation Audits: 403(b) and 457(b) and (f)*, at 4-5 (2005), American Law Institute—ABA, Executive Compensation: Strategy, Design and Implementation, at http://files.ali-aba.org/old/aliaba/aliaba_pdf/freelc1067.pdf (last accessed Sept. 17, 2007).

⁷⁵ *Id.*

⁷⁶ *Id.* at 6.

⁷⁷ *See id.* at 1-3; *see also* Internal Revenue Service, Testimony: Charitable Giving Problems, <http://www.irs.gov/newsroom/article/0,,id=124203,00.html> (last accessed Sept. 17, 2007).

A tax-exempt organization is always permitted to pay reasonable compensation for the services it receives. High compensation may be paid, provided it is warranted by the value of the services performed for the exempt organization. In order to determine what is reasonable, the organization must look to what similar organizations pay for similar work. The focus of IRS inquiry is the exempt organization’s compensation practices and procedures for determining what is reasonable, including the manner in which executive compensation is reported. In addition to general compensation practices, however, IRS inquiries have also focused on the amounts earned by the five highest paid officers, directors, employees and independent contractors, or their related entities.

GT Alert, *IRS Increases Enforcement Activity for Non-Profits; Congress Examines Exempt Hospital*, Aug. 2005, <http://www.gtlaw.com/pub/alerts/2005/0807.pdf> (last accessed Sept. 17, 2007).

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ Ann K. Batlle, *IRS Audits of Tax-Exempt Organizations: Understanding and Preparing for an Examination*, in *TAX PRAC. & PROC.* 29 (June-July 2004).

⁸¹ *Id.* at 30.

⁸² *See* IRS FORM 990 (2006), <http://www.irs.gov/pub/irs-pdf/f990.pdf> (last accessed Sept. 17, 2007).

⁸³ Batlle, *supra* note 80, at 30.

⁸⁴ *Id.*

⁸⁵ Siske & Baker, *supra* note 74, at 1.

notices of an intermediate sanction penalty.⁸⁶ Total assessed penalties were in excess of \$21 million for 40 disqualified persons.⁸⁷

The year 2007 also saw revisions to the Form 990 annual report.⁸⁸ Of particular note is the creation of a new schedule to the form directed specifically toward health care providers.⁸⁹ The schedule, among other things, enables more detailed disclosure of community benefit activities undertaken by hospitals.

B. Illustrative State Efforts

Recently, state legislatures and attorneys general have moved rapidly to enhance the accountability of tax-exempt health care providers. Although the genesis for the various initiatives varies depending upon particular circumstances in each state, in large part these efforts have coalesced around community reporting requirements and billing and collection practices. Three states have gone farther, mandating specific levels of community benefit.

Reporting obligations typically require that hospitals conduct a community needs assessment and report how the institution is meeting identified needs. For example, New York requires each hospital to prepare and submit a community service plan (CSP) every three years.⁹⁰ The CSP must delineate the hospital's operational and financial commitment to meeting identified community health care needs, such as providing charity care and improving access to the underserved. In addition, each hospital must submit a financial statement disclosing, on a combined basis, a summary of the resources of the hospital and its related corporations and the amount allocated by the hospital to providing charity care and reduced or free services.⁹¹

Similarly, California requires each hospital to adopt an annually updated community benefit plan to satisfy identified community needs.⁹² The plan must set forth the objectives to be achieved and a comprehensive time frame for implementation.⁹³ The plan must also include the community groups and local officials consulted during development of the plan. This helps ensure

⁸⁶ McDermott Will & Emory, *IRS Sharpens Focus on Tax-Exempt Organization Compensation*, Mar. 14, 2007, http://www.mwe.com/index.cfm/fuseaction/publications.nldetail/object_id/fcf1722d-8dd5-431b-885b-997da73b72fc.cfm (last accessed Sept. 13, 2007).

⁸⁷ *Id.*

⁸⁸ See Internal Revenue Service, *Highlights of the Redesigned Form 990*, http://www.irs.gov/pub/irs-tege/highlightsform990redesign_061307.pdf (last accessed Sept. 13, 2007). Among the highlights of the new form is a portion requiring governance information, including the composition of the board and certain other governance and financial statement practices and schedules that will focus reporting on areas of interest to the public and the IRS.

⁸⁹ See IRS FORM 990, *supra* note 82.

⁹⁰ N.Y. PUB. HEALTH LAW § 2803.1 (2007).

⁹¹ *Id.*

⁹² CAL. HEALTH & SAFETY CODE § 127340 (West 2006).

⁹³ *Id.*

that the community will benefit from the services provided by the hospital.⁹⁴ In addition to the community benefit plan, each hospital must conduct and complete an updated community needs assessment every three years.⁹⁵ Other states, such as Massachusetts,⁹⁶ rely upon a voluntary reporting scheme to hold exempt hospitals accountable.⁹⁷

Texas, Pennsylvania, and Utah mandate specific community benefit levels for property to be tax exempt. Texas has been the leader in this regard, adopting legislation in 1993.⁹⁸ Texas requires that hospitals provide charity care at a level meeting one of three statutory standards: (i) charity care and other community benefits equal to at least 5% of net patient revenue (with charity care, Medicaid, and other government-sponsored health care programs equal to 4% of net patient revenue); (ii) charity care and government-sponsored indigent health care equal to 100% of the hospital's state tax-exemption benefits; or (iii) charity care and government-sponsored indigent care provided at a reasonable level relative to community need, hospital resources, and tax-exempt benefits received.⁹⁹

Pennsylvania mandates the provision of charity care from every "institution of purely public charity."¹⁰⁰ Pennsylvania law stipulates that these institutions, which include exempt hospitals, can meet the charity care obligation by, among other things, spending at least 75% of their net income, but not more than 3% of total operating costs, on uncompensated care.¹⁰¹

Since the *IHC* case, Utah relies upon community benefits standards issued by the state tax commission.¹⁰² Although not a statutory approach, the Utah Tax Commission hears appeals of county tax decisions and, through its promulgation of standards used to judge these appeals, has created consistency among the various property assessors in the state.¹⁰³ Clarifying the

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ MARTHA COAKLEY, ATTORNEY GENERAL OF THE COMMONWEALTH OF MASSACHUSETTS, COMMUNITY BENEFIT GUIDELINES FOR NONPROFIT ACUTE CARE HOSPITALS (July 2007), <http://www.cbsys.ago.state.ma.us/healthcare/hccbnpguide.pdf>; see OFFICE OF THE MASSACHUSETTS ATTORNEY GENERAL: STATUTES AND REGULATIONS—NONPROFIT/CHARITIES Ch. 12, available at <http://www.ago.state.ma.us/spcfm?pageid=1217> (last accessed Sept. 17, 2007).

⁹⁷ Coalition, *supra* note 47, at 13-16.

⁹⁸ TEX. HEALTH & SAFETY CODE ANN. § 311.041 (2001); see also OFFICE OF MASSACHUSETTS ATTORNEY GENERAL, HEALTHCARE, available at <http://www.cbsys.ago.state.ma.us/healthcare/hccbindex.asp?head2=Community+Benefits&parent=338&ion=15> (last visited Sept. 13, 2007); FREE CARE: A COMPENDIUM OF STATE LAWS BOSTON: COMMUNITY CATALYST (Sept. 2003), available at <http://www.communitycatalyst.org> (last visited Sept. 17, 2007).

⁹⁹ TEX. HEALTH & SAFETY CODE ANN. § 311.041 (2001) (Duties of Nonprofit Hospitals); *Id.* § 311.031 (2001) (Hospital Data Reporting and Collection System); *id.* § 61.001 (2001) (Indigent Health Care and Treatment).

¹⁰⁰ Coalition, *supra* note 47, at 18-19.

¹⁰¹ *Id.*; see also 10 PA. CONS. STAT. ANN. § 371-85 (West 1997).

¹⁰² Coalition, *supra* note 47, at 21.

¹⁰³ Utah State Tax Commission, www.tax.ex.state.ut.us (last accessed Sept. 17, 2007).

Utah Supreme Court's "gift to the community" requirement set forth in *IHC*, the Commission mandates hospitals and nursing homes provide such "gifts" in an amount exceeding what their annual property tax liability would have been had they not been exempt.¹⁰⁴ The Commission adopted a broad definition of "gift," which includes charity care, donations of time and money, and community service, including research and professional education.¹⁰⁵

Still other states have focused upon clarifying hospital charity care determinations and billing and collection practices. In 2005, for example, all Minnesota hospitals entered into agreements with the state attorney general agreeing to specific financial guidelines for the determination of free or reduced cost care, as well as uniform billing and collection procedures.¹⁰⁶

Recent activities in Illinois bear special mention. Following a nationally publicized episode in the state involving a Catholic hospital that authorized "body attachments" for collection of hospital debt, the hospital found itself subject to intense scrutiny of its charitable mission.¹⁰⁷ In 2004, the Illinois Department of Revenue revoked the hospital's property tax exemption, finding the property was not being used for a charitable purpose under state law.¹⁰⁸ (In February of 2007, a similar decision was reached regarding a neighboring hospital.¹⁰⁹) Specifically, in the Provena Covenant determination, the Department found the hospital had provided a "seriously deficient" amount of charity care as measured against its total revenue, allowed private parties (for example, physicians under certain exclusive contracts) to use the property for profit making purposes, and engaged in collection practices inconsistent with a charitable mission.¹¹⁰ Even though the Department's position and rationale created great concern within the hospital and legal communities, the case was reversed by the circuit court (although the attorney general announced that the decision will be appealed).¹¹¹

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ MINNESOTA DEPARTMENT OF HEALTH, MINNESOTA HOSPITALS: UNCOMPENSATED CARE, COMMUNITY BENEFIT, AND THE VALUE OF TAX EXEMPTION 1 (Jan. 2007), available at <http://www.health.state.mn.us/divs/hpsc/hep/publications/costs/uc2007report.pdf> (last accessed Sept. 18, 2007).

¹⁰⁷ COHN, *supra* note 8, at 156-57; see also Lucette Lagnado, *Hospital Found "Not Charitable" Loses Its Status as Tax Exempt*, WALL ST. J., Feb. 9, 2004, available at http://www.trinity.edu/eschumac/HCAD5313/WSJ_com%20-%20Hospital%20Found%20Not%20Charitable%20Loses%20Its%20Status%20as%20Tax%20Exempt.htm (last accessed Sept. 17, 2007).

¹⁰⁸ Lagnado, *supra* note 107; see also Stephen E. Weyl, *Illinois Department of Revenue Upholds Revocation of Hospital's State Property Tax Exemption*, 3 ABA Health eSource (2006), available at <http://www.abanet.org/health/esource/Volume3/02/weyl.html> (last accessed Sept. 17, 2007).

¹⁰⁹ ANDERSON & GEVAS, *supra* note 64, at 3.

¹¹⁰ Provena Covenant Med. Center and Provena Hosps. v. Department of Revenue of the State of Illinois, No. 2006-MR-597 (Sangamon County, Ill., filed Mar. 9, 2007).

¹¹¹ Mike Colas, *Provena Wins Ruling to Restore Tax-Exempt Status*, CHICAGO BUSINESS (July 20, 2007), available at <http://www.chicagobusiness.com/cgi-bin/news.pl?id=25730&seenIt=1> (last accessed Sept. 17, 2007). Additional information is on file with author.

The Provena Covenant case spurred significant legislative attention within the state. A community benefits reporting law was passed in 2003, mandating exempt health care institutions to file a report with the attorney general.¹¹² Also introduced, and expected to be acted upon in the next legislative session, is a mandatory charity care requirement.¹¹³ The initial proposal was to set this limit at 8% of gross revenue.¹¹⁴ This high a standard has no realistic chance of passage. However, it is quite possible Illinois will join Texas, Pennsylvania, and Utah in imposing a strict charity care standard. Further, it is all but certain that other states will be following Illinois' lead and enhancing their examination of hospital community benefits.

C. Litigation and Union Initiatives

A primary driver of tax exemption rising back onto the radar screen has been the well-funded efforts of plaintiffs' law firms and unions to either (depending upon one's point of view) seize this issue for their personal gain or serve a valuable public function by raising serious concerns about the operation of exempt hospitals. Regardless of one's stance on the genesis of this interest, there is no doubt that these efforts have been successful in shining a light on exemption.

On the litigation front, the leading protagonist has been Richard Scruggs, a Mississippi plaintiffs' attorney who made vast sums in the national litigation against cigarette companies.¹¹⁵ Scruggs, who also had success spearheading suits against health insurance and health maintenance companies for wrongful denial of claims, became interested in charity care when presented with information from a physician who had also been a hospital administrator.¹¹⁶

Eventually this interest blossomed into the filing of suits against 18 hospitals and health care systems across the United States. Scruggs moved to

¹¹² 210 ILL. COMP. STAT. 76/20 (2003).

¹¹³ The Tax-Exempt Hospital Responsibility Act (the Act), H.B. 5000, 94th ILL. Gen. Assem., Reg. Sess. (Ill. 2007). The Act sets forth charity care requirements for Illinois tax-exempt, nonprofit hospitals and exempts only critical access hospitals. Nonprofit hospitals would be required to comply with the act to maintain their tax-exempt status under the Illinois Income Tax Act, the Use Tax Act, the Service Use Tax Act, the Service Occupation Tax Act, the Retailers' Occupation Tax Act, and the Property Tax Code. The Act also prohibits the Illinois Finance Authority from exercising any of its powers for the benefit of any hospital that is out of compliance. The Tax-Exempt Hospital Responsibility Act mandates that Illinois tax-exempt, nonprofit hospitals provide charity care in an amount equal to 8% of the hospital's total annual operating costs (as reported each year in the hospital's most recently settled Medicare cost report).

¹¹⁴ *Id.*

¹¹⁵ COHN, *supra* note 8, at 157.

¹¹⁶ The Business Word, *Hospitals Sued by Richard Scruggs for Charging Uninsured More than Insured*, http://www.businessword.com/index.php/weblog/comments/hospitals_sued_for_charging_uninsured_more_than_insured/ (last accessed July 30, 2007).

consolidate the suits into class litigation in 2004.¹¹⁷ The essence of these suits was that, by virtue of tax-exemption law, exempt hospitals have an implied contract with the federal government to provide a minimal level of charity care, and that the organizations breached this contract.¹¹⁸ Scruggs also argued violation of various consumer protection laws, as uninsured patients were often billed charge master rates even though insured patients typically received a discount from charges.¹¹⁹

Ultimately, class certification was denied and the federal suits were largely dismissed, courts holding that Section 501(c)(3)¹²⁰ does not constitute an implied contract and private litigants lack standing to enforce these federal tax laws.¹²¹ The litigation did result in several settlements, however, and in several states the consumer fraud claims continue to be prosecuted.¹²²

Contemporaneous with the Scruggs litigation, two national unions turned to the exemption issue to assist in their organizing campaigns. In Chicago, the American Federation of State, County, and Municipal Employees (AFSCME)¹²³ has targeted Resurrection Health Care, while the Service Employees International Union (SEIU) has targeted Advocate Health Care.¹²⁴ A primary focus of these efforts has been highlighting alleged disconnects

¹¹⁷ Premier, *Nonprofit Hospitals and Health Systems: Caring for Our Communities—A Charge to Keep*, available at <http://www.premierinc.com/about/advocacy/issues/06/nonprofit/issue-overview.jsp> (last accessed Sept. 17, 2007).

¹¹⁸ Christopher Guadagnino, *Lawsuits Indict Hospital Charity Care*, PHYSICIAN'S NEWS DIGEST (Sept. 2004), available at <http://www.physiciansnews.com/cover/904.html> (last accessed Sept. 17, 2007).

¹¹⁹ *Id.*

¹²⁰ IRC § 501(c)(3).

¹²¹ Premier, *supra* note 117.

¹²² The Scruggs Law Firm, P.C., *Uninsured Patients Secure First Class Action Settlement with a Nonprofit Hospital System*, PR NEWSWIRE, Nov. 1, 2006, <http://sev.prnewswire.com/health-care-hospitals/20051101/NYTU2310112005-1.html> (last accessed Sept. 17, 2007).

In the first settlement of its kind in the nation, uninsured patients have reached a settlement with Providence Health System of Oregon, a nonprofit hospital system with hospitals throughout Oregon, to establish fair pricing and charity care policies for uninsured patients of those hospitals. Uninsured plaintiffs filed the class action suit against Providence in December 2004 in Multnomah County Circuit Court in Portland. Plaintiffs alleged that Providence charged its uninsured patients much higher rates than it required any of its other patients to pay for the same services. Hospitals have traditionally defended this pricing differential by explaining that insured patients pay discounted rates negotiated between their private insurance companies and the hospitals. However, uninsured patients are the least able to pay, have no negotiating power and thus are charged the highest rates for identical medical services.

¹²³ AFSCME, <http://www.afscme.org> (last visited Sept. 18, 2007). The American Federation of State, County, and Municipal Employees is the nation's largest public service employees union.

¹²⁴ SEIU, <http://www.seiu.org> (last visited Sept. 18, 2007). The Service Employees International Union is comprised of both working and retired individuals from three sectors of industry: health care; property services; and public services. SEIU alleges that Advocate engages in discriminatory pricing, predatory collections, limited charity care, and anti-union activities. *See generally* Hospital Monitor, www.hospitalmonitor.org (last accessed Sept. 17, 2007).

between a charitable organizational mission and patient billing and collection practices at the health care systems.¹²⁵ The goal of doing so arguably has been to embarrass these organizations, encouraging them to reach a settlement with the unions to enable potential representation of the workers to move forward.

D. Industry Response

Certainly, hospital billing and collection practices and community benefit reporting have significantly changed with the onslaught of attention. Clear statements of eligibility for charity care, as well as relaxing of assistance guidelines, have occurred at most hospitals. The recent joint Catholic Hospital Association (CHA)¹²⁶ and VHA¹²⁷ initiative and the efforts by the American Hospital Association (AHA)¹²⁸ to enhance community benefit reporting bear special mention.

The CHA/VHA effort for the first time represents a widespread consensus on the definition of “community benefits” and how to account for these benefits.¹²⁹ *A Guide for Planning and Reporting Community Benefit* is a revision of CHA’s 1989 *Social Accountability Budget* and CHA/VHA’s *Community Benefit Reporting*. The *Guide* defines community benefit and provides examples in an effort to standardize reporting of community benefit within the industry. CHA was specifically praised by Senator Grassley for its approach.¹³⁰

The AHA, although also moving to refine community benefit reporting and in general agreeing with the CHA/VHA *Guide* on most points, caught some legislative ire as it insisted upon categorizing bad debt and Medicare payment shortfalls as charity care.¹³¹ The AHA argues that, because hospitals

¹²⁵ AFCSME, *AFCSME Press Release: Council 31 Releases Report on Resurrection Health Care* (Nov. 10, 2005), available at <http://www.afscme.org/publications/4187.cfm> (last accessed Sept. 17, 2007). A copy of the full report on which AFCSME based its decision to target Resurrection Health Care is available at <http://www.afscme31.org/cmaextras/qualityofcare.pdf> (last accessed Sept. 17, 2007).

¹²⁶ Catholic Health Association, <http://chausa.org> (last visited Sept. 18, 2007). The Catholic Health Association is the largest group of not-for-profit health care sponsors, systems, and facilities in the United States. Founded in 1915, its primary purpose is to serve the nation’s Catholic health care organizations by supporting the strategic directions of mission, ethics, and advocacy.

¹²⁷ VHA, formerly known as Voluntary Hospitals of America, is a health care provider alliance of more than 2,400 not-for-profit health care organizations. Founded in 1977, VHA’s primary mission is to improve members’ clinical and economic performance. See VHA, www.vha.com (last visited Sept. 18, 2007).

¹²⁸ The American Hospital Association is the national organization that represents and serves all types of hospitals, their patients, and communities to ensure that members’ perspectives and needs are heard in matters of health policy development, legislative and regulatory debates, and judicial matters. Founded in 1898, the AHA provides education for health care leaders and is a source of information on health care issues. See <http://www.aha.org/aha/about/index.html> (last accessed Sept. 17, 2007).

¹²⁹ Catholic Health Association, *Guide*, <http://www.chausa.org/Pub/MainNav/ourcommitments/CommunityBenefits/Resources/TheGuide> (last accessed Sept. 17, 2007).

¹³⁰ Grassley, *supra* note 68, at 2.

¹³¹ AMERICAN HOSPITAL ASSOCIATION, IMPROVING ACCOUNTABILITY FOR TAX-EXEMPT STATUS 1, available at <http://www.aha.org/aha/content/2007/pdf/07-am-accountability-tax-exempt.pdf> (last accessed Sept. 17, 2007).

are required to care for Medicare and Medicaid beneficiaries as well as participate in other indigent care programs as a basis for receiving federal tax exemption, the below-cost reimbursement rates of these programs and the burden of bad debt primarily coming from low-income patients should be factored in as a community benefit.

E. Summary

There is no doubt that what many had previously considered perhaps a sleepy, hyper-technical area of law has now generated significant attention, even among the general public.¹³² Tax-exemption issues were “hot” 15 years ago, only to fizzle out with little resolution, but it is highly doubtful the same result will occur today. One way or the other, most states, and perhaps Congress, will be enacting refinements—if not significant changes—to exemption standards.

III. SUGGESTED APPROACHES

The tax-exemption issues under consideration by the federal and state governments have long been fodder for the academy.¹³³ Many legal, policy, and academic scholars have argued that the current community benefit and charity care statutes are flawed. Some advocate eliminating hospitals’ eligibility for tax exemption, while others envision a reworked exemption system that measures charity care and community benefit in a more comprehensive way. Still others advocate developing new approaches to exemption. A brief review of some of the more recent thinking in this area is set forth below.¹³⁴

¹³² Evanston Citizens’ Coalition for St. Francis Hospital, *The Facts About Saint Francis Hospital, On April 5th Vote No on the Referendum*, <http://www.evanstoncitizenscoalition.org/thefacts.asp> (last accessed Sept. 18, 2007). The referendum—sponsored by a labor union, AFSCME Council 31—was a petition challenging the not-for-profit tax exemptions of Saint Francis Hospital and its Resurrection Health Care affiliates. The referendum was soundly defeated.

¹³³ See, e.g., Kevin M. Wood, *Legislatively-Mandated Charity Care for Nonprofit Hospitals: Does Government Intervention Make Any Difference?*, 20 REV. LITIG. 709 (2001); Shelley A. Sackett, *Conversion of Not-for-Profit Health Care Providers: A Proposal for Federal Guidelines on Mandated Charitable Foundations*, 10 STAN. L. & POL’Y REV. 247 (1999); Alice A. Noble et al., *supra* note 58.

¹³⁴ For a review of past articles, see M. Gregg Bloche, *Health Below the Waterline: Medical Care and the Charitable Exemption*, 80 MINN. L. REV. 299, 390-91 (1995) (recommending the complete repeal of exemption). Perhaps the seminal piece in this area of law, published at the height of the first wave of tax exemption focus in 1991, was Colombo, *supra* note 38. See also Rob Atkinson, *Altruism in Nonprofit Organizations*, 31 B.C.L. REV. 501 (1990); David Falcone & David G. Warren, *The Shadow Price of Pluralism: The Use of Tax Expenditures to Subsidize Hospital Care in the United States*, 13 J. HEALTH POL. POL’Y & L. 735 (1988); Theodore R. Marmor et al., *A New Look at Nonprofits: Health Care Policy in a Competitive Age*, 3 YALE J. REG. 323 (1986); H. Hansmann, *The Rationale of Exempting Nonprofit Organizations from Corporate Income Tax*, 91 YALE L.J. 59 (1981); Robert Charles Clark, *Does the Nonprofit Form Fit the Hospital Industry?*, 93 HARV. L. REV. 1417 (1980).

A. Eliminating Hospital Tax Exemption

Several scholars have proposed eliminating the tax-exempt status for hospitals or increasing the rigor of tax-exemption standards to the point at which many hospitals would likely no longer qualify for exemption. In *The Failure of Community Benefit*,¹³⁵ Professor Colombo advocates revoking the community benefit test developed in Revenue Ruling 69-545, due in part to the belief that many nonprofit hospitals would still be tax exempt under other Code provisions.¹³⁶ Colombo argues that, because Section 501(c)(3) would actually remain untouched as a general test, the standard for charity care set out in Revenue Ruling 56-185 would remain intact, and “any health care provider whose ‘primary purpose’ was relief of the poor and distressed (e.g., an inner city clinic providing free or below-cost care for the poor) would continue to be exempt under the traditional notion of charity.”¹³⁷

Colombo concedes that, even with these provisions in place, many hospitals would still lose their exempt status and notes the criticism of repealing the exemption. Still, he advocates an approach that relieves the tax authorities of their duties and forces government “to own up to our serious, systematic health care problems.”¹³⁸

In *Turning Back the Clock on the Health Care Organization Standard for Federal Tax Exemption*, John Quirk recognizes that the most extreme option would be to abolish the community benefit standard and revoke tax exemption for most or all existing nonprofit health care organizations.¹³⁹ However, he believes repealing the law might be appropriate.¹⁴⁰ He envisions a system wherein hospitals would be taxed like businesses on a for-profit basis, with the money generated used to fund care for indigent patients.¹⁴¹ Quirk notes this may be the “best of all worlds as the goals—hospital accountability, objective guidelines and reimbursing the hospitals that provide ‘charitable’ relief—would all be met.”¹⁴² However, Quirk realizes that, in the short term, this type of sweeping change would be extremely negative to the nation’s health care system.¹⁴³

¹³⁵ See John D. Colombo, *The Failure of Community Benefit*, 15 HEALTH MATRIX 29, 52-62 (2005).

¹³⁶ Rev. Rul. 69-545, 1969-2 C.B. 117.

¹³⁷ Colombo, *supra* note 135, at 52-62.

¹³⁸ *Id.*

¹³⁹ John M. Quirk, *Turning Back the Clock on the Health Care Organization Standard for Federal Tax Exemption*, 43 WILLAMETTE L. REV. 69, 102-03 (2007).

¹⁴⁰ *Id.* at 102.

¹⁴¹ *Id.*

¹⁴² *Id.*

¹⁴³ *Id.* at 102-03. Another author takes the debate to the state and local level. In *Are Nonprofit Hospitals Really Charitable?: Taking the Question to the State and Local Level*, Burns looks at how state and local governments address charity care and community benefits. Burns sees the IRS’s interpretation of the charity care standard as placing an increasingly heavy burden on state and local governments, and sees state and local governments as the leaders in demanding stricter exemption standards. He

B. Minimum Charity Care Approach

In *The Community Benefit Standard for Non-Profit Hospitals: Which Community, and for Whose Benefit?*, Cecelia McGregor harshly criticizes approaches that eliminate the hospital Section 501(c)(3) exemption, noting that doing so would have catastrophic effects on the health care industry by causing hospitals to pay new tax bills while facing the elimination of charitable contributions and the involuntary refinancing of bonds.¹⁴⁴ This likely would cause some institutions to seek bankruptcy protections or move toward closure, further contributing to the access-to-care problem in this country and eliminating resources for those most in need.¹⁴⁵

Instead, McGregor advocates that hospitals should satisfy minimum charity care requirements. She argues: “Without specific guidance on how to account for the community benefit provided, nonprofit health organizations are left to their own interpretation of how to best achieve the requisite level of community benefit which in turn results in uneven access to charitable services.”¹⁴⁶ She also advocates for additional categorical guidance on the part of the IRS in making the distinctions between charity care and bad debt.¹⁴⁷

Professor Colombo also discusses reformulating the Community Benefit Test. He looks at a Behavior-Specific Test, which would encourage specific behavior, such as tying an exemption to certain levels of care.¹⁴⁸ Colombo recognizes, however, that charity care might not be the only benefit worth measuring, noting that some exempt hospitals provide services to the community that for-profits do not, such as education and primary care programs, and that these need to find their way into the formula as well.¹⁴⁹

C. New Approaches

A few authors have sought a middle ground, finding complete revocation of exemption too drastic, yet believing that the current exemption scheme is so flawed it cannot be repaired. For example, in *Nonprofit Hospitals and the Federal Tax Exemption: A Fresh Prescription*, Helena Rubinstein notes that

recommends state governments reevaluate whether their exempt hospitals meet the current criteria necessary to operate as such. He also advocates passing legislation that requires minimum amounts of charity care to be provided to meet the needs of the communities the hospital serves, but stresses the legislation should be flexible and broad in the sense that it “recognizes more than just charity care as a basis for a tax exempt status, while still requiring a minimum level, and flexible enough to allow for warranted exceptions.” Burns, *supra* note 29, at 679-81.

¹⁴⁴ Cecelia McGregor, *The Community Benefit Standard for Non-Profit Hospitals: Which Community, and for Whose Benefit*, 23 J. CONTEMP. HEALTH L. & POL’Y 302, 338-39 (2007).

¹⁴⁵ *Id.* at 338.

¹⁴⁶ *Id.* at 338-39; see also William P. Elliott, *The Beginning of a New Era in Tax-Exempt Healthcare?*, 49 EXEMPT ORG. TAX REV. 69, 71 (2005).

¹⁴⁷ *Id.*

¹⁴⁸ Colombo, *supra* note 135, at 60-61.

¹⁴⁹ *Id.*

the standards “lack the flexibility to capture the ways in which some exempt hospitals provide benefit to the national community.”¹⁵⁰ Rubinstein advocates measuring community benefit in a more global sense, arguing for a specific “categorical exemption” for those hospitals that demonstrate a significant amount of research and innovation in techniques such as telemedicine and specialized medical care.¹⁵¹

Rubinstein proposes a set of criteria for exemptions for hospitals under this model, recognizing that not all hospitals will fit within the categorical exemption.¹⁵² A two-tiered exemption structure is envisioned for hospitals, wherein traditional hospitals continue to be guided in their exemption by Revenue Ruling 69-545, while categorical exempts are required to detail the research grants they have received, the results of that research, surgical and medical breakthroughs pioneered at the hospital, and any other relevant information demonstrating innovation on the part of the hospital or its medical staff.¹⁵³ Only hospitals that demonstrate a high level of research and innovation would be considered for categorical tax exemption. All other hospitals would continue to be governed by Revenue Ruling 69-545.¹⁵⁴

In *Turning Back the Clock*, Quirk suggests a system that requires exempt hospitals that do not reach their tax exempt quota to pay a penalty. The amount could be based on the hospital’s annual revenue, with the proceeds funneled back into the health care system.¹⁵⁵

Professor Colombo considers adoption of Nina Crimm’s Specific Behavior Reward Approach, a protocol that designates certain services as “charitable activities,” expenditures for which would entitle the provider to a tax deduction or tax credit.¹⁵⁶ This method would disregard whether a hospital was for-profit or nonprofit; instead, it would compensate particular behavior with specific tax benefits.¹⁵⁷ However, commentators (including Crimm herself) admit the system would be extremely complex because of the wide variety of hospitals and regions across the country.¹⁵⁸ Colombo contemplates whether the resources needed to implement this approach would be better

¹⁵⁰ See Helena G. Rubinstein, *Nonprofit Hospitals and the Federal Tax Exemption: A Fresh Prescription*, 7 HEALTH MATRIX 381, 416-24 (1997).

¹⁵¹ *Id.*

¹⁵² *Id.* at 425-26.

¹⁵³ *Id.*

¹⁵⁴ *Id.*

¹⁵⁵ Quirk, *supra* note 138, at 102; see also *Hearing on the Tax-Exempt Hospital Sector Before the H. Comm. on Ways and Means*, 109th Cong. (2005).

¹⁵⁶ Colombo, *supra* note 134, at 61-62; see Nina J. Crimm, *Evolutionary Forces: Changes in For-Profit and Not-for-Profit Health Care Delivery Structures: A Regeneration of Tax Exemption Standards*, 37 B.C.L. REV. 1 (1995).

¹⁵⁷ Colombo, *supra* note 135, at 61-62.

¹⁵⁸ *Id.*

spent on direct services in the form of health initiatives funded by the federal government and the states.¹⁵⁹

Colombo most strongly advocates finding middle ground by implementing an “access based test.”¹⁶⁰ He suggests formulating a test that ties exemption, at least in part, to specific, verifiable behavior, but argues that exempt organizations should have latitude to pursue community benefit activities beyond those encompassed within either a strict charity care standard or Professor Crimm’s behavioral reward approach.¹⁶¹

IV. HOSPITALS’ WORTHINESS OF TAX EXEMPTION

There is a strong argument to be made that government benefits should be awarded judiciously and organizations receiving benefits should be accountable for fulfilling the terms of their receipt. That said, the tax-exemption focus is really driven by the fact that health care, as currently structured and delivered, is underfunded. There is great concern that things are going to get worse, as health care costs increase and fewer employers elect to provide full coverage at an affordable price.¹⁶² Projected declines in government health care reimbursement over the next several years also bode ill for the nation’s hospitals to continue their strategy of cost shifting to fund charity care.

Retention of charitable, mission-driven hospitals is important to our society.¹⁶³ These hospitals often play a vital safety net role that would vanish should hospital care be delivered primarily through for-profit enterprises.

While it is true that business practices of tax-exempt and for-profit hospitals have largely coalesced, the underlying business model remains fundamentally different. Nonprofit hospitals are community owned, by law required to dedicate all of their resources in furtherance of their charitable mission.¹⁶⁴ Abuses can and do occur, but these aberrations can be dealt with through enhanced accountability mechanisms (discussed below) and more effective policing efforts.

For-profit hospitals play an important role in their communities. They, too, provide high quality care and meet vital health care needs. But, their primary reason for being is to generate a return for their shareholders. This, rather than service to the community, is the ultimate filter through which decisions are made.

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

¹⁶² The movement to “consumer directed” health care is predicated upon shifting costs to employees. See Marshall B. Kapp, *Consumer-Driven Health Care*, THE PHAROS OF ALPHA OMEGA ALPHA MEDICAL HONOR SOCIETY, Spring 2007, at 12.

¹⁶³ See Lawrence E. Singer, *Does Mission Matter?*, 6 HOUS. J. HEALTH L. POL’Y 347, 349 (2006).

¹⁶⁴ IRC § 501(c)(3) (2006); see *supra* note 33 (discussion regarding tax exemption requirements).

Some might argue that, because the majority of the health care industry (when considered in its totality) is for-profit—pharmaceutical companies, insurers, equipment and device suppliers, and for-profit providers (including individual providers such as physicians and therapists)—we should not worry if the hospital industry were to become dominated by proprietary providers. I believe the opposite. The mere fact that these other providers are for-profit means that the exempt hospital has a vital role to play in providing a mission overlay to the services and goods of these diverse parties.¹⁶⁵

Many hospitals have done a poor job of communicating—and perhaps living out—their charitable mission. As hospitals adopted corporate business practices, they may have gone too far in ignoring the communities they were founded to serve.

There is a legitimate question as to whether the current accountability standards for hospitals set too low a benchmark. Federal and state laws in this area rest upon principles enunciated when hospitals were nowhere near the level of sophistication present today. Think about it: The guiding Revenue Ruling for community benefit dates to 1969.¹⁶⁶ In 1969, few hospitals were members of health care systems, the panoply of insurance products many rely upon today had largely not yet been developed, ambulatory care would have been viewed as abhorrent and the prospective payment system had not been invented. At that time, it was apparent that exempt hospitals were, indeed, operating in a charitable manner because they had very close ties with and active participation from their communities. Fast forward 40 years and the health care universe is radically different.

Charity care is a legitimate piece of the community benefit determination. It is not, however, an acceptable replacement for the community benefit concept. To narrow the validity of tax exemption to charity care will drive behavior in a way that would have serious negative consequences for health care delivery.

First, it incentivizes patients to seek care at the most expensive sites of care delivery, as the community message becomes: “If you cannot afford care, come to the hospital.” Rather, we should be developing ways to deliver care in a more economically responsible setting. Requiring hospitals to provide specific levels of charity care actually may stifle innovative ways for care to be delivered, as the focus would become meeting certain monetary targets, as opposed to innovatively serving the community and responding to the totality of its needs.

Second, an absolute focus on charity care may force hospitals to reassess the vast array of (arguably beneficial) community benefits they provide, since these benefits will not “count.” This approach is all but certain to lead to the

¹⁶⁵ Singer, *supra* note 163, at 376-77.

¹⁶⁶ Rev. Rul. 69-545, 1969-2 C.B. 117.

dropping of activities and services that must be sacrificed to devote dollars strictly to charity care. As a society, we could make the choice that charity care trumps all, but do we really want to legislate this and strip the balancing of community needs away from hospital boards and management who have the skills and experience to weigh choices?

Third, although I have no proof this may occur, I fear that strict mandates on charity care, without fundamental changes to the way we reimburse hospitals, could very well upset the “shell game” currently used by hospitals (and sanctioned by government through its payment practices) to generate sufficient funding to remain in business.¹⁶⁷ Hospitals are among the most complex businesses to operate, with the various financial pieces of the enterprise highly interdependent. To impose pressure on one factor is all but certain to lead to unintended consequences in another. This is not to say that change should never be made, but rather an argument for understanding the complexity of the change instead of legislating the quick fix.

Fourth, health lawyers are some of the most sophisticated members of the bar. Should legislators mandate a sole focus on charity care, I have little doubt corporate reorganizations will begin in earnest to moot the requirement. One need only look back 30 or 40 years or so, when hospitals restructured themselves to maximize cost-based reimbursement and avoid state health planning laws.¹⁶⁸ The hospital within a hospital model or service “spin-offs” in which portions of the hospital are operated by third parties who might not be subject to charity care requirements, could quite readily become the model *du jour*, as hospitals move to reduce the impact of obligations imposed upon them.

Charity care will not solve the access problem. A 2002 study by the Congressional Budget Office of the value of tax exemption found that this benefit was worth \$12.6 billion to hospitals.¹⁶⁹ Of this, almost half (\$6 billion) was attributable to state property, sales, and income tax breaks; 20% was due to not paying federal income tax.¹⁷⁰ These dollars come nowhere near what is needed to provide health care access to all.

Enhancing accountability is a given, and should have occurred long ago. The efforts by the CHA and VHA to define and standardize community benefit

¹⁶⁷ Cost shifting, whereby higher reimbursement is provided by some payers to compensate for “low pay/no pay” patients, has been a mainstay of the hospital industry. This common practice is under attack as payors have exercised their market power to drive reimbursement down, squeezing that which had been used to fund indigent care. See Singer, *supra* note 17, at 627: “[A]s the number of uninsured have grown, and private and governmental insurance programs have slashed reimbursement, decreasing institutional funding is available for charity care, causing institutions to aggressively parcel out charity to only the most desperate needy.”

¹⁶⁸ MARK A. HALL & WILLIAM S. BREWBAKER, HEALTH CARE CORPORATE LAW: FACILITIES AND TRANSACTIONS 4.6-4.7 (1999).

¹⁶⁹ Salinsky, *supra* note 13, at 8.

¹⁷⁰ *Id.*

reporting are excellent and should be adopted by the industry. Enhanced community benefit reporting to federal and state authorities also should occur. In this regard, laws in the states of New York and California would serve as useful models. The enhanced Form 990 is also a step in the right direction. Better policing of hospital charity care, billing, and collection practices, which many states have begun, also is important.

Finally, it may be worthwhile to expand the focus on community benefit outside of tax law, which is an imperfect reporting and enforcement mechanism. Perhaps this obligation should be strengthened in the body of law pursuant to which charitable hospitals are created: the relevant state nonprofit statute. For all practical purposes, for an organization to be granted tax-exempt status, it must be organized as a nonprofit under state law. Requiring nonprofits to commit to certain Board of Director training obligations and other corporate obligations—such as annual or biennial review by the Board of fulfillment of mission or community benefit, coupled with mandatory, widely disseminated community benefit reporting—would go a long way toward instilling the notion of community responsibility in organizational leadership.¹⁷¹

CONCLUSION

The next several years will have a significant impact upon the expectations exempt hospitals are required to meet, as Congress and the Internal Revenue Service increase their focus in this area and states continue to examine use of exempt assets. In many ways, the examination is perceived by the industry as severe because it is something that should have occurred long ago. Nevertheless, we must be careful to not overreact, legislating “solutions” that create still more problems in health care delivery.

Every person in the United States should be entitled to high quality, accessible health care.¹⁷² Hospitals have a leading role to play in this quest. Tax-exempt hospitals have an even larger role to play, as they enjoy substantial tax breaks for which society should earn a return. Significant improvements in engaging the community served by the institution, coupled with improved accountability (reporting, data collection, and policing), will go a long way toward assuring that hospitals fulfill the necessary charitable mission they were founded to serve.

¹⁷¹ Panel on the Nonprofit Sector, *Strengthening Transparency Governance Accountability of Charitable Organizations: A Final Report to Congress and the Nonprofit Sector* (June 2005), available at http://www.nonprofitpanel.org/final/Panel_Final_Report.pdf (last accessed Sept. 17, 2007).

¹⁷² Singer, *supra* note 17, at 629.