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HEALTH MATRIX: Journal of Law-Medicine

THE FUTURE OF TAX- EXEMPTION FOR NONPROFIT HOSPITALS AND OTHER HEALTH CARE PROVIDERS

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I. INTRODUCTION

FROM THE inception of federal and state taxing systems until the mid-1980's, nonprofit hospitals enjoyed virtually unquestioned exemption from federal and state income and property taxes as "charitable" institutions.¹ Over the past few years, however, the tax-exempt status of nonprofit hospitals has come under increasing scrutiny by both federal and state governments. At the state level, this trend can be traced to a landmark decision by the Utah Supreme Court in 1985 that upheld the denial of an exemption to

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1. Federal law has provided for an exemption from income tax for charitable organizations virtually since the inception of the income tax. See Boris I. Bittker & George K. Rahdert, *The Exemption of Nonprofit Organizations from Federal Income Taxation*, 85 YALE L.J. 299, 301 (1976); Kenneth Liles & Cynthia Blum, *Development of the Federal Tax Treatment of Charities*, 39 LAW & CONTEMP. PROBS. 6 (Autumn 1975).

Administrative rulings relating to the charitable status of hospitals date back at least to 1928. I.T. 2421, VII-2 C.B. 150 (1928); Douglas M. Mancino, *Income Tax Exemption of the Contemporary Nonprofit Hospital*, 32 ST. LOUIS U.L.J. 1015, 1016-17, 1038-39 (1988). State law property tax exemptions for charitable organizations have existed since colonial times. *Id.* at 1016 n.1.

two nonprofit hospitals primarily on the grounds that they failed to provide sufficient charity care.² At the federal level, warning signals began with the repeal of tax exemption for Blue Cross/Blue Shield insurance in the 1986 Tax Reform Act,³ continued in hearings on the unrelated business income tax (UBIT) held in 1987-88,⁴ and most recently have surfaced in the form of two separate legislative proposals that would impose more stringent standards for tax exemption of nonprofit hospitals.⁵ In addition, the Internal Revenue Service (IRS) recently announced a "crackdown" on exemption through more stringent interpretation and enforcement of existing standards.⁶

The primary purpose of this article is to assess the potential impact of the proposed federal legislation on the tax exemption of nonprofit hospitals and other health care providers. Part II reviews federal and state exemption standards currently in force. Part III summarizes and critiques each of the new federal legislative propos-

2. *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265 (Utah 1985)(split decision upholding county equalization board's revocation of exempt status for two nonprofit hospitals primarily due to the hospital's lack of charity care). The majority first recounted the historical shift in the mission of nonprofit hospitals from treating the poor to treating the community at large on a fee for service basis as a prelude to reexamining the issue of exemption for nonprofit hospitals. *Id.* at 270-72. The majority then noted that the hospitals in question derived virtually all their operating revenues from patient charges, committed less than one percent of their gross revenues to charity care, and charged patients prevailing market rates. *Id.* at 273-74. According to the majority, the hospitals "confuse[d] the element of gift to the community, which an entity must demonstrate in order to qualify as a charity under our Constitution, with the concept of community benefit, which any of countless private enterprises might provide." *Id.* at 276. The majority also placed weight on the fact that the hospitals did not demonstrate any reliance on donations and gifts for their operations. *Id.* at 273.

3. Tax Reform Act of 1986, Pub. L. 99-514 § 1012(a), 100 Stat. 2085, 2390-94 (1986)(enacting I.R.C. § 501(m) prohibiting exemption for an entity providing "commercial-type insurance").

4. *Unrelated Business Income Tax: Hearings Before the Subcomm. on Oversight of the House Comm. on Ways and Means*, 100th Cong., 1st Sess. 11 (1987).

5. These two efforts are H.R. 790, 102d Cong., 1st Sess. (1991) [hereinafter Roybal Bill] and H.R. 1374, 102d Cong., 1st Sess. (1991) [hereinafter Donnelly Bill]. See *infra* Part III for a full discussion of both bills.

6. See *For EO's, Topics Include Audits, Hospitals, and Lobbying*, 51 TAX NOTES 963 (May 27, 1991)(quoting John Burke, IRS assistant commissioner, as warning of more "profound and penetrating" audits of hospitals). See also *Hospitals' Rx for Exempt Status: Medicare and Emergency Access*, 51 TAX NOTES 415 (April 29, 1991) (quoting James J. McGovern, IRS Associate Chief Counsel for Employee Benefits-Exempt Organizations, as insisting that an open emergency room and treatment of Medicare patients are virtual requirements for exemption under the IRS's 1969 revenue ruling discussed *infra* at notes 10-13 and accompanying text); Ron Winslow, *IRS Reviews Non Profit Hospitals for Abuses of Tax Exempt Status*, WALL ST. J., April 3, 1992 at B1 (noting publication of extensive audit guidelines for IRS agents examining nonprofit hospitals).

als. Part IV then offers some overall commentary on the proposed approaches to revising tax-exemption standards and some thoughts on the future of tax exemption for nonprofit hospitals and other health-care providers.

II. BACKGROUND: FEDERAL AND STATE EXEMPTION STANDARDS

A. Federal Law

Section 501(c)(3) of the Internal Revenue Code (I.R.C.) exempts from income taxation “[c]orporations . . . organized and operated exclusively for religious, charitable, scientific, . . . or educational purposes”⁷ Although neither hospitals nor health care services are enumerated as exempt activities, the Internal Revenue Service (IRS or Service) has long recognized that a hospital will be exempt if it meets the general requirements of “charitable” status.⁸

Prior to 1969, the position of the IRS regarding the tax exemption of nonprofit hospitals reflected traditional notions that “charity” involved helping the poor. Thus in a 1956 ruling, the Service stated that in order to be exempt, a hospital must “be operated to the extent of its financial ability for those not able to pay for services rendered”⁹ In 1969, however, the IRS altered its “charity

7. Although the statutory language uses the term “exclusively” in defining exempt organizations, the Treasury Regulations under I.R.C. § 501(c)(3) make clear that “exclusively” really means “primarily.” Tax-exempt organizations often engage in a variety of activities that are not themselves tax-exempt. As long as such activities relate to the exempt purpose of the entity, however, or are “insubstantial,” the entity generally will not lose exempt status. “Unrelated” business activities, however, are subject to tax under the Unrelated Business Income Tax contained in I.R.C. §§ 511-514. See Treas. Reg. § 1.501(c)(3)-1(e); BRUCE R. HOPKINS, *THE LAW OF TAX-EXEMPT ORGANIZATIONS* 105 (5th ed. 1987); PAUL E. TREUSCH, *TAX-EXEMPT CHARITABLE ORGANIZATIONS* 107-17 (3d ed. 1988); I.R.C. § 501(c)(3).

The regulations further explain that the tests for charitable status contain both organizational and operational components. Treas. Reg. § 1.501(c)(3)-1(a). The organizational component is met if the organizing documents of the entity both limit the entity’s purposes to one or more exempt activities and do not expressly permit the entity to engage in activities that do not further the exempt purpose. Treas. reg. § 1.501(c)(3)-1(b)(1)(i). The operational test simply requires that the entity actually pursue its exempt purposes. Treas. Reg. § 1.501(c)(3)-1(c). In addition, the statute provides that in order to be exempt, no part of the net earnings of the entity can inure to the benefit of any private shareholder or individual, and the entity must not engage in substantial lobbying activity or any political campaign activity. *Id.*

8. See *supra* note 1.

9. Rev. Rul. 56-185, 1956-1 C.B. 202. The ruling recognized that free care was not the only measure of charity, but explicitly cautioned that a hospital that operates with the expectation of full payment from all patients does not dispense charity merely because it has bad

care” standard for hospital exemption in response to hospital industry concerns that Medicare, Medicaid and other social programs had rendered this standard anachronistic.¹⁰ Adopting the broader view of the law of charitable trusts, the IRS in its 1969 ruling stated that a hospital pursues an exempt purpose as long as it is engaged in the “promotion of health” for the benefit of the general community, even though a portion of that community, such as indigents, are excluded from participation.¹¹ The IRS took the position that the hospital’s operation of an open emergency room, treatment of Medicare and Medicaid patients, and maintenance of an open medical staff and an independent board of directors drawn from community leaders established that the hospital served a broad enough segment of the community to justify continued exemption.¹² The

debts. *Id.* Nevertheless, as explained by the D.C. Circuit in *Eastern Kentucky Welfare Rights Ass’n v. Simon*, 506 F.2d 1278, 1289-90 n.26 (1974), *vacated on other grounds*, 426 U.S. 26 (1976):

[H]ospitals were required to provide free care only to the extent of their financial ability. Hospitals operating at a deficit would have no obligation under Ruling 56-185. In addition the Ruling qualified the “financial ability” standard by providing: “[t]he fact that [a hospital’s] charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes A nominal charity record for a given period of time, in the absence of charitable demands of the community, will not affect its right to continued exemption.”

10. *Tax Reform Act of 1969: Hearings Before the Committee on Ways and Means*, 91st Cong., 1st Sess. 1427 (1969) (statement of Julius M. Greisman, attorney, American Hospital Association). See ANNE SOMERS, *HOSPITAL REGULATION: THE DILEMMA OF PUBLIC POLICY* 41 (1969) (“Thanks to Medicare, Medicaid, and numerous other public and private mechanisms for financing care for the indigent and medically indigent, in a few years free hospital care will approach the vanishing point.”). For a critical history of Rev. Rul. 69-545, see Daniel M. Fox & Daniel C. Schaffer, *Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts*, 16 J. HEALTH POL., POL’Y & L. 251 (1991).

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

12. *Id.* Commentators have sometimes characterized the change in IRS position as an adoption of the “community benefit” theory of charity, as opposed to the “quid-pro-quo” or “relief of government burden” theory embodied in the charity care standard. The latter theory posits that exemption is warranted because the exempt organization undertakes an activity — in this case, treatment of the poor — that otherwise would have to be paid for by government. Thus, the exemption is really a quid-pro-quo for the hospital relieving the government of the burden of paying for health care for the poor. The community benefit theory, on the other hand, posits that an activity can be charitable simply because it provides a general benefit to the community, even if there is no specific government burden that is assumed by the exempt entity. See, e.g., Robert S. Bromberg, *The Charitable Hospital*, 20 CATH. U. L. REV. 237, 238-40 (1970). For a thorough discussion of these and other theories of exemption, see Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307, 332-87 (1991) [hereinafter Hall & Colombo I].

Public interest advocates challenged the validity of the 1969 ruling in *Eastern Kentucky Welfare Rights Ass’n v. Simon*, 506 F.2d 1278 (D.C. Cir. 1974), *vacated on other grounds*, 426 U.S. 26 (1976) (D.C. Circuit upheld the ruling on the merits, but the Supreme Court vacated the opinion on the grounds that the plaintiffs lacked standing).

“promotion of health” standard for exemption was further entrenched by a 1983 ruling that specialized hospitals without an open emergency room, such as cancer or ophthalmological hospitals, may qualify for exemption by demonstrating that the hospital operates exclusively to benefit the community.¹³

The current standard for exempting nonprofit hospitals at the federal level, therefore, focuses on the health care services provided to the community in which the hospital operates. If the hospital is “promoting health” for the general benefit of the community, then the hospital is pursuing a charitable purpose and should be exempt provided other requirements of I.R.C. § 501(c)(3) are met.¹⁴ Nevertheless, recent statements by IRS officials indicate that the agency may be attempting to narrow the scope of the “promotion of health” standard. For example, James J. McGovern, IRS Associate Chief Counsel for Exempt Organizations, recently stated that the IRS views an open emergency room and treatment of Medicaid (low income) patients as virtual substantive requirements for exemption of the typical acute care hospital, notwithstanding the fact that these items were used simply as examples of the requisite breadth of services needed to meet the “promotion of health” standard of Rev. Rul. 69-545.¹⁵ In any event, the federal standard makes clear that charity care is *not* a requirement of exemption,

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

14. See *supra* note 7 for a discussion of these other requirements.

15. *Hospital Charity Care and Tax Exempt Status: Restoring the Commitment and Fairness, Hearings Before the Select Committee on Aging*, at 58 (1990) (Statement of James J. McGovern, Associate Chief Counsel, IRS) [hereinafter *Roybal Hearings*]. See *Hospitals Rx for Exempt Status: Medicare and Emergency Access*, 51 TAX NOTES 415 (April 29, 1991). Compare the actual language of Rev. Rul. 69-545:

[T]he promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community. By operating an emergency room open to all persons and by providing hospital care for all those persons in the community able to pay the cost thereof either directly or through third party reimbursement, [the hospital] is promoting the health of a class of persons that is broad enough to benefit the community.

Rev. Rul. 69-545, *supra* note 11 (citations omitted).

This language clearly uses the operation of the emergency room and treatment of all patients able to pay as merely illustrative examples. The only firm substantive requirement of the ruling is that the hospital in question serve a sufficiently broad class to provide a community benefit. Moreover, in a later ruling, the IRS appeared to minimize the importance of the open emergency room by holding that hospitals without emergency room operations could be exempt if they nevertheless demonstrated other indicia of community benefit, such as treating Medicare/Medicaid patients, having a board of directors drawn from the general community, maintaining an open-staff policy, and the like. Rev. Rul. 83-157, 1983-2 C.B. 94.

although operation of an open emergency room and acceptance of underfunded Medicaid payments may be required for the typical acute-care hospital.

With respect to non-hospital health care providers, federal exemption standards are in open conflict. The IRS purports to have extended the promotion of health standard to a variety of nonhospital health care services, such as entities providing home health care,¹⁶ and providing housing, transportation, and other services to visiting family members of critically ill patients.¹⁷ In virtually all these cases, however, the entity granted exemption was engaged in at least some subsidization of services for patients unable to pay.¹⁸ The same "charity care" theme runs through the IRS standards for exemption of nursing homes, which are prohibited from discharging any patient whose insurance coverage runs out.¹⁹ In contrast, nonhospital health care services limited to paying patients generally have been denied exemption, despite their undisputed promotion of health and service to the entire paying community.²⁰

16. Rev. Rul. 72-209, 1972-1 C.B. 148.

17. Rev. Rul. 81-28, 1981-1 C.B. 328. *See also* Rev. Rul. 79-358, 1979-2 C.B. 225 (exemption to entity paying to upgrade hospital patients to a private room when medically necessary).

18. In Rev. Rul. 72-209, 1972-1 C.B. 148, the entity in question was a "qualified home health agency" under the Social Security Act, and received most of its payments for services from Medicare. Surplus income was used in part to provide services to patients unable to pay and in part to expand services. In Rev. Rul. 81-28, 1981-1 C.B. 328, modest housing and transportation services were provided without charge to visitors of patients and the entity was supported by donations. *See also* Rev. Rul. 79-358, *supra* note 17 (the entity provided private hospital rooms where medically necessary to patients who otherwise could not afford such a room).

19. Rev. Rul. 72-124, 1972-1 C.B. 145. However, nursing homes are not required to accept uninsured patients at the outset. *See generally*, John D. Colombo, *Are Associations of Doctors Tax-Exempt? Analyzing Inconsistencies in the Tax Exemption of Health Care Providers*, 9 VA. TAX REV. 469, 485-500 (1990).

20. In *Federation Pharmacy Services, Inc. v. Commissioner*, 72 T.C. 687 (1979), *aff'd*, 625 F.2d 804 (8th Cir. 1980), for example, the IRS denied exempt status to a nonprofit pharmacy that sold drugs at cost to the elderly and handicapped. The Service based its denial on the grounds that sales of drugs was ordinarily an activity carried on for profit, and thus was not a charitable purpose. The Service conveniently ignored the fact that a pharmacy selling drugs promotes health as much as a hospital providing health care equipment and services. In a split decision, the Tax Court upheld the denial, and the Eighth Circuit affirmed the Tax Court decision. The IRS also has shown virulent hostility to exempting HMO's, associations of doctors, and other entities providing or assisting health care services on a fee basis. *See* Colombo, *supra* note 19, at 519-20. *See also* *Geisinger Health Plan*, 62 T.C.M. (CCH) 1656 (1991) (IRS denial of tax exemption to HMO based on claim that HMO effectively limited membership to healthy individuals overturned by tax court. HMO in question did not have emergency room, did not treat Medicare patients or indigent to any substantial degree, but tax court found that open membership resulted in delivery of health care to a broad class of community).

B. State Law

While federal law concerns itself primarily with the income tax,²¹ states often impose property and sales taxes as well. In all states, statutory or constitutional provisions exempt "charitable" entities from property and income taxes. Most states automatically confer an income tax exemption on any entity exempt from federal income tax under I.R.C. § 501(c)(3),²² although a few have independent statutory exemptions that are virtually identical in language to the federal provision.²³ Property tax exemptions exist by virtue of independent state law provisions, but again uniformly provide for exemption for "charitable" entities.²⁴ Sales tax exemptions are more varied: a number of states exempt charitable entities from *paying* sales tax on purchases,²⁵ and a few states exempt charities from *charging* sales tax to their customers.²⁶

The majority of states, in applying their exemption provisions to hospitals, adhere to the federal view that the "promotion of health" for the benefit of the general community is a charitable activity, despite the absence of substantial free or subsidized care for the poor.²⁷ These states, however, appear to suffer from the same interpretation malady as their federal counterparts when nonhospital health care services are at issue.²⁸ Nevertheless, a small number of

21. Federal law also confers on exempt hospitals the ability to issue tax-exempt bonds, I.R.C. §§ 141(e)(1)(G), 145, and to receive donations deductible from the federal estate and gift tax, I.R.C. §§ 2055, 2522.

22. See Hall & Colombo I, *supra* note 12, at 323 n.53 for a list of state income tax statutory provisions.

23. *Id.*

24. William R. Ginsberg, *The Real Property Tax Exemption of Nonprofit Organizations: A Perspective*, 53 TEMP. L.Q. 291, 292 (1980) (every state has a statute regarding property tax exemption for charitable organizations, and all but seven have constitutional provisions); Hall & Colombo I, *supra* note 12, at 324 n.55.

25. Hall & Colombo I, *supra* note 12, at 404 n.345.

26. *Id.* at 405 n.347.

27. Roger C. Nauert, et al., *Hospitals Face Loss of Federal Tax-Exempt Status*, 42 HEALTHCARE FIN. MGT. 48, 52 (Sept. 1988); Phelon S. Rammell & Robert S. Parsons, *Utah County v. Intermountain Health Care: Utah's Unique Method for Determining Charitable Property Tax Exemption — A Review of Its Mandate and Impact*, 22 J. HEALTH & HOSP. L. 73, 73-74 (1989); N. Keith Enge, Jr., Note, *Nonprofit Hospitals and the State Tax Exemption: An Analysis of the Issues Since Utah County v. Intermountain Health Care, Inc.*, 9 VA. TAX REV. 599, 599 (1990). But see James B. Simpson & Sarah D. Strum, *How Good a Samaritan? Federal Income Tax Exemption for Charitable Hospitals Reconsidered*, 14 U. PUGET SOUND L. REV. 633 (1991). Based on cases over the past 50 years including many where the issue was not in dispute, the authors conclude that "[i]n the majority of jurisdictions where the question of free care has been raised in the hospital context, the provision of charity care and the accessibility of the hospital to indigent patients continue to be determinative, or at least important, criteria for entitlement to tax exemption." *Id.* at 647.

28. See Hall & Colombo I, *supra* note 12, at 343 n.128; Phillip A. Rothermich, Note,

states cling to the view that community-wide health care itself is not a charitable activity. These states require some additional showing of a contribution to society, such as charity care, before conferring an exemption.²⁹

The leading judicial exposition of the latter position is the Utah Supreme Court's opinion in *Utah County v. Intermountain Health Care, Inc.*³⁰ This decision spawned a rash of cases in which state officials challenged the exempt status of nonprofit hospitals; however, none of these revocation efforts prevailed in state court.³¹ Nevertheless, challenges continue. Most recently, the attorney gen-

Defining "Charitable" in the Context of State Property Tax Exemption for Nonprofit Nursing Homes, 34 ST. LOUIS U. L.J. 1109 (1990). The most striking example is a 1986 Maryland case that denied exemption to a Maryland HMO despite the fact that the HMO had unrestricted membership and, at the time of the case, served approximately 60,000 Maryland residents. *Montgomery County v. Group Health Ass'n*, 517 A.2d 1076 (Md. 1986). See also *In re Pittsburgh NMR Inst.*, 577 A.2d 220, 224 (Pa. Commw. Ct. 1990) (diagnostic clinic denied exemption solely on grounds that the Institute failed to prove its donation of a 'substantial' portion of its services). Compare *Geisinger Health Plan*, 62 T.C.M. (CCH) 1656 (1991) (HMO with unlimited membership except for about 11 percent of applicants deemed unhealthy entitled to federal exemption because it "promotes health" for broad class of the community even though it treats no charity patients).

29. Rammell & Parsons, *supra* note 27, at 74. In addition to Utah, Pennsylvania is the most notable jurisdiction, whose caselaw is described in *infra* note 31. See generally, Hall & Colombo I, *supra* note 12, at 325 n.63; Simpson & Strum, *supra* note 27.

30. 709 P.2d 265 (Utah 1985). See analysis *supra* note 2.

31. *Callaway Community Hosp. Ass'n v. Craighead*, 759 S.W.2d 253 (Mo. Ct. App. 1988); *Downtown Hosp. Ass'n. v. Tenn. State Bd. of Equalization*, 760 S.W. 2d 954 (Tenn. Ct. App. 1988); *Medical Ctr. Hosp. of Vt., Inc. v. Burlington*, 566 A.2d 1352 (Vt. 1989). See generally, NORTH CAROLINA CTR. FOR PUB. POL'Y RESEARCH, *COMPARING THE PERFORMANCE OF FOR-PROFIT AND NOT-FOR-PROFIT HOSPITALS IN NORTH CAROLINA* 159-66 (1989); Jay Greene, *Governmental Units Challenge Not-for-profits' Tax Exemption*, 17 MOD. HEALTHCARE, Dec. 4, 1987 at 67; Terese Hudson, *Not-for-Profit Hospitals Fight Tax-Exempt Challenges*, HOSP., Oct. 20, 1990, at 32-37; Robert Pear, *Tax Exemptions of Non-profit Hospitals Scrutinized*, N.Y. TIMES, Dec. 18, 1990, at A1, col. 2.

Pennsylvania appears to be the only state other than Utah with a legal climate hostile to hospital tax exemption, although its precedents are presently in conflict. In *West Allegheny Hosp. v. Board of Property Assessment, Appeals & Review*, 455 A.2d 1170 (Pa. 1982), the court upheld a hospital's exemption despite its low level of charity care. The same court, however, subsequently ruled that an organization providing administrative support to hospitals does not earn the exemption where the organization does not have an "open-admission" policy and fails to prove that it "provides its services without regard to the health care facility's ability to pay." *Hospital Utilization Project v. Commonwealth*, 487 A.2d 1306, 1316 (Pa. 1985). Following this apparent inconsistency, one Pennsylvania trial court upheld a hospital's tax exemption, *St. Luke's Hosp. v. Bd. of Assessment Appeals*, No. 88-C-2691 (Pa. Ct. Cm. Pl., Lehigh Co., April 19, 1990), while another revoked the exemption. *School Dist. v. Hamot Medical Center*, No. 138-A-1989 (Pa. Ct. Cm. Pl., Erie Co., May 18, 1990), *aff'd*, 1319 C.C. 1990 and 1320 C.D. 1990 (Pa Commw. Ct. 1992). *Hamot Medical Ctr.*, however, presented unusually strong facts, with the hospital in question failing to maintain an open admissions policy of any kind, transferring earnings to for-profit subsidiaries, and paying executives excessive compensation. Nevertheless, the most recent Pennsylvania court deci-

eral of Texas sued in state court to revoke the exemption of Methodist Hospital of Houston;³² this is apparently the first case in which tax exemption has been challenged by state officials other than tax authorities, and may be a harbinger of the future.³³ Reconsideration of tax exemption for nonprofit hospitals has also been on the legislative agenda in more than a dozen states recently, although no significant legislative changes have been enacted.³⁴

To summarize, federal law exempts nonprofit hospitals without regard to charity care, although the current position of the IRS appears to be that a typical acute care hospital must maintain an open emergency room and treat Medicare patients in order to qualify for exemption. Most states follow the "promotion of health" standard of federal law in granting exemptions to nonprofit hospitals, although a few states cling to some kind of charity care standard. With respect to nonhospital health care services, some subsidization of services for people unable to pay appears to be a prerequisite to exemption both at the federal and state levels, despite the lip service paid to the "promotion of health" standard.

III. THE NEW FEDERAL LEGISLATIVE PROPOSALS: ANALYSIS AND CRITIQUE

Simple coincidence does not explain why state challenges to and federal rumblings about hospital tax exemption both began in the mid-1980's. Throughout the early and middle part of that decade, a torrent of press reports and articles on "patient dumping" chronicled the plight of the indigent patient refused emergency room

sion denied an exemption to a diagnostic clinic solely on the grounds of inadequate charity care. In *Re Pittsburgh NMR Inst.*, 557 A.2d 220, 224 (Pa. Commw. Ct. 1990).

Taxing authorities in Pittsburgh were successful in obtaining increased revenues from the Presbyterian-University Hospital without revoking its exemption, when it agreed to pay \$11 million over 10 years for city services. Telephone Interview with Dan Pelligrini, City Attorney, City of Pittsburgh, Aug. 17, 1988. See also Michele L. Robinson, *Via Donation or Tax, Cities Want More Revenues*, *HOSP.*, March 20, 1989, at 55. A number of other hospitals have agreed to pay settlements in exemption-challenge cases, and Allegheny County tax authorities continue their challenges to exemption for hospitals in the Pittsburgh area. David Burda, *Pa. Files More Challenges to Tax Exemption*, *MOD. HEALTHCARE*, Feb. 18, 1991, at 2; Leigh Page, *Pa. Hospitals Facing Fights over Tax-Exempt Status*, *AM. MED. NEWS*, July 22, 1991, at 1, 31.

32. *State v. Methodist Hosp. Sys.*, No. 494,212 (126th J. Dist., Travis County, Tex. filed Nov. 26, 1990). See Gary Taylor, *Charity Begins in Court? Hospital Sued in Novel Lawsuit*, *NAT'L. L.J.*, Feb. 18, 1991, at 3, col. 1.

33. Taylor, *supra* note 32, at 3, col. 1.

34. NORTH CAROLINA CENTER FOR PUB. POL'Y RESEARCH, *supra* note 31, at 159-66 (summarizing state activity in detail). See generally, Hall & Colombo I, *supra* note 12, at 326 n.64.

treatment at private hospitals due to lack of insurance or other ability to pay.³⁵ Estimates are that 37 million Americans have no health insurance, a 30% increase from 1979.³⁶ Therefore, the naive premise behind the earlier liberalization of hospital exemption standards that the lack of demand for indigent care rendered the charity standard anachronistic has been proven woefully wrong. Concurrent with these developments, federal and state fiscal crises have made the estimated \$8 billion in tax revenue foregone³⁷ a tempting target for financing some or all of the gap in health care coverage.³⁸

In 1990, Representative Edward R. Roybal, Chairman of the House Select Committee on Aging, conducted hearings on the subject of charity care provided by nonprofit hospitals.³⁹ The result of these hearings was a bill originally introduced in 1990, then reintroduced in 1991, to provide specific standards of charity care that hospitals must meet in order to receive a federal tax exemption.⁴⁰ Shortly after the re-introduction of the Roybal Bill, another legislative proposal dealing with standards for hospital exemption was introduced by Representative Brian Donnelly.⁴¹ These proposals have now taken center stage in the national debate over the charitable status of nonprofit hospitals.

35. See EQUAL ACCESS TO HEALTH CARE: PATIENT DUMPING, H.R. Rep. No. 531, 100th Cong., 2d Sess. (1988); Geraldine Dalleck & Judith Waxman, *Patient Dumping: A Crisis in Emergency Medical Care for the Indigent*, 19 CLEARINGHOUSE REV. 1413 (1986); Mark A. Hall, *The Unlikely Case in Favor of Patient Dumping*, 28 JURIMETRICS J. 389 (1988); David U. Himmelstein, et al., *Patient Transfers: Medical Practices as Social Triage*, 74 AM. J. PUB. HEALTH 494 (1984); Robert L. Schiff, *Transfers to a Public Hospital*, 314 NEW ENG. J. MED. 552, 553 (1986); Karen I. Treiger, Note, *Preventing Patient Dumping: Sharpening COBRA's Fangs*, 61 N.Y.U. L. REV. 1186 (1986).

36. CONGRESSIONAL RESEARCH SERVICE, HEALTH INSURANCE AND THE UNINSURED: BACKGROUND DATA AND ANALYSIS 3 (June, 1988).

37. *Roybal Hearings*, *supra* note 15, at 60.

38. In the words of Rep. Roybal, "With the . . . value of hospital . . . tax-exempt status estimated at over \$8 billion annually, we must once again target this vital Federal resource at providing hospital care to uninsured, underserved, and disadvantaged Americans. . . . [U]ntil this nation commits itself to a national health policy protecting all Americans, it cannot afford to lose the \$8 billion in protection that the value [sic] tax-exempt status potentially offers." 137 CONG. REC. E396 (1991).

39. *Roybal Hearings*, *supra* note 15.

40. 137 CONG. REC. E395-97 (1991).

41. 137 CONG. REC. E896 (1991). Representative Donnelly plans to retire at the end of his current term (Representative Roybal also plans to retire). Adam Clymer, *Citing Rise in Frustration, Dozens of Lawmakers Quit*, N.Y. TIMES, April 5, 1992 at 1.

A. Substantive Tests for Exemption

1. The Roybal Bill

The Roybal Bill imposes two basic requirements for exemption. First, the hospital must maintain an "open door" policy toward Medicare and Medicaid patients, serving a "reasonable number" of such patients.⁴² The second, and far more elaborate, test requires that the hospital earn its exemption by spending specific amounts on unreimbursed charity care and community benefits. This part of the bill starts with a two-part general statement that a hospital can be exempt only if it "provides in a nondiscriminatory manner sufficient qualified charity care and provides sufficient qualified community benefits."⁴³ Sufficient qualified charity care is then defined as unreimbursed charity care costs equal to 50% or more of the value of the hospital's tax-exempt status for the taxable year.⁴⁴

Charity care costs for these purposes are the aggregate of the hospital's costs of providing services to persons unable to pay in whole or in part, the hospital's costs of services charged off as bad debts, the excess of a hospital's costs of services to Medicaid patients over the reimbursement for such services, and the costs of preventive health and health promotion programs targeted to members of the community who are medically underserved and disadvantaged.⁴⁵ This latter category applies, however, only "if the community has too few charity care patients in need of charity hospital care."⁴⁶

The value of exempt status to the hospital is determined by a

42. Roybal Bill, *supra* note 5, § 2(a)(proposing new I.R.C. § 501(n)(1)(A)). The bill contains no specific guidelines on the number of Medicare patients deemed "reasonable," stating simply that the determination shall be made under all the facts and circumstances. *Id.* (proposing new I.R.C. § 501(n)(2)(A)).

43. *Id.* (proposing new I.R.C. § 501(n)(1)(B)).

44. *Id.* (proposing new I.R.C. § 501(n)(2)(B)(i)(I)).

45. *Id.* (proposing new I.R.C. § 501(n)(2)(B)(ii)). Because the bill speaks in terms of the costs of these services, it is clear that hospitals would no longer be allowed to continue valuing these services based on their standard charges, which is the present accounting practice. This raises the complexity of identifying the costs of isolated services when most hospital costs are shared across many services. A marginal cost measure is probably not intended, although conceivable to justify. More likely, the bill intends an average cost measure. The standard methodology is to start with the normal hospital charges for the services in question and discount them by a hospital-wide average cost-to-charge ratio. Thus, if a hospital would have charged \$1 million for its uncompensated care, and if its overall cost-to-charge ratio is 75 percent, it would be credited with \$750,000 of charity care. However, for specialized health promotion outreach programs that traditionally have no charge base to start from, it may be necessary to measure the costs more directly. This technical deficiency presumably would need the remedy of interpretive regulations.

46. *Id.*

national average computation, taking into account federal, state and local taxes, rather than on a hospital-specific basis.⁴⁷ Nevertheless, the bill permits the IRS to apply a different percentage (higher or lower than the national average) to a particular hospital based upon facts and circumstances that indicate that the national percentage is inappropriate.⁴⁸ Moreover, it requires that the value of the exemption be measured in a fashion that results in no more than 25% of currently-exempt hospitals losing their exemption.⁴⁹

Sufficient qualified community benefits exist under the bill if the associated costs equal or exceed 35% of the value of the hospital's exemption (computed in the manner just described).⁵⁰ Eligible community benefit services are those "*not otherwise provided by hospitals which are not exempt from tax.*" Hospitals may also count charity care costs in excess of the 50% threshold.⁵¹ The remaining 15% of exemption value is automatically attributed to unspecified community benefits, which hospitals must report annually.⁵² Overall, therefore, the bill aims to require hospitals to justify the full value of their tax exemptions by spending at least 50% of this value in the form of unreimbursed charity care, 35% on quantifiable community benefits, and 15% presumptively credited for intangibles.

2. The Donnelly Bill

Under the Donnelly Bill, a hospital will be exempt only if it meets three separate criteria. First, the hospital must operate an "open" emergency room that is, provide emergency care to all persons regardless of ability to pay.⁵³ Second, the hospital must have a

47. *Id.* (proposing new I.R.C. § 501(n)(2)(C)(ii)). Specifically, the bill requires the IRS to compute the percentage of gross revenues of all tax-exempt hospitals that equals the estimated federal, state and local tax revenues foregone as a result of exemption. This percentage is then applied to the gross revenues of the hospital in question to determine the "value of the exemption" for that specific hospital. Finally, the bill directs the IRS to implement a methodology for estimating foregone federal, state and local tax revenues as a result of exemption, and to report back to Congress on any changes the IRS feels are desirable in the bill's definition of the value of an exemption.

48. *Id.* (proposing new I.R.C. § 501(n)(2)(C)).

49. *Id.*

50. *Id.* (proposing new I.R.C. § 501(n)(2)(B)(i)(II)).

51. *Id.* (proposing new I.R.C. § 501(n)(2)(B)(iii)(II)).

52. *Id.* § 2(b)(proposing new I.R.C. § 6033(e)(5)). It is anticipated that Congress will use this reporting information to determine whether the presumption should continue that these unspecified benefits in fact exist. Telephone Interview with Gary A. Christopherson, Former Director, Health Legislation, House Select Committee on Aging (Oct. 11, 1990 & Jan. 7, 1991).

53. Donnelly Bill, *supra* note 5, § 1(a)(proposing new I.R.C. § 501(n)(2)(A)(i)). The bill also states that if a particular hospital receives certain sanctions for engaging in "patient

provider agreement under which it treats Medicaid patients.⁵⁴ Finally, the hospital must meet one of five alternative tests of "community benefit." The hospital must (1) be a sole community hospital;⁵⁵ (2) treat a disproportionate number of Medicaid or low-income Medicare patients;⁵⁶ (3) maintain a "disproportionate patient percentage" as defined under Medicare that is within one standard deviation of the mean for all hospitals in the geographic area;⁵⁷ (4) devote at least 5% of its gross revenues to providing charity care;⁵⁸ or (5) devote at least 10% of its gross revenues to designated outpatient services, such as operating a community health center or drug rehabilitation center in a medically underserved area.⁵⁹ Unlike the Roybal Bill, the 5% charity care standard in the Donnelly Bill does *not* include bad debts or Medicare/Medicaid contractual allowances, but it does include money contributed by a hospital to a state charity care pool.⁶⁰ According to Rep. Donnelly, a charity

dumping" as prohibited under the Medicare statute (transferring emergency patients to other hospitals for economic reasons), it shall be considered as not operating an open emergency room. *Id.* (proposing new I.R.C. § 501(n)(2)(A)(ii)). Exceptions to the open emergency room requirement are made for situations in which the emergency room is deemed unnecessary or duplicative by state health authorities, or when the hospital is a specialty hospital as defined in § 1886(d)(1)(B) of the Social Security Act. *Id.* (proposing new I.R.C. § 501(n)(2)(A)(iv)(II)). Such hospitals include psychiatric, rehabilitation, and children's hospitals, or other hospitals with an average inpatient state of greater than 25 days. 42 U.S.C. § 1395ww(d)(1)(B).

54. Donnelly Bill, *supra* note 5, § 1(a)(proposing new I.R.C. § 501(n)(2)(B)).

55. *Id.* (proposing new I.R.C. § 501(n)(2)(C)(i)). "Sole community hospital" is defined by reference to the Medicare provisions of the Social Security Act. Social Security Act § 1886(d)(5)(D)(iii), 42 U.S.C. § 1395ww(d)(5)(D)(iii). This provision states that a sole community hospital is one located more than 35 road miles from another hospital, or that because of other factors is the sole source of inpatient hospital services reasonably available to individuals in the geographic area, or is an "essential access community hospital" as defined in § 1819 of the Social Security Act, 42 U.S.C. § 1395i-4(i)(1).

56. Donnelly Bill, *supra* note 5, § 501(n)(2)(C)(ii)(sufficient to qualify for the Medicare "disproportionate share adjustment" described *infra* note 57).

57. *Id.* (proposing new I.R.C. § 501(n)(1)(C)(iii)). The disproportionate patient percentage is the sum of two fractions. The first fraction has in the denominator total Medicare patient days and in the numerator the patient days attributable to low-income Medicare patients (those who receive cash benefits under the Social Security Supplemental Security Income (SSI) program). The second fraction divides total patient days attributable to Medicaid patients by total patient days. 137 CONG. REC. E897 (1991) (remarks of Rep. Donnelly). These computations are designed to detect when a hospital is committing more than its "fair share" of resources to the extra costs of treating low-income patients, and is used to calculate whether a hospital will receive a disproportionate share payment adjustment under Medicare to offset these expenses. For further detail, see *infra* text accompanying notes 80-85.

58. Donnelly Bill, *supra* note 5, § 1(a)(proposing new I.R.C. § 501(n)(2)(C)(iv)).

59. *Id.* (proposing new I.R.C. § 501(n)(2)(C)(v)). The IRS may designate other such services.

60. *Id.* (proposing new I.R.C. § 501(n)(2)(C)(iv)). "Contractual allowances" refers to the difference between a hospital's normal charge for a given service and the amount the

care patient is one from whom the hospital expected no payment at the time the service was rendered.⁶¹

3. Commentary on the Substantive Exemption Standards

a. The Roybal Bill

The substantive standard of the Roybal Bill is based on a hospital "earning" its exemption with charity care or other community benefits whose value equals the exemption. In essence, the bill adopts the "relief of government burden" or "quid-pro-quo" theory that often has been advanced as a justification for exemption, a theoretical approach that we previously have commented on favorably.⁶² This theory posits that exemption is warranted because, in the absence of the exemption, government would have to pay for services rendered by the exempt entity.⁶³ From a theoretical perspective, it is hard to fault a requirement that hospitals annually earn their exemption, other than the general complaint, discussed more fully below, that such a system is more logically administered as a direct government subsidy through an agency other than the IRS.⁶⁴ However, the Roybal Bill in its actual implementation of this theory proposes a grossly inadequate computation of charity care.

The basic flaw of the Roybal Bill is its failure to measure whether a nonprofit hospital earns its exemption by comparing its

hospital actually receives from Medicare/Medicaid for the service, which is less than the normal charge.

61. In the words of Rep. Donnelly,

For example, if a hospital provides care to an individual and at the time of providing the services had no expectation of receiving payment, the cost of that care could be considered charity care for purposes of the standard. Consequently, the hospital's motives in providing the care are relevant under this standard. Factors which would have sufficient probative value to establish a charitable intent under such a "no expectation" standard would include the income of the patient, whether or not the patient was eligible for a public assistance program, whether or not the hospital billed the patient for the care provided, and how aggressively and over what period of time the hospital sought payment.

137 CONG. REC. E897 (1991)(statement of Rep. Donnelly).

62. See Hall & Colombo I, *supra* note 12, at 350-54. In the taxonomy of that article, an exemption so earned is deserved, it is precisely proportionate to the size of the subsidy, and it has historical and intuitive support. Our chief criticism of this theory is that, to the extent it is limited to charity care, it is not the exclusive basis for exemption, and to the extent it extends to other community benefits, there is no reliable mechanism to determine which are deserving.

63. *Id.* at 345-46.

64. See *infra* text accompanying notes 110-113 (noting that a direct subsidy or a system under which the government itself treats the medically indigent is overall easier to administer and better able to account for varying needs in different locales).

level of uncompensated care to uncompensated care levels provided by for-profit hospitals. As we previously have observed, even for-profit hospitals "give away" a substantial dollar amount of services in the form of bad debts.⁶⁵ In fact, in proportionate terms, for-profit hospitals are closing in on nonprofit levels of uncompensated care and may have overtaken them.⁶⁶ The federal government's General Accounting Office (GAO), for example, estimated that for 1988, investor-owned hospitals devoted 5.2% of revenues to uncompensated care as compared with 4.8% of nonprofit hospitals' revenues.⁶⁷

If exempt hospitals do not have proportionately more uncompensated care than for-profit hospitals, then the exempt hospitals in fact are not relieving any government burden and do not deserve exemption under this theory. Put another way, if exempt hospitals are providing no greater uncompensated care than for-profits, presumably all nonprofits could convert to a proprietary status overnight and the government would suffer no detriment in the amount of charity care provided, plus it would have \$8 billion in additional revenue to boot.⁶⁸ Therefore, nonprofit hospitals earn their exemption only with uncompensated care that exceeds in proportionate terms that provided by their for-profit counterparts.⁶⁹ Indeed, this is precisely the rationale adopted by the Roybal Bill when it insists that community benefit services not count toward the 35% quota if they are customarily provided by for-profit hospitals,⁷⁰ why the bill

65. Hall & Colombo I, *supra* note 12, at 346.

66. *Id.* at 348. A recent analysis by the Prospective Payment Review Commission, based on 1984-1989 data from AHA surveys, found that nonprofits spent 4.6% of their total expenses on uncompensated patient care, as compared with 4.3% of for-profit hospital expenses (unpublished data of the Prospective Payment Review Commission).

67. UNITED STATES GENERAL ACCOUNTING OFFICE, NONPROFIT HOSPITALS: BETTER STANDARDS NEEDED FOR EXEMPTION 12 (1990) [hereinafter, GAO REPORT] (based on AHA survey data).

68. See Hall & Colombo I, *supra* note 12, at 346.

69. In other words, if for profits typically provide four percent of their care for free, nonprofits could count toward meeting their charity care requirement only the amounts of uncompensated care that exceed four percent of their operations. See David Hyman, *The Conundrum of Charitability: Reassessing Tax Exemption for Hospitals*, 16 AM. J. L. & MED. 327, 331 (1990); Arnold Relman, *Are Voluntary Hospitals Caring for the Poor?*, 318 NEW ENG. J. MED. 1198, 1199 (1988) (tax exemption would be "troubling" and "hard to justify" if nonprofits are not doing more for the poor than for-profits).

70. Roybal Bill, *supra* note 5, § 2(a)(proposing new I.R.C. § 501(n)(2)(B)(iii)(I)). The reason for this limitation is that many of these services are simply sound business practices. Services like health promotion fairs, health screening, child-birth classes and the like are effective marketing devices, introducing the public to the hospital in the hope that many will return for acute care. Thus, it makes no sense to credit nonprofit hospitals with the same

failed to use this same approach in the basic charity care standard is unclear, but a major error.

Taken as a whole, the Roybal Bill in effect creates a form of tax credit for the charity care and community benefit services that non-profit hospitals provide. The bill attempts to measure the actual tax liability of hospitals, compares that with the cost of charity care and community benefit services, and then assesses the difference as an excise tax. Thinking in terms of a tax credit is a helpful way to expose the fundamental policy choice: whether the services being counted are deserving of a tax subsidy. Allowing nonprofit hospitals to take a direct, dollar-for-dollar tax credit for their bad debts and "contractual adjustments" is clearly not sensible tax policy, particularly when these same expenses are borne by for-profit hospitals to approximately the same degree without any such credit.

Addressing this flaw requires some means of measuring only true "charity" care: that is, the free care provided by nonprofit hospitals that exceeds the proportion provided by proprietary institutions. The Donnelly Bill attempts to do this, but because it defines charity care by reference to the hospital's intent when the patient is admitted, it requires difficult if not unworkable subjective determinations of altruistic motives.⁷¹ A more administratively feasible alternative would be to measure the actual proportion of for-profit uncompensated care and subtract this from nonprofit uncompensated care percentage in order to arrive at a true charity care figure, using the assumption that for-profits do not render any free care simply out of the goodness of their hearts. This approach, however, creates the additional complexity of deciding whether the for-profit benchmark should be local or national, and how often it should be measured. Therefore, perhaps the most satisfactory compromise would be to set a flat legislative presumption that the first 5% of gross revenues devoted to uncompensated care does not count.⁷²

revenue shortfalls that for-profit hospitals suffer simply as an economic decision to generate more business or as a cost-benefit assessment of the worth of pursuing bad debts.

71. See *supra* note 61. For a general discussion of the difficulties entailed in separated altruistic from self-interested motivation, see Mark A. Hall & John D. Colombo, *The Donative Theory of the Charitable Tax Exemption*, 53 OHIO ST. L.J. 1379 (1992) [hereinafter Hall & Colombo II].

72. See, e.g. GAO REPORT, *supra* note 67 (noting that in 1988, proprietary hospitals on average gave away 5.2% of their revenues in the form of bad debts and charity care). Moreover, Medicaid shortfalls and other so-called "contractual adjustments" should not be counted since they are suffered approximately to the same extent by for-profit hospitals. See also *Chisago Health Services v. Commissioner of Revenue*, 462 N.W.2d 386, 391 (Minn. 1990) ("The fact that CHS discounts its market fees in accepting Medicare and Medicaid payments does not, by itself, constitute the extension of charity to the patients involved. . . .

In addition to its flawed application of the quid-pro-quo theory of the exemption, the Roybal Bill has technical flaws relating to matters of administrative enforcement. Primarily,⁷³ the attempt to use a nationwide percentage of revenues as the measure of the value of the tax exemption to an individual hospital is at least unfair, probably unwise, and in the context of the bill, a nightmare. For example, the largest component of the value of the federal exemption is the ability to issue tax-exempt bonds.⁷⁴ This subsidy varies widely across hospitals depending entirely on how much and how recently each one has raised capital through bond financing. Two hospitals of exactly the same size and income, but one with relatively new, bond-financed facilities and the second with relatively old, debt-free facilities, would gain dramatically different benefits from the exemption but would be assessed the same burden by this legislation. In addition, the rates and the types of taxes imposed by states vary just as dramatically. While virtually every state has some kind of property tax, rates vary tremendously.⁷⁵ Attempting to estimate the value of exemption on a national level and then imposing that estimate on an individual hospital, therefore, is sheer nonsense. If the underlying rationale of making each hospital pay back the value of its exemption is to have any meaning, the wide variation in state and local tax burdens must be taken into account.

In fact, the Roybal Bill implicitly recognizes these problems. It allows the IRS to adjust the national percentage up or down as facts and circumstances demand. This method, however, may not be the best to use given that all hospitals in high-tax jurisdictions are likely to demand this adjustment, but those in low-taxed states will not. Therefore, a less biased and more straightforward approach would be to meet reality head-on and calculate the value of the exemption on a hospital-specific basis. This could be done rather simply by having each hospital file the equivalent of a federal tax return, plus information on state and local taxes, including property tax assess-

There is little conceptual difference between these discounts and the business discounts negotiated by HMO's and health insurers on behalf of their insureds with both public and private . . . hospitals."); Frank A. Sloan, *Property Rights in the Hospital Industry*, in *HEALTH CARE IN AMERICA* 103, 134 (H.E. Frech III ed., 1988).

73. A secondary technical problem is the lack of definition of "costs" in calculating uncompensated care. See *supra* note 45.

74. See, e.g., John Copeland & Gabriel Rudney, *Federal Tax Subsidies for Not-for-Profit Hospitals*, 46 *TAX NOTES* 1559, 1565 (1990) (\$1.7 billion, as compared with \$1.6 billion for the income tax exemption and \$1.2 billion for the deductibility of charitable contributions).

75. See Henry Hansmann, *The Effect of Tax Exemption and Other Factors on the Market Share of Nonprofit Versus For-Profit Firms*, 40 *NAT'L TAX J.* 71, 76 (March 1987).

ments that many jurisdictions record on even exempt property. If necessary, each hospital could simply be required to make a good faith estimate of state taxes foregone, backed by certified appraisals and audits. This would greatly relieve the burden on the IRS in making these determinations in the first instance.

b. The Donnelly Bill

The Donnelly Bill adopts a curious mixture of charity care and community service standards that at first glance appear to be a return to a more restrictive charity-care standard, but on closer inspection would codify the permissive exemption approach of the 1969 ruling with more objective criteria. The main focus of the bill is its adoption of a flat 5% charity care requirement. On first appearance, this seems to be a return to the 1956 ruling under which IRS agents used 5% as an operating rule of thumb to determine sufficiency of charity care for exemption purposes.⁷⁶ As a matter of theory, such a rule is a perfectly sound legislative determination that 5% charity care is sufficient to earn the exemption in all cases. Such a determination provides both the industry and the IRS with a measure of desired certainty and avoids ensnaring them in the quagmire of calculating an exact match for each hospital. Moreover, the technical definition of charity care in the Donnelly Bill may avoid some of the problems encountered in the Roybal Bill. Charity care expenses, for example, properly exclude bad debts and contractual adjustments; and by tying the standard to a percentage of gross revenues, the bill provides a bright-line standard that does not depend on the vagaries of state tax burdens.⁷⁷

76. *Roybal Hearings*, *supra* note 15, at 62-63 (statement of James J. McGovern, Associate Chief Counsel, IRS).

77. However, the charity care definition raises other problems. Unlike the Roybal Bill which clearly states that costs are the measure of charity care and community benefit services, the Donnelly Bill suggests that charges are the measure since it speaks in terms of devoting a percentage of "gross revenues." Donnelly Bill, *supra* note 5, § 1(a)(proposing new I.R.C. § 501(n)(2)(C)(iv), (v)). On the other hand, when the bill sets the measure of the excise tax penalty, it creates a contradictory inference by speaking in terms of "the cost of charity care." *Id.* (proposing new I.R.C. § 501(n)(4)(B)(i)(II)).

The bill is also unclear as to how state rate regulation programs will affect the measurement of charity care. Some states impose a hospital industry tax to create a state-wide charity care pool from which hospitals may then collect based on the charity care they provide. The bill credits hospitals with their payments into these pools *without* any offset for reimbursement they receive from these pools. *Id.* (proposing new I.R.C. § 501(n)(2)(C)(iv)). This might contemplate that hospitals may count both their tax payments *and* the actual charity care they render, even though they are compensated from the pool—but that would be nonsensical. More likely, the pool payments knock out the actual charity care (but not the tax assessment). In addition, the bill fails to address the manner in which other rate regulation

The bill makes clear, however, that the 5% charity care standard is not the sole criterion for exemption; it is only one of five alternatives. A hospital may receive exemption for treating low-income Medicare and Medicaid patients, being a sole community hospital, or operating certain outpatient clinics in medically underserved areas. Thus, the bill in essence codifies the "community benefit" approach of the 1969 ruling while avoiding the problem of quantifying the inherently "soft" benefits often set forth by hospitals as a justification for exemption.⁷⁸ Offering hospitals this limited menu prevents them from endlessly rationalizing that everything they do is equally deserving.

Despite the appearance of greater rigor, the Donnelly Bill contains a gaping technical hole that allows any hospital to qualify for exemption if its "disproportionate patient percentage" is within one standard deviation of the mean for all hospitals in its geographic area (usually, the Standard Metropolitan Statistical Area (SMSA)). The disproportionate patient percentage, more appropriately termed the "disproportionate *share* percentage," refers to a calcula-

states handle uncompensated care. Maryland, for instance, has no tax-funded pool; instead, it builds into each hospital's rate base a hospital-specific measure for uncompensated care. Michael R. Merson, *Managing in Maryland*, 13 HEALTH MGMT. Q 24, 25 (1991); Stewart H Rome, *Medicine and Public Policy: Let Us Look Before We Leap Again*, 41 MD. L. REV. 46, 51 (1981) (article critical of data collection process). What happens to the cost of care these hospitals render uninsured patients? One might conclude that the cost to treat uninsured patients is included in the hospital specific measure for uncompensated care. However, like the pooling states, these hospitals receive explicit reimbursement from the rate-setting program, and only through other patients. On the other hand, there is fundamentally no difference between this arrangement and the manner in which unregulated hospitals fund their charity care, which is to "cost-shift" by increasing their charges to paying patients. Finally, the Donnelly Bill, unlike the Roybal Bill, does not allow a shortfall in the 10% community services category to be made up through the charity care category.

78. Hall & Colombo I, *supra* note 12, at 378-80. Technical problems exist with these alternative tests as well. In addition to the problems related in the text below with respect to the disproportionate patient percentage test, the test requiring a hospital to spend 10% of its gross revenues on outpatient clinics has the same "costs or charges?" definitional problem noted with respect to the 5% charity care standard. *Supra* note 78. Whichever measure is intended — costs or charges — the bill creates additional confusion when it requires the hospital to "devote at least 10 percent of its gross revenues to qualified services and benefits." Donnelly Bill, *supra* note 5, § 1(a)(proposing new I.R.C. § 501(n)(2)(C)(v)). Do such "qualified services" count even if the hospital receives full reimbursement? Possibly, under the bill's language, but surely not, given the bill's rationale. If reimbursed services are not counted, it is simply unrealistic that any hospital could devote fully ten percent of its operations to unreimbursed specified *outpatient services*, because in order for the unreimbursed portion to reach 10 percent of the hospital's overall operations, an even larger portion of the hospital's operation would have to be devoted to nonhospital services. Thus, to meet the 10% test, a hospital might have to derive 40-to-50 % of its income from *outpatient specialized services* (such as drug and alcohol treatment) in order to have such services of sufficient scope to generate the requisite quantity of uncompensated outpatient care.

tion under Medicare to compensate those hospitals that treat a disproportionate number of Medicaid and low-income Medicare patients. The theory behind this provision presumes that hospitals treating a large number of these patients deserve extra compensation because such patients tend, on average, to be more severely ill,⁷⁹ and because hospitals that tend to receive a large number of publicly insured low-income patients are probably located in areas where they also receive a large number of uninsured patients.⁸⁰ Any hospital with a "disproportionate share" of such patients, which varies according to hospital size and location, receives an extra payment for their Medicare patients only.⁸¹

The Donnelly Bill uses the disproportionate share calculation in two of the five alternative "community benefit" tests. First, it deems that any hospital that receives a disproportionate share payment automatically satisfies the charity care requirement.⁸² The problem with this is that a hospital could meet this standard without ever treating a single uninsured person because the computation refers entirely to Medicare and Medicaid patients. Such hospitals are already receiving compensation through Medicare for this additional burden. Nevertheless, a rationale can be imagined for exempting such hospitals if it is assumed that both a hospital's disproportionate share percentage is a good proxy for the number of uninsured patients and that the extra Medicare payments do not fully compensate for these proxied costs. Both assumptions are reasonable ones, although the magnitude of the effects are debatable.⁸³

79. See Arnold M. Epstein et al., *Do the Poor Cost More? A Multihospital Study of Patients' Socioeconomic Status and Use of Hospital Resources*, 322 NEW ENG. J. MED. 1122 (1990).

80. See generally PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, TECHNICAL APPENDIXES TO THE APRIL 1986 REPORT AND RECOMMENDATIONS TO THE SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES 57-63 (1986); CONGRESSIONAL BUDGET OFFICE, MEDICARE'S DISPROPORTIONATE SHARE ADJUSTMENT FOR HOSPITALS (May 1990) [hereinafter CBO REPORT].

81. PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, TECHNICAL APPENDIXES TO THE MARCH 1988 REPORT AND RECOMMENDATIONS TO THE SECRETARY OF HEALTH AND HUMAN SERVICES 16 (1988). The size of the payment ranges from about 3% to about 30% of the total Medicare payments, depending on the hospital's actual disproportionate share percentage. CBO REPORT, *supra* note 80.

82. Donnelly Bill, *supra* note 5, § 1(a)(proposing new I.R.C. § 501(n)(2)(C)(ii)).

83. According to a tentative simulation analysis performed by the Congressional Budget Office, if hospitals in 1987 were paid the disproportionate share adjustment in force in 1991, disproportionate share hospitals would have had an overall operating profit of 3.3%, as compared with an overall profit margin of 4.4% for nondisproportionate share hospitals. CBO REPORT, *supra* note 80, at xiii. Assuming the goal were to equalize the profit margins of these two groups, these figures suggest that disproportionate share hospitals are still an increment away from full parity. However, given that the total amount paid as a disproportionate

The second use of the disproportionate share calculation, which exempts hospitals whose disproportionate share calculation is no more than one standard deviation *below* the area-wide mean is more questionable. Essentially, this tells hospitals they are exempt even if they treat *significantly fewer* low-income Medicare and Medicaid patients than the local average. Thus, the uncompensated care proxy rationale identified above is much weaker here. Indeed, as noted with respect to the first test, a hospital could meet this second standard also without ever treating a single uninsured patient, and hospitals located in comparatively affluent areas could meet the standard without even treating very many publicly insured patients. Presently, no agency keeps figures on the one-standard-deviation-in-each-locality calculation, so the precise number of hospitals covered is not known with certainty. However, estimates performed by the American Hospital Association indicate that over three-quarters of nonprofit hospitals would automatically qualify by virtue of this provision, again without necessarily having to treat a single charity case outside of the emergency room.⁸⁴ Given these results, it is impossible to imagine a legitimate rationale for including this item in the list of five qualifying community benefits.

While providing a Mack-truck-sized loophole for exemption of typical acute care hospitals, the bill curiously makes it potentially more difficult for specialty hospitals to qualify for exemption than general hospitals. It essentially repeals an IRS 1983 ruling which treats these two types of hospitals equally (excluding a requirement to operate an emergency room).⁸⁵ While the Donnelly Bill continues to exempt specialty hospitals from the requirement of operating an open emergency room,⁸⁶ it does not exempt them from the five-part alternative tests of community benefit. These hospitals virtually by definition will not be sole community hospitals under the Medicare laws,⁸⁷ and many are unlikely to have a disproportionate number of low-income Medicare and Medicaid patients.⁸⁸ Unless

share adjustment in 1991 was estimated at \$1.6 billion, it appears that an \$8 billion tax subsidy far exceeds what is necessary to close this differential. On the other hand, not all of the \$8 billion in tax subsidy goes to disproportionate share hospitals.

84. Fewer than 600 of the nation's approximately 3200 nonprofit hospitals would fail to qualify under this provision. Telephone Interview with Michael Rock, Senior Associate Director, Legislative Affairs, American Hospital Association (July 25, 1991).

85. Rev. Rul. 83-157, 1983-2 C.B. 94. See *supra* note 15.

86. Donnelly Bill at § 1(a)(proposing new I.R.C. § 501(n)(2)(A)(iv)).

87. See *supra* note 55 and accompanying text.

88. See *supra* note 57. This presumes that few specialty hospitals would market themselves to patients whose payors might provide less than sufficient reimbursement.

these hospitals fall within the one-standard-deviation mark, they are left to the 5% and 10% expenditure tests. The 10% test has little relevance since, by virtue of their specialized nature, these hospitals are unlikely to offer the designated outpatient services. Thus, for no apparent reason specialized hospitals will be virtually the only hospitals that will be subjected to the rigorous 5% charity care requirement.

4. "Spillover" Effects

In addition to the problems outlined above, a closer reading of both the Roybal and Donnelly Bills reveals that in their zeal to rein in exemption for typical acute-care hospitals, each creates certain "spillover" effects that threaten the exempt status for certain specialized hospitals which virtually everyone would agree are entitled to exemption and other exempt institutions, such as universities, that operate hospitals. In its opening language, the Roybal Bill states that "An organization which [sic] operates a hospital shall not be exempt from tax under this section unless" the relevant substantive standards are met for "each hospital" operated by the entity seeking exemption.⁸⁹ The Donnelly Bill similarly states that "an organization shall be exempt from tax . . . *only if no substantial part of its activities consists of operating a nonqualified hospital.*"⁹⁰ The language cited for each bill has two puzzling effects. First, it prohibits hospitals from using other portions of I.R.C. § 501(c)(3) to justify their exemption. Historically, charity care and community benefit are merely the residual I.R.C. § 501(c)(3) categories to which hospitals have been relegated in their search for exemption when they have been unable to qualify under the enumerated categories of religious, educational, or scientific institutions. Under current law, many hospitals may not need to rely on these residual categories if they serve as teaching and research institutions at private universities.⁹¹ Each bill appears to eliminate this route to ex-

89. Roybal Bill, *supra* note 5, § 1(a)(proposing new I.R.C. § 501(n)(1)).

90. Donnelly Bill, *supra* note 5, § 1(a)(proposing new I.R.C. § 501(n)(1))(emphasis added).

91. Although we know of no specific IRS rulings dealing with university hospitals, a number of rulings have held that school-related organizations are exempt as educational institutions. *See e.g.*, Rev. Rul. 58-194, 1958-1 C.B. 240 (cafeteria operated for convenience of students and faculty); Rev. Rul. 63-235, 1963-2 C.B. 210 (law review); Rev. Rul. 66-103, 1966-1 C.B. 134 (organization providing low interest loans to students). *See also*, *Squire v. Student Book Corp.*, 191 F.2d 1018 (1951) (university book store exempt). It is likely that this issue simply has not yet arisen in the context of university-affiliated or research hospitals because hospitals themselves generally have been exempt.

emption by virtue of their requirements that *every* hospital seeking exemption must meet the residual criteria, rather than imposing its regimen only on those hospitals that fail to qualify through the standard categories.⁹²

Second, the quoted language in each bill removes the exemption from any nonhospital institution if the institution operates a hospital that does not meet the bill's substantive tests for exemption.⁹³ Therefore, an entire university or church could lose its exemption if its hospital did not meet the bill's requirements, even though the rest of the institution pursues other qualifying activities. The rationale for structuring the bills in this fashion is not readily apparent, and seems to serve no useful purpose.⁹⁴

B. Enforcement Provisions.

1. Differences in the Bills.

In addition to the substantive standards for exemption, each bill provides new sanctions for violations.⁹⁵ The Roybal Bill would im-

92. Donnelly Bill, *supra* note 5, § 1(a)(proposing new I.R.C. § 501(n)(1)); Roybal Bill, *supra* note 5, § 2(a)(proposing new I.R.C. § 501(n)(1)).

93. Actually, the Donnelly Bill provides a sort of *de minimis* exception, since it states that an entity loses exemption only if operation of a "nonqualified" hospital constitutes a "substantial" part of the entity's activities. Donnelly Bill, *supra* note 5, § 1(a)(proposing new I.R.C. § 501 (n)(1)). The Roybal Bill contains no such *de minimis* language, and is quite specific in requiring each "hospital" operated by an entity to meet the substantive requirements of the bill. Roybal Bill, *supra* note 5, § 2(a)(proposing new I.R.C. § 501 (n)(1)(A) and (B)).

94. Other than perhaps as a penalty to encourage compliance, the fact that an otherwise exempt institution operates a nonexempt hospital should have no more bearing on its exemption than the operation of any other unrelated business. In general, operation of unrelated businesses does not jeopardize an entity's exempt status, although profits from such a business are subject to the Code's unrelated business income tax. *See supra* note 7. The authors, at least, find somewhat incongruous the notion that the tax system would permit (to take one famous example) New York University to operate a macaroni factory but forbid it to operate a for profit hospital. On the other hand, a University that faced revocation of its exempt status because of failures related to its hospital operation might well take its compliance duties more seriously than if loss of exemption was confined to the hospital operation.

95. Each bill also imposes new reporting requirements for exempt hospitals. The Roybal bill requires an exempt hospital to report annually (1) the number of Medicare/Medicaid patients treated and whether such a number is reasonable for the hospital and was provided on a nondiscriminatory basis, (2) the total number of patients for the year, (3) the total number of charity care patients for the year and whether such treatment was done on a nondiscriminatory basis, (4) the hospital's aggregate charity care costs, (5) the hospital's aggregate community benefit costs, and (6) the community benefits provided by the hospital that are not customarily provided by non-exempt hospitals. Roybal Bill, *supra* note 5, at § 2(b)(proposing new I.R.C. § 6033(3)). The Roybal Bill also directs the IRS to establish rules for exempting from reporting requirements certain hospitals that consistently meet the proposed tests for exemption — apparently, the bill envisions the reporting requirement applying to "marginal" exemption cases only. *Id.* § 2(c). In addition, each exempt hospital is

pose a new excise tax on any hospital that fails to meet the charity care/community benefit standards in a given year.⁹⁶ The tax is the amount by which the hospital's actual charity care/community benefit expenditures fall short of the bill's requirements (i.e., the difference between the actual expenditures and 85% of the "value of the exemption" for the hospital computed as described above).⁹⁷ In a novel move, the amounts collected by the IRS under the new excise tax must be paid over to the state in which the offending hospital operates. States may use this tax to fund state-provided charity care.⁹⁸ The bill specifically states that, except in "egregious" cases,

required to furnish to the IRS a statement from the state Medicare/Medicaid administrator that (a) either the hospital participates in the Medicare/Medicaid program or, in cases where such participation is limited by contract, that the hospital made a "reasonable effort" to be awarded such a contract but did not get one and (b) that to the best of the official's knowledge, the hospital is expected to meet the requirements of the proposed bill in the following year. *Id.* § 2(b). Presumably, this statement would cover all parts of the proposed exemption standards, i.e., that the hospital would meet the Medicare participation, charity care and community benefit expenditure standards. State officials are also given the opportunity to comment on an application for exempt status. The bill requires that an application include the same kind of statement discussed above from state officials that the bill requires in a hospital's annual return. *Id.* § 4.

The Donnelly Bill similarly imposes a number of new reporting requirements. It requires a hospital to report to the IRS (1) the nature and costs of charity care for the year; (2) the nature and costs of other "community benefit" services; (3) whether the hospital receives disproportionate share payments under Medicare/Medicaid programs, the geographic area for determining such adjustments, the hospital's disproportionate patient percentage, and its Medicaid inpatient utilization rate; and (4) whether the hospital is a specialty hospital as defined in § 1886(d)(1)(B) of the Social Security Act. Donnelly Bill, *supra* note 5, § 1(b)(1)(proposing a new I.R.C. § 6033(e)). The Donnelly Bill does not provide for state comment on a hospital's exemption application, but does require the IRS to notify a state when a hospital either becomes or ceases to be exempt under the standards of the bill, and requires the Department of Health and Human Services to inform the IRS of hospitals that terminate Medicare/Medicaid provider agreements.

The information reporting requirements of either bill undoubtedly will be an additional headache for hospital administrators, but should pose no major problems once definitional issues (i.e., the definition and allocation of costs in order to calculate charity care) are resolved. Since most exempt organizations already file an informational return on Form 990 (I.R.C. § 6033 requires information returns by exempt organizations), the additional reporting requirements will not necessitate radically new filing procedures.

96. The tax would not apply to the first year a hospital failed to meet the exemption standards; instead, the bill requires the IRS to publish a notice of these "first time offenders" in the Federal Register. Roybal Bill, *supra* note 5, (proposing new I.R.C. § 4913(a)(3)). It is unclear whether this one-year grace period is a one-time benefit for each hospital, or whether a hospital could strategically time its expenditures to repeatedly exploit it by bouncing in and out of compliance. See *Joint Committee on Taxation Staff Description On Proposals and Issues Relating to the Tax-Exempt Status of Not-For-Profit Hospitals*, reprinted in *DAILY TAX REP.*, July 10, 1991, at L-1, L-14 [hereinafter *Joint Committee Report*].

97. Roybal Bill, *supra* note 5, § 3(a)(proposing new I.R.C. § 4913).

98. *Id.* § 3(b)(proposing an amendment to § 1903 of the Social Security Act (42 U.S.C. § 1396(b))).

this excise tax should supplant revocation of exemption as the primary enforcement tool.

In contrast, the Donnelly Bill continues to rely on revocation of exempt status as the primary enforcement mechanism along with a provision that permits reinstatement of exempt status after two years.⁹⁹ The bill, however, provides one alternative sanction: if a hospital fails the exemption test because it does not meet one of the five alternative "community benefit" expenditure standards discussed above, the hospital may elect to pay a penalty that generally equals the difference between 10% of the hospital's gross revenues and the cost of charity care provided by the hospital.¹⁰⁰ The Donnelly Bill also makes clear that a hospital that fails the new exemption standards will not be treated as a charitable entity for purposes of receiving tax-deductible charitable contributions or issuing tax-exempt debt, a point left open in the Roybal Bill.¹⁰¹ However, the Donnelly Bill is not clear about whether and when these ancillary benefits of exemption status would be lost in the event a nonqualifying hospital elects to pay the penalty tax.

2. Commentary on Enforcement Provisions

Currently the only enforcement tool available to the IRS to police most exempt organizations is revocation of the exemption. The IRS previously has complained of the unwieldy task of policing exempt organizations with only the "death penalty" at its disposal. In 1989, for example, a special task force formed to study the tax code's civil penalties concluded that revocation of exempt status was a penalty "of doubtful utility except in major abuse situations."¹⁰² The problem, of course, is that revocation of exempt status can effectively destroy an exempt entity, and often results in punishing the beneficiaries of an organization rather than its managers.¹⁰³ Thus, revocation of exemption is equivalent to dropping a nuclear bomb: it is a drastic step with such sweeping consequences

99. Donnelly Bill, *supra* note 5, § 1(a)(proposing new I.R.C. § 501(n)(4)).

100. *Id.* (proposing new I.R.C. § 501(n)(4)(B)). However, for the first year of noncompliance, the penalty is only 10% of the calculated amount (that is, 10% of the difference between 10% of the hospital's gross revenues for the year and costs of charity care).

Curiously, the bill does not credit the hospital with the costs of qualified community benefit (outpatient) services it in fact provides.

101. *Id.* § 1(a)(proposing new I.R.C. § 501(n)(3)).

102. REPORT ON CIVIL TAX PENALTIES BY THE EXECUTIVE TASK FORCE, COMMISSIONER'S PENALTY STUDY, INTERNAL REVENUE SERVICE (1989), *reprinted in* DAILY TAX REP., Feb. 23, 1989 at S-1, S-102 [hereinafter, TASK FORCE REP.].

103. *Id.*

that the IRS rarely invokes it.¹⁰⁴ Indeed, in the last decade only one hospital has lost its exemption.¹⁰⁵ The task force, therefore, concluded that excise tax penalties similar to those currently imposed on private foundations for violations of exemption standards would permit the IRS to police exempt organizations more effectively.¹⁰⁶ Therefore, the Roybal Bill, which utilizes an excise tax as the primary enforcement tool, appears preferable to the approach of the Donnelly Bill, which still relies on revocation of exemption as the primary enforcement alternative, albeit with an excise tax alternative in certain cases.¹⁰⁷ Nevertheless, even the Roybal sanction

104. See Leslie G. Espinoza, *Straining the Quality of Mercy: Abandoning the Quest for Informed Charitable Giving*, 64 S. CAL. L. REV. 605, 671 n. 315 (1991).

105. *Roybal Hearings*, *supra* note 15, at 175 (statement of James J. McGovern, assistant chief counsel, IRS).

106. *Id.* These excise taxes imposed on private foundations are contained in I.R.C. §§ 4940-4948 (1991). In general, the Code distinguishes between charitable private foundations and "public charities." The classic example of a private foundation is a charitable trust funded by contributions from a single family (e.g., the Ford family) which in turn makes contributions to other charities. Throughout the late 1950's and early 1960's, tax policy analysts were increasingly concerned that the general retention of control over family funds represented by the private foundation device created a potential for self-dealing between the foundation and the managers/founders. As a result, Congress in the 1969 Tax Reform Act enacted a comprehensive system to control the potential for private foundation abuse, relying largely on excise taxes to enforce prohibitions against self-dealing, improper investing and the like. See generally, Hall & Colombo II, *supra* note 71 at 1448; Council on Foundations, *Private Foundations and the 1969 Tax Reform Act*, in 4 U.S. Dept. of Treasury, *Research Papers Sponsored by the Committee on Private Philanthropy and Public Needs* 1557 (1977). In addition, private foundations are subject to lower contribution limits under I.R.C. § 170 (permitting tax-deductible contributions) than their public charity counterparts. I.R.C. § 170(b)(1) (individuals may contribute 50% of adjusted gross income to public charities, but only 30% to private foundations).

The lack of alternative sanctions for enforcement of exemption standards for public charities is particularly striking when compared to the private foundation excise tax scheme. For example, one of the primary requirements of exempt status under § 501(c)(3) is that an exempt organization not be guilty of "private inurement" — that is, the managers of the entity cannot siphon off the economic benefit of exemption through, for example, unreasonably high salaries, low-interest loans, free cars, etc. See Colombo, *supra* note 19, at 482-84. In the case of private foundations, inurement-type issues are generally controlled through an imposition of an excise tax on acts of "self dealing." I.R.C. § 4941. This section imposes a tax on the *manager or founder* of the foundation, not the entity itself, on any act of self-dealing, which generally are defined as transactions between the foundation and its managers or founders at below-market rates. I.R.C. § 4941(d). Thus in the public charity arena, acts of self-dealing can be punished only by invoking the private inurement prohibition and revoking exempt status; in the private foundation arena, the IRS can turn to the excise tax sanction before considering revocation. See generally, TASK FORCE REPORT, *supra* note 102, at S-100 to S-102.

107. The Donnelly Bill's sanction system also suffers from a potential "ping-pong" effect, that is, hospitals bouncing in and out of exempt status depending on whether they meet the bill's substantive exemption criteria. The Donnelly Bill states that a hospital that fails the exemption criteria of the bill may reapply for exempt status after two years, akin to the

could be improved. The sanction gives no incentive for a hospital to comply with the charity care and community benefit expenditure standards. If a hospital fails the test, it simply pays the difference to the federal government. In the meantime, the hospital remains exempt and thus gets to keep the 15% difference between the exemption standard and the estimated exemption value as well as the associated benefits of exemption (the ability to attract tax-deductible contributions and access to the tax-exempt bond market). It is easy to imagine a hospital consciously choosing to pay the excise tax in lieu of the hassles of providing charity care in order to maintain the other benefits of exemption.¹⁰⁸ Accordingly, some kind of "second-tier" tax would appear necessary to make hospitals actually render the desired services. In fact, current excise tax sanctions used to police the private foundation area contain a penalty tax that encourages both remedial action and future compliance.¹⁰⁹

NFL's "lifetime ban" for player drug-use violations that permits a player to petition for readmission after one year. Donnelly Bill, *supra* note 5, § 1(a)(proposing new I.R.C. § 501(n)(4)). Using excise taxes to enforce exemption standards avoids this ping-pong effect since the entity technically remains exempt.

The Donnelly Bill's alternative excise tax sanction for a hospital's failure to meet one of the five tests of community benefit expenditures also appears to suffer from a technical flaw. As noted above, the bill provides for an excise tax of 10% of the difference between 10% of the hospital's gross revenues and its charity care costs in the first year of noncompliance, and 100% of the difference in each subsequent year "with respect to the same failure." *See supra* note 99. That is, the 100% penalty is applicable only to successive years of noncompliance; if the hospital meets the five criteria test in a subsequent year, then the 10% penalty kicks back in. The Treasury observed that this system could encourage hospitals to engage in "creative cost allocation," by trying to push charity care costs for a two-year period into a single accounting year, and paying the 10% tax the next year. Assume, for example, that a hospital's charity care costs average 4% over a two-year period. If the hospital fails to meet any of the other five "community benefit" criteria, the hospital will suffer a 10% penalty in year 1, and a 100% penalty in year 2. If, on the other hand, the hospital can through accounting devices compress part of its year 2 care into year one, so that, for example, the charity care percentages are now 5% in year 1 and 3% in year 2, the hospital will pay no tax at all in year 1, and only a 10% tax in year 2. *See Joint Committee Report, supra* note 96, at L-1, L-14.

108. The Roybal Bill does provide for the assessment of a higher tax "because of unusual circumstances," but limits this to one percent of the hospital's gross receipts for the year, Roybal Bill, *supra* note 5, § 2(a), which in many cases would be less than the entire charity care burden. The bill also allows for revocation of exemption in "egregious" cases, so perhaps repeat offenders at some point would suffer loss of exempt status. *Id.* § 3 (proposing new I.R.C. § 4913(c)). Nevertheless, if a hospital consistently misses the 85% target by, say, 1% per year, is this "egregious" conduct?

109. For example, the excise tax on acts of self-dealing between a private foundation and its founders/managers start at 5%, but failure to remedy the act of self-dealing results in a 200% tax. I.R.C. § 4941.

IV. HEALTH POLICY, TAX POLICY AND THE CONGRESS.

This section explores more broadly several questions raised by these proposed bills that lie at the intersection of health policy and tax policy. First, it examines whether legislation of this type, which essentially addresses health policy concerns by manipulating the tax system, is the best solution to the problems of access to health care. Then, taking tax reform as a second-best option, it questions whether these bills are consistent with wise tax policy.

A. Is Tax Legislation the Best Route?

Both the Roybal and Donnelly Bills are aimed in a broad sense at ensuring that the government receives adequate return for the benefit of tax exemption by specifically tying exemption to expenditures for charity care, treatment of Medicare/Medicaid patients, operation of open emergency rooms and the like. Both, therefore, are premised on the recognition that exemption is a substantial government subsidy that needs to be more closely monitored.¹¹⁰ If one accepts the subsidy premise, however,¹¹¹ then the natural question is why use a *tax* subsidy at all? Currently, both federal and state governments provide *direct* subsidies for health care in the form of the Medicare and Medicaid programs, and states have begun to subsidize care for uninsured patients through hospital rate regulation.¹¹² A direct subsidy can accommodate widely varying needs for charity care over time and among different localities, taking into account the particular state's generosity in Medicaid reimburse-

110. In his statement opening the hearings before the House Select Committee on Aging, Rep. Roybal stated, ". . . until this Nation commits itself to a national health policy protecting all Americans, [we] cannot afford to lose the \$8 billion in [foregone federal revenues] that the [Federal] tax-exempt status potentially offers." *Roybal Hearings, supra* note 15, at 2 (statement of Rep. Roybal). Rep. Donnelly echoed this sentiment in introducing his bill. "Mr. Speaker, the fundamental basis under which Congress exempts organizations from taxation is the belief that those organization will relieve a governmental burden. . . My legislation, consequently, imposes some realistic requirements on hospitals if they wish to enjoy the generous benefits which the Government provides." 137 CONG. REC. E896 (statement of Rep. Donnelly).

111. As we previously have observed, characterization of the exemption as a tax subsidy is not universally adopted by tax commentators. In one of the classic articles on tax exemption, Boris Bittker and George Rahdert argued that exemption was not a subsidy at all, but merely a natural consequence of the inability of charitable institutions to accurately measure income. Boris Bittker & George Rahdert, *The Exemption of Nonprofit Organizations from Federal Income Taxation*, 85 YALE L.J. 299 (1976). For reasons stated in our previous work, we disagree. See Hall & Colombo I, *supra* note 12, at 313 n.12, 385-87.

112. Hall & Colombo I, *supra* note 12, at 358, n. 176. See also Michael A. Dowell, *State Health Insurance Programs for the Uninsured Poor*, 23 CLEARINGHOUSE REV. 141 (1989).

ment, the presence of government-owned hospitals, and other demographic factors.¹¹³ A direct subsidy also is just as simple to administer, especially in the case of health care where administrative machinery already exists.¹¹⁴ Government could also treat the indigent directly through the public hospital system, as is already the case with Veterans Administration hospitals, the Indian Health Service, and various state and municipal hospitals. Such direct treatment for needed services is surely at least as efficient as indirect coaxing through tax exemption standards.

Even if the tax subsidy route were preferable, another serious flaw in both the federal and state legislative efforts is that they are aimed exclusively at *hospitals*. Both the Roybal and Donnelly Bills fail to address issues of tax exemption that arise with respect to HMOs, physician group practices, various outpatient clinics, nursing homes, pharmacies and the myriad other parts of the nation's health care system. Surely these are just as necessary to a sound health care delivery system for the poor as is hospital care. Addressing hospital tax exemption without considering the health care system *as a system* invites continued irrational treatment of these other important parts of health care delivery. Unfortunately, neither the states nor the federal government appear much interested in fashioning an exemption standard that makes sense across the range of health care providers.

Our view, therefore, is that the best way to address issues regarding tax exemption is to do so within the confines of a broad re-examination of health care financing policy as a whole.¹¹⁵ Whether such a broad re-examination will occur given the current political climate, however, is questionable. Washington, D.C. is currently deluged with health care reform proposals, and the House Ways and Means Committee, which is considering these hospital exemption bills, is presently at the eye of this storm. Democrats, who are desperately searching for domestic issues for the fall, 1992 presidential campaign, see health care reform as a potentially powerful

113. Hall & Colombo I, *supra* note 12, at 358.

114. See STANLEY S. SURREY & PAUL R. MCDANIEL, *TAX EXPENDITURES* 100-102 (1985) (observing that administrative complexity is not a function of the method of subsidy); Alvin C. Warren, Jr. et al., *Property Tax Exemptions for Charitable, Educational, Religious and Governmental Institutions in Connecticut*, 4 CONN. L. REV. 181, 295-298 (1971) (apparent simplicity of the tax subsidy is illusory since it is purchased at the price of a sacrifice in monitoring and accuracy).

115. However, we would support Congress addressing the more technical parts of the legislation, relating to enforcement provisions and possibly including some measures concerning private inurement and unrelated business income, as pure tax legislation.

“wedge” issue in the 1992 election.¹¹⁶ Rep. Pete Stark, a Democrat from California who chairs the House Ways and Means Health Subcommittee, has held an extensive series of hearings over the past two years on health care insurance and cost containment. As a consequence of this considerable interest, when the Democratically-controlled House Ways and Means Committee convened its hearings on this tax legislation in July, 1991, the primary focus became the politics of health care financing reform. Several Democratic members lambasted the witnesses from Health and Human Services and Treasury, who opposed the core substantive requirements of both bills, for the administration’s lack of leadership on health care reform issues. Therefore, it appears highly unlikely given the Committee’s present mood that the exemption legislation will proceed ahead of or apart from some larger package of health care reform measures.¹¹⁷ Such measures, however, will not receive serious consideration until after the 1992 election, and even then a final compromise proposal could take years to finalize.

B. Tax Legislation as the Second-Best Choice

Because we are pessimistic about the chances for fundamental health care financing reform in the near term, we accept the proposition that some tax-based legislation may be the next best alternative for dealing at least incrementally with the issue of access to health care. Because nonprofit hospitals are presently widely distributed across the country and, realistically, there will always be demand for hospital charity care, government should take advantage of the charitable tax exemption to pursue, even at the margin, pressing health policy objectives.

Equally clear is the fact that pursuing such incremental change will require legislative intervention. Although the IRS has recently announced its intention to toughen enforcement of current stan-

116. Senate majority leader Sen. George Mitchell has spearheaded a year-long effort by key congressional leaders to fashion a viable comprehensive reform bill. See Susan B. Garland, *Suddenly the Health Care Crisis Has Democrats Feeling Robust*, BUS. WK., June 10, 1991, at 47.

117. Even if the bills were to be considered more as a matter of tax policy, the debate appears likely to be heavily influenced by stakeholder interests. The highly politicized hearings were dominated by hospital interest groups and contained precious few witnesses with a disinterested, analytical perspective on the issues. There were 11 witnesses representing nonprofit hospital interests, five representing various federal government agencies, two representing state and local governments, one representing health care lawyers, and only one representing consumers of health care. Academic tax theorists were not to be found at the witness table. *The Tax-Exempt Status of Hospitals, Hearings Before the House Committee on Ways and Means*, 102d Cong., 1st Sess. D880 (1991).

dards, which is reminiscent of the politics that led to the 1969 ruling where the IRS was prompted by Congressional inquiry to dramatically alter its conception of hospitals' charitable status¹¹⁸, the agency will apparently focus only on such marginal issues as maintaining an open emergency room and avoiding unseemly proprietary ventures. Moreover, even if the policy environment were primed for regulatory change, we question whether a revenue collecting agency should act on matters that require health policy expertise. Therefore, a good case exists for legislative intervention.

Nevertheless, we have serious difficulties with both bills. At the outset, we wonder whether either of the bills actually will increase charity care even incrementally. On balance, both bills as presently drafted will have only a marginal effect on hospital exemption. The Roybal Bill makes this explicit by providing that the charity care standard will be set at whatever level is necessary to ensure that 75% of all presently tax-exempt hospitals remain exempt, even with no change in behavior. The Donnelly Bill has similarly limited aims, although they are hidden in the five-part community benefit test. By permitting continued exemption for hospitals whose disproportionate patient percentage falls within one standard deviation of the mean for the geographic area, the bill allows most nonprofit hospitals to continue to conduct business as usual.¹¹⁹ We question whether a multiple-page statute that undoubtedly will require a hundred-page regulatory effort, with multiple new reporting requirements and maintenance of lists by both the IRS and HHS, is really an efficient use of resources to obtain such limited goals, especially in the already-too-complicated Internal Revenue Code.

Therefore, rather than address this issue from the framework of the particular legislative proposals that are pending, we will tackle the problem head-on by analyzing the basis for charitable tax exemption from the ground up. The rationale that underlies the 1969 ruling, taken from the law of charitable trusts, is that merely providing hospital services to a broad group of paying patients is a sufficient public benefit to deserve the exemption.¹²⁰ However, everyone who now considers the issue, even the hospital industry, concedes that something more is required.¹²¹ The debate really

118. See Hall & Colombo I, *supra* note 12, at 320 n.43 (referring to Rev. Rul. 69-545 and its timing in the 1969 legislative calendar). See also Fox & Schaffer, *supra* note 10.

119. See *Joint Committee Report*, *supra* note 96, at L-13.

120. Hall & Colombo I, *supra* note 12, at 321-22, 332-34.

121. *Id.* at 344-45.

turns on what that "something else" is that hospitals should provide.

Charity care is certainly a sufficient "extra", but the grounds are weak for making it the sole basis for exemption. Historically, charity care has never been the exclusive basis for exemption, although it has always been a primary touchstone.¹²² However, for charity care even to be a sufficient test of exemption, hospitals must demonstrate that they provide proportionately *more* uncompensated care than their for-profit counterparts, in an increment that equals or exceeds the value of the exemption. Neither bill quite achieves this measure, but a combination of their provisions is capable of doing so. The Roybal bill compares the cost of charity care with the value of the exemption, but it fails to take account of the for-profit baseline. The Donnelly bill corrects this defect, but abandons any comparison with the value of the exemption. We suggest a combination of the two concepts. If administrative complexities create problems, *then* perhaps adoption of a legislative presumption of five percent of gross revenues (the current approach of the Donnelly Bill) would be justified.

A good number of nonprofit hospitals probably would fail to meet this more rigorous approach to charity care as a sufficient standard for exemption. If encouraging additional charity care were the only policy consideration, then perhaps any new legislation should be limited to this demanding quid-pro-quo test. We believe, however, that any new legislation should also consider whether some general theory apart from the demanding quid-pro-quo approach could support exemption.

The traditional response of the hospital industry has been that various "community benefits" they provide also warrant exemption. This position suffers from two major weaknesses. First, it is unclear how one determines whether these "community benefits" in fact exist. For instance, some commentators argue that community benefits should be determined primarily by a "process-based" standard with no eye to the actual outcomes of this process.¹²³ This approach enmeshes Congress in a metaphysical "values" debate over the comparative performance of for-profit hospitals. Ample research has demonstrated no significant, consistent advantage of

122. *Id.* at 358-63.

123. J. David Seay & Robert M. Sigmond, *Community Benefit Standards for Hospitals: Perceptions and Performance*, FRONTIERS OF HEALTH SERVICES MGMT., Spr. 1989, at 4.

nonprofit health care over for-profit care.¹²⁴ Moreover, determining which particular services warrant special subsidy is more a matter of health policy expertise than of revenue collection techniques, and thus is not properly housed in the Treasury Department.¹²⁵

Second, a major problem exists with measuring the quantity of community benefits against the value of the exemption. Even hospitals concede that treating paying patients alone is insufficient, so surely they must admit that only the *unreimbursed* costs of these unspecified community benefits should be the basis for exemption, a measure that is readily quantified as the Roybal bill in fact proposes. Hospitals, however, try to duck the inevitable result of the quantification trap by citing unspecified, intangible community benefits that result from rendering hospital care to paying patients in a nonprofit setting. The result, therefore, is that we lack any objective, reliable mechanism for determining what aspects of nonprofit hospital care are inherently *more* beneficial than for-profit care, sufficient to justify an \$8 billion subsidy. While the Donnelly bill attempts to meet these two objections, and in some ways does provide additional objectivity, it continues to delegate to the IRS and HHS the core policy issue of what other community benefits are deserving of a social subsidy.

To address this problem, in two prior articles we proposed a "market in altruism" as an alternative mechanism for making this substantive policy determination.¹²⁶ We maintain that the proper way to demonstrate true community benefit, of sufficient proportions to merit a tax subsidy, is through the ability to solicit substantial donative support from the public at large. Thus, if contributors find the services of a particular hospital so worthy and in need of support that they donate at least one third of the organization's revenues, then a strong case exists for conferring an additional, shadow subsidy through the tax system. This market-like mechanism makes the difficult policy judgments automatically by allowing people to "vote" with their contributions. The donative theory thus provides a workable means for circumscribing which entities pro-

124. *Id.* at 5-7. See also BRADFORD H. GRAY, *THE PROFIT MOTIVE AND PATIENT CARE* 99-110 (1991).

125. See Fox & Schaffer, *supra* note 10, at 277-78 (criticizing IRS's role in setting health policy).

126. Hall & Colombo I, *supra* note 12, at 389-410; Hall & Colombo II, *supra* note 71; see generally, *Developments in the Law—Nonprofit Corporations*, 105 HARV. L. REV. 1579, 1623-25 (summarizing the donative theory).

vide services beyond charity care that should count toward justifying charitable status.

C. Conclusion

If either of the current federal legislative proposals ultimately becomes law, state efforts to attack exemption of nonprofit hospitals probably will die out. This almost certainly will be the result of the Roybal bill, since hospitals could now point to an official determination of their having fully earned their entire exemption through charity care and community benefit expenditures. If these federal efforts fail, however, nonprofit hospitals will still face challenges to exempt status from state taxing and other authorities, as well as more stringent interpretation of existing federal exemption standards by a politically-sensitive IRS. Open emergency rooms and full participation in Medicare/Medicaid programs appear headed to becoming substantive requirements for federal exemption of general acute care hospitals. Specialty hospitals may find the relative generosity of Rev. Rul. 83-157 a distant memory, as the IRS strives for more quantifiable expressions of "community benefit." Meanwhile, nonhospital health care providers will be left to the current exemption quagmire. Although there is much to be applauded in these initiatives to toughen exemption standards (and even more to be nit-picked), the issue of hospital exemption is best resolved in the context of a thorough review and revision of national policy regarding health care delivery.