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# A Veil of Tax Exemption ?: A Proposal for the Continuation of Federal Tax-Exempt Status for "Nonprofit" Hospitals

Jeremy J. Schirra

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# NOTE

## A VEIL OF TAX EXEMPTION?: A PROPOSAL FOR THE CONTINUATION OF FEDERAL TAX- EXEMPT STATUS FOR “NONPROFIT” HOSPITALS<sup>†</sup>

Jeremy J. Schirra<sup>††</sup>

*“The modern hospital, whether operated by a city, a church,  
or a group of private investors, is essentially a business.”<sup>1</sup>*

*“A business that makes nothing but money is a poor business.”<sup>2</sup>*

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<sup>1</sup> Parker v. Highland Park, 273 N.W.2d 413, 417 (Mich. 1978).

<sup>2</sup> Henry Ford. 1000 CEOs 8 (Andrew Davidson ed., 2009).

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## INTRODUCTION

To say that many hospitals originated from very modest means would be a gross understatement. For instance, to help establish Massachusetts General Hospital, one man donated a pig "of an uncommonly fine breed" while another donated an Egyptian mummy.<sup>3</sup> Prisoners quarried the granite blocks used for the walls of the building.<sup>4</sup> After several years, advocates of the hospital collected enough

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<sup>3</sup> Scott Allen & Marcella Bombardieri, *Much is Given by Hospitals, More is Asked*, BOS. GLOBE, May 31, 2009, at Metro 1, available at [http://www.boston.com/business/healthcare/articles/2009/05/31/much\\_is\\_given\\_by\\_hospitals\\_more\\_is\\_asked/](http://www.boston.com/business/healthcare/articles/2009/05/31/much_is_given_by_hospitals_more_is_asked/).

<sup>4</sup> *Id.*

charitable gifts from the wealthy to construct the hospital.<sup>5</sup> Similarly, the contribution of money and property by wealthy donors allowed for the establishment of numerous other hospitals. For example, donors and a matched gift from the Crown established The Pennsylvania Hospital,<sup>6</sup> while The Roosevelt Hospital was built with money willed by James H. Roosevelt for its establishment.<sup>7</sup>

From the eighteenth through the late nineteenth century in the United States, hospitals primarily served the extremely poor and insane.<sup>8</sup> In fact, as one historian noted, during the mid-nineteenth-century physicians did not expect to earn their livelihood from hospital-related work.<sup>9</sup> Rather, "hospital patients were, by definition, hospital patients because they could not pay a private practitioner."<sup>10</sup>

Today, a majority of nonprofit<sup>11</sup> hospitals' income is exempt from federal taxation. This tax exemption for nonprofit hospitals in the United States is currently, as it has been in previous decades, the target of much criticism. Among the criticisms are that nonprofit hospitals: (1) operate in virtually the same manner as their commercial

<sup>5</sup> It took several years to aggregate enough money to break ground on the Massachusetts General Hospital. Two men wrote a letter to raise funds on behalf of the desires of "a number of respectable gentlemen, that a hospital for the reception of lunatics and other sick persons should be established . . ." This letter asked the influential and wealthy recipients to contribute to create a hospital for the indigent and insane as something essential to the city's needs. The letter also discusses the benefits to the members of the community who are unable to afford medical care. Additionally, the letter mentions that the means of medical education were limited in the area and that the creation of a hospital was essential to the advancement of the medical school. The hospital would provide an opportunity for the local medical students (presumably primarily for what is now known as Harvard Medical School) to gain practical experience. NATHANIEL INGERSOLL BOWDITCH & GEORGE EDWARD ELLIS, *A HISTORY OF THE MASSACHUSETTS GENERAL HOSPITAL 1-71* (2d ed. 1872).

<sup>6</sup> See THOMAS G. MORTON & FRANK WOODBURY, *THE HISTORY OF THE PENNSYLVANIA HOSPITAL: 1751-1895* 3-35 (rev. ed. 1897).

<sup>7</sup> JAMES R. LATHROP, *HISTORY AND DESCRIPTION OF THE ROOSEVELT HOSPITAL, NEW YORK CITY* 7-8 (1893).

<sup>8</sup> CHARLES E. ROSENBERG, *THE CARE OF STRANGERS: THE RISE OF AMERICA'S HOSPITAL SYSTEM* 18, 98-99 (1987); see also MORTON & WOODBURY, *supra* note 6 (recounting the hospital's establishment and early years as a health care provider for the insane and the poor alike).

<sup>9</sup> ROSENBERG, *supra* note 8, at 252.

<sup>10</sup> *Id.*

<sup>11</sup> The terms "nonprofit" and "tax-exempt" have distinct meanings, especially as they apply to the Internal Revenue Code (IRC). The use of the words "nonprofit" or "tax-exempt" within this Note means the organization meets the requirements for tax exemption under 501(c)(3) of the IRC. State governments typically grant nonprofit status with the requirements varying by state. See *Applying for Exemption—Difference Between Nonprofit and Tax-Exempt Status*, INTERNAL REVENUE SERV., <http://www.irs.gov/charities/article/0,,id=136195,00.html> (last updated Jul. 30, 2010). For purposes of this Note, these terms are used interchangeably to mean tax-exempt.

counterparts; (2) consume resources in an inefficient and wasteful manner; and (3) favor caring for paying patients, thus failing to fulfill their promise to provide care to those in need.<sup>12</sup> Because of the pervasiveness of these and other criticisms, nonprofit hospitals are presently at a greater risk of losing their exempt status than virtually any other type of entity or association.<sup>13</sup> Further fueling this decades-old debate is the recently enacted Patient Protection and Affordable Care Act (PPACA) that may effectively eliminate the opportunity to provide charitable healthcare in a meaningful way by substantially decreasing the number of uninsured patients (although the tax-exempt status of nonprofit hospitals was already under fire).<sup>14</sup>

As the baby boomer generation ages and new epidemics emerge, nonprofit hospitals will become increasingly important organizations in American society. Nonprofit hospitals represent the vast majority of hospitals in the United States—over three-quarters of hospitals in the northeastern states.<sup>15</sup> While this is undoubtedly a great societal responsibility, does responsibility alone justify a continuation of the tax

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<sup>12</sup> The criticisms will be discussed further in Part III, *infra*. See generally THOMAS K. HYATT & BRUCE R. HOPKINS, *THE LAW OF TAX-EXEMPT HEALTHCARE ORGANIZATIONS* 39-51 (3d ed. 2008) (discussing criticisms of the tax exemption for healthcare organizations); Melvin Horwitz, *Corporate Reorganization: The Last Gasp or Last Clear Chance for the Tax-Exempt, Nonprofit Hospital?*, 13 AM. J.L. & MED. 527, 530-34 (1988); David A. Hyman, *The Conundrum of Charitability: Reassessing Tax Exemption For Hospitals*, 16 AM. J.L. & MED. 327 (1990) (discussing the overall issues facing the hospital tax exemption, including many criticisms not discussed in this Note but pertinent to the proposal discussed herein); John Carreyrou & Barbara Martinez, *Nonprofit Hospitals, Once for the Poor, Strike It Rich: With Tax Breaks, They Outperform For-Profit Rivals*, WALL ST. J., Apr. 4, 2008, at A1 (describing tax-exempt hospitals as essentially “cash machines” with significant advantages over their for-profit counterparts).

<sup>13</sup> See HYATT & HOPKINS, *supra* note 12, at 3; Margaret A. Potter & Beaufort B. Longest, Jr., *The Divergence of Federal and State Policies on the Charitable Tax Exemption of Nonprofit Hospitals*, 19 J. HEALTH POL. POL’Y & L. 393, 393-94 (1994); Barbara Martinez, *Senators Consider Curtailing Hospitals’ Tax Breaks—Exemptions, Historically Tied to Charity Care, Expected to Fall in an Overhaul; Industry Says It’s Already Taking Hits*, WALL ST. J., July 10, 2009, at A4; see also INTERNAL REVENUE SERV., IRS EXEMPT ORGANIZATIONS (TE/GE) HOSPITAL COMPLIANCE PROJECT FINAL REPORT (2009), available at <http://www.irs.gov/pub/irs-tege/frepthospproj.pdf> [hereinafter EXEMPT ORGANIZATIONS FINAL REPORT] (demonstrating current IRS interest in the matter of nonprofit hospital tax exemption).

<sup>14</sup> See Martinez, *supra* note 13; see also *infra* Part IV.D (discussing the broad impact of the PPACA and the reduction of the number of uninsured individuals in the United States).

<sup>15</sup> See U.S. GOV’T ACCOUNTABILITY OFF., GAO-08-880, *NONPROFIT HOSPITALS: VARIATION IN STANDARDS AND GUIDANCE LIMITS COMPARISON OF HOW HOSPITALS MEET COMMUNITY BENEFIT REQUIREMENTS* 9 (2008), available at <http://www.gao.gov/new.items/d08880.pdf>.

exemption?<sup>16</sup> Nonprofit hospitals enjoy many benefits that their for-profit counterparts do not. Among the advantages are the ability to receive tax-deductible gifts from donors,<sup>17</sup> to avoid most taxation, and to issue tax-exempt bonds.<sup>18</sup>

This Note does not oppose the continuation of the tax-exempt status of nonprofit hospitals. Rather, it explores a new proposed method for continuing the tax exemption. Under this method, hospitals would be more accountable to the public and would have the ability to “earn” their exemption based on their reported public contributions. The foundation of the current method by which hospitals qualify for the exemption is charitable services rendered.<sup>19</sup> The current method of qualifying for the tax exemption, as this Note will discuss later, does not require specific reporting requirements.<sup>20</sup> This lack of accountability provokes criticism because it confuses the public as to what exactly hospitals give back to the community and how much they contribute. Certainly, some of the criticism is warranted. Nevertheless, is the criticism directed at the right entities and institutions?

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<sup>16</sup> The basis of tax exemption for the majority of nonprofit hospitals, as will be explained in detail later, is the broader idea that benefits to the community constitute charity and are not limited to free or below cost services provided. *See* Rev. Rul. 69-545, 1969-2 C.B. 117; JOINT COMM. ON TAXATION, JCX-40-06, PRESENT LAW AND BACKGROUND RELATING TO THE TAX-EXEMPT STATUS OF CHARITABLE HOSPITALS, 5-8 (Sept. 12, 2006) (providing an overview of the present law relating to charitable hospitals).

<sup>17</sup> These gifts provide the donor with a tax deduction. Additionally, the donor does not have the expectation that the tax-exempt entity will provide a financial return. The donor/tax-exempt entity relationship is the antithesis of the for-profit corporation/shareholder relationship, where shareholders invest primarily for the prospect of receiving a return on their investment.

<sup>18</sup> In general, tax-exempt bonds (bonds whose interest is nontaxable to the recipient of the interest payments) provide a lower interest rate to investors than bonds issued by for-profit corporations. This is advantageous to the nonprofit entity because the cost of debt is lower (before tax consequences are considered)—all while maintaining market demand. This is the advantage of tax-exempt bonds—interest that escapes taxation in the hands of the bondholder. For example, a hypothetical taxpayer in a 30 percent tax bracket is presented with a choice between a tax-exempt bond from a nonprofit hospital that pays 8 percent interest or a bond from a for-profit entity that pays 10 percent interest (both are going market rates for the type of security, respectively). After taxes, the tax-exempt bond would still give the bondholder an 8 percent return. Conversely, the bond of the for-profit entity gives the same taxpayer a 7 percent return (10 percent interest less 30 percent for taxes yields an after-tax return of 7 percent). The taxpayer would be economically better off receiving an additional one percent interest on his investment after tax by choosing the nonprofit hospital bond. This assumes other risk factors among the bonds are equivalent.

<sup>19</sup> *See* I.R.C. § 501(c)(3) (West 2010).

<sup>20</sup> *See infra* Part I.D.2.

Hospitals demand much public attention for a plethora of reasons. In large metropolitan areas, it is hard to ignore the size and beauty of many of America's foremost hospitals, the majority of which are non-profit.<sup>21</sup> These hospitals are often some of the largest employers in any given area<sup>22</sup> and reap great financial rewards from local and state governments in the form of tax exemption.<sup>23</sup> In the end, most of these financial benefits can be traced back to the Internal Revenue Code (IRC) provision exempting hospitals from taxation.<sup>24</sup>

The purpose of this Note is to propose a modernized method by which hospitals can maintain their tax-exempt status while improving the efficiency of the United States healthcare system. The proposal accomplishes this goal by improving measurability and accountability that is lacking in the current system. This proposal does not include all nonprofit hospitals. It specifically excludes those hospitals that do not earn revenues in excess of expenses, Critical Access Hospitals,<sup>25</sup> and those with gross revenues not exceeding \$25 million. To include such hospitals would be administratively inefficient and would not significantly further public interest.

Part I of this Note provides a brief history of nonprofit hospitals and discusses the current state of their tax exemption in the United States. Part II discusses a number of rationales justifying the tax exemption for nonprofit hospitals. Part III explores several of the major criticisms facing nonprofit hospitals in the ongoing tax exemption debate and provides some arguments reconciling those criticisms. Finally, Part IV develops arguments that support a continuation of the

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<sup>21</sup> See Avery Comarow, *America's Best Hospitals: The 2009-10 Honor Roll*, U.S. NEWS (July 15, 2009), <http://health.usnews.com/articles/health/best-hospitals/2009/07/15/americas-best-hospitals-the-2009-2010-honor-roll.html>; see also CONG. BUDGET OFFICE, *NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS 3* (2006), available at <http://www.cbo.gov/ftpdocs/76xx/doc7695/12-06-Nonprofit.pdf>.

<sup>22</sup> See, e.g., *50 Largest Employers in Tennessee by Individual Location*, TENN. DEPT. ECON. & CMTY. DEV. (Feb. 24, 2010), [http://www.tennessee.gov/eecd/pdfs/TN\\_50LargestEmployers.pdf](http://www.tennessee.gov/eecd/pdfs/TN_50LargestEmployers.pdf); *Major Employers*, MD. DEP'T OF BUS. AND ECON. DEV., <http://www.choosemaryland.org/factsstats/pages/majoremployers.aspx> (last visited Jan. 10, 2011); *The Globe 100's Top Large Employers*, BOS. GLOBE, [http://www.boston.com/jobs/topworkplaces/2009/globe100\\_top\\_places\\_to\\_work\\_large/](http://www.boston.com/jobs/topworkplaces/2009/globe100_top_places_to_work_large/) (last visited Jan. 10, 2010).

<sup>23</sup> Hyman, *supra* note 12, at 327-31.

<sup>24</sup> All states have utilized Section 501(c)(3) of the Internal Revenue Code as a starting point for the creation of their tax exemption laws. See *id.* at 330.

<sup>25</sup> See discussion *infra* notes 187 through 190 and accompanying text explaining Critical Access Hospitals.

tax exemption for nonprofit hospitals through a proposed new method to qualify for tax exemption.

## I. BACKGROUND

### A. Origins of Hospitals in the United States

In 1800, only 322,000 of the 5,328,483 people in the United States lived in communities with populations larger than 2,500.<sup>26</sup> In times of illness, one frequently turned to relatives or neighbors, who often possessed no training, for remedies and advice. If the illness persisted, a physician ordinarily would treat the patient in the comfort of his or her home.<sup>27</sup> Physicians at this time had limited credentials, which usually consisted only of an apprenticeship with a local practitioner.<sup>28</sup>

Benjamin Franklin and William Penn were two of the founders of the first hospital in a colony that later would become part of the United States.<sup>29</sup> They called it Pennsylvania Hospital and it was incorporated in 1751 when it obtained a charter from the Crown.<sup>30</sup> Its purpose was "to care of the sick-poor and insane who were wandering the streets of Philadelphia."<sup>31</sup> Many other hospitals followed in Pennsylvania Hospital's footsteps in the subsequent century and a half.

With the twentieth century approaching, a shift in the focus of hospitals occurred. Beginning in the 1870s and 1880s, practitioners started making advances in medicine that would forever change the medical landscape. As a result, hospitals become more attractive to paying patients.<sup>32</sup>

<sup>26</sup> ROSENBERG, *supra* note 8, at 18.

<sup>27</sup> *Id.*

<sup>28</sup> *Id.* In addition to apprenticeships, physicians could attend one of the few medical schools in existence at the time. The education they offered lasted three to four months and consisted only of lectures. *Id.* at 20.

<sup>29</sup> See *History of Pennsylvania Hospital*, PENN MEDICINE, <http://www.uphs.upenn.edu/paharc/features/creation.html> (last visited Mar. 7, 2011); *Hospital*, ENCYCLOPEDIA BRITANNICA ONLINE, <http://www.britannica.com/EBchecked/topic/272626/hospital> (last visited Jan. 10, 2011).

<sup>30</sup> ENCYCLOPEDIA BRITANNICA ONLINE, *supra* note 29.

<sup>31</sup> *History of Pennsylvania Hospital*, *supra* note 29. Pennsylvania Hospital had paying patients dating back to its origins in 1751. ROSEMARY STEVENS, IN SICKNESS AND IN WEALTH 19-20 (1989); see also *History of Pennsylvania Hospital*, *supra* note 29.

<sup>32</sup> See ROSENBERG, *supra* note 8, at 244-61. The history and transitions hospitals went through in the U.S. are expertly chronicled within the books written by Rosenberg, *supra* note 8, and Stevens, *supra* note 31.



### B. The Modern Hospital "Business" Model: Fee-for-Service

The notion of nonprofit hospitals earning a "profit" from patients is not a recent development. Most hospitals in the United States that were established in the last century were not founded with large endowments or charitable gifts. The majority of hospitals operated on fees collected for rendering medical services and had little support from wealthy donors.<sup>33</sup> In fact, several hospitals in San Francisco had income in excess of their expenses in 1903.<sup>34</sup>

By the beginning of the twentieth century, American hospitals emerged as places of efficiency and scientific excellence, but they had also become increasingly capital-intensive organizations.<sup>35</sup> These institutions were no longer strictly for the indigent. The affluent became aware that hospitals were the best providers of some medical procedures because of the superior equipment, postoperative nursing, and medical care available.<sup>36</sup> The stigma of the previous century and a half faded and hospital care became socially acceptable for the wealthy.<sup>37</sup>

Evolving social attitudes toward hospitals around the turn of the twentieth century also helped spur hospital growth, as paying patients were able to cover the vast majority of hospital expenses, providing hospitals with a new source of capital.<sup>38</sup> By the 1930s, hospitals derived two-thirds their income from patient fees.<sup>39</sup> However, the paying patient usually received a private room, sometimes decorated to be homelike, while the poor usually were placed in wards, which were much less private or welcoming environments.<sup>40</sup>

An important point of emphasis is the marked difference between hospitals and other nonprofit organizations. Many nonprofit entities,

<sup>33</sup> See STEVENS, *supra* note 31, at 10.

<sup>34</sup> *Id.* at 30-31. This development occurred ten years before the Sixteenth Amendment, which permits Congress to levy an income tax. The Sixteenth Amendment provides that: "The Congress shall have power to lay and collect taxes on incomes, from whatever source derived, without apportionment among the several States, and without regard to any census or enumeration." U.S. CONST. amend. XVI.

<sup>35</sup> ROSENBERG, *supra* note 8, at 311.

<sup>36</sup> *Id.* at 245-61.

<sup>37</sup> *See id.*

<sup>38</sup> *Id.*

<sup>39</sup> Somewhat at odds with its fee-for-service transformation, hospitals continued to present themselves to the public in ways that carried the original themes of voluntarism and community throughout the twentieth century. However, nonprofit hospitals today conduct many activities that positively enhance their communities. See STEVENS, *supra* note 31, at 9-10.

<sup>40</sup> ROSENBERG, *supra* note 8, at 33-34, 245-61.

such as orchestras,<sup>41</sup> social organizations,<sup>42</sup> certain media outlets (e.g., NPR affiliate stations),<sup>43</sup> and museums<sup>44</sup> are primarily supported by donations and government grants. This is despite having some fee-for-service characteristics. For example, a local orchestra or playhouse may charge admissions fees to patrons but these fees generally cover only a small portion of operating costs.<sup>45</sup> Hospitals are extremely expensive institutions to maintain and operate—donor contributions are insufficient to cover hospital operating costs. Thus, the fee-for-service model for hospitals is necessary to ensure that the public has access to healthcare.

### C. What is a "Hospital?"

There are three common classifications of hospitals: proprietary, nonprofit, and governmental.<sup>46</sup> Research and teaching hospitals typically have their roots in charitable contributions or foundations and operate as nonprofit entities. Thus, they are classified as such and include some of the foremost hospitals in America.<sup>47</sup> Government

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<sup>41</sup> See, e.g., Zachary Lewis, *Cleveland Orchestra Posts \$2 Million Operating Loss, Drop in Endowment*, PLAIN DEALER, [http://www.cleveland.com/musicdance/index.ssf/2009/12/cleveland\\_orchestra\\_posts\\_2\\_mi.html](http://www.cleveland.com/musicdance/index.ssf/2009/12/cleveland_orchestra_posts_2_mi.html) (last updated Dec. 11, 2009, 3:49 PM) (stating that ticket sales were only one-third of the annual revenues, while the endowment and charitable donations made up the majority of the operating budget).

<sup>42</sup> These organizations are often supported by membership fees and donations.

<sup>43</sup> See, e.g., Paul Farhi & Reilly Capps, *NPR Given Record Donation: McDonald's Heiress Leaves \$200 Million*, WASH. POST, Nov. 6, 2003, at A1.

<sup>44</sup> See, e.g., Peter Baumann, *UW Geological Museum Needs Help*, LARAMIE BOOMERANG (Mar. 8, 2010), <http://www.laramieboomerang.com/articles/2010/03/08/news/doc4b9332ec6a3dc910647220.txt>.

<sup>45</sup> See, e.g., *Geffen Playhouse: Current Season*, GEFFEN PLAYHOUSE, [http://www.geffenplayhouse.com/Current\\_Season](http://www.geffenplayhouse.com/Current_Season) (last visited Mar. 12, 2010) ("DONATE NOW: Ticket revenue covers only a portion of presenting live theater. Your support is vital in ensuring that our artistic and educational programming will continue to grow and flourish.").

<sup>46</sup> See CONG. BUDGET OFFICE, *supra* note 21; see also STEVENS, *supra* note 31, at 29 ("Proprietary, religious, private charitable, and local-government hospitals have provided the great bulk of hospital care in the United States throughout this century."). Examples of for-profit hospitals include Hospital Corporation of America and Tenet Healthcare Corporation. See *Corporate Profile*, HOSP. CORP. AM., <http://phx.corporate-ir.net/phoenix.zhtml?c=63489&p=irol-homeprofile> (last visited Feb. 16, 2011); *Tenet Healthcare Corp. (THC): Profile*, YAHOO! FINANCE, <http://finance.yahoo.com/q/pr?s=THC> (last visited Mar. 9, 2011).

<sup>47</sup> Examples of such hospitals are the Cleveland Clinic, Mayo Clinic, Massachusetts General Hospital, and New York-Presbyterian Hospital. These hospitals are

hospitals include Veterans Administration (VA) hospitals, nonfederal community general hospitals, federal hospitals, and any other hospital administered by state or local governments. This Note focuses primarily on the nonprofit hospital, while the other two hospital types will be discussed for purposes of comparison.

In the context of taxation, the definition of “hospital” is somewhat elusive because it is never defined in the IRC.<sup>48</sup> The term “hospital” actually has three meanings depending on the tax purpose at issue. The traditional definition of hospital used by the Internal Revenue Service (IRS) and Congress is the one contained in the Medicare Act.<sup>49</sup> While the definition is lengthy, it is best summarized by the following language:

The term “hospital” . . . means an institution which—(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons . . . .<sup>50</sup>

The IRC uses the term “hospital” a second way when defining contributions to charities that qualify for a tax deduction.<sup>51</sup> Section 170 of the Code includes as a public charity “an organization the principal purpose or functions of which are the providing of medical or hospital care or medical education or medical research, if the organization is a hospital . . . .”<sup>52</sup> The explanation as to what constitutes a hospital is circular but is supplemented by Treasury Regulation § 1.170A-9(d). The regulation states that an organization qualifies if: (1) it is a hospital; and (2) its principal purpose is to provide medical or hospital care, medical education, or medical research.<sup>53</sup> The definition also includes federal, state, county, and municipal hospitals that are instrumentalities of government units.<sup>54</sup>

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also teaching hospitals for health care practitioners, many of which have an affiliation with specific universities.

<sup>48</sup> See HYATT & HOPKINS, *supra* note 12, at 213-14.

<sup>49</sup> *Id.*

<sup>50</sup> 42 U.S.C. § 1395x(e) (2009).

<sup>51</sup> I.R.C. § 170(b)(1)(A)(iii) (West 2010) (providing a deduction for individuals and corporations).

<sup>52</sup> *Id.*

<sup>53</sup> Treas. Reg. § 1.170A-9(d) (2010).

<sup>54</sup> *Id.* However, these are governmental hospitals—not nonprofit entities. This places governmental hospitals in competition with nonprofit hospitals for donor contributions.

A third use of "hospital" applies to organizations that are not hospitals at all, as the word is commonly used, but rather, cooperative hospital service organizations.<sup>55</sup> These organizations carry out certain enumerated services for two or more tax-exempt hospitals.<sup>56</sup> The services included are: rehabilitation, data processing, purchasing, warehousing, billing and collection, food, outpatient clinical, industrial engineering, laboratory, printing, communications, record centers, and personnel.<sup>57</sup> This third use demonstrates how broad the definition of hospital can be when it pertains to taxation. For purposes of this Note, the meaning of "hospital" is encompassed by the first two definitions, as the third definition describes organizations that primarily support what most would consider a "hospital."

#### D. The Nonprofit Hospital Tax Exemption Standard

The tradition of the United States' federal "tax exemption for hospitals predates the Revolutionary War."<sup>58</sup> The very basis of the IRC's concept of charity is founded in English charitable trust common law.<sup>59</sup> Before 1913, all Congress' previous versions of taxation exempted hospitals from taxation by virtue of failing to specifically include hospitals as an entity subject to taxation in legislation.<sup>60</sup> Federal income tax in the United States as we understand it today began in 1913, with the ratification of the Sixteenth Amendment to the Constitution.<sup>61</sup> And while there are currently many ways by which a hospital may qualify as a public charity (and thus for tax exemption), the most traditional understanding as to what activities constitute charity is providing relief for the poor.<sup>62</sup>

An underlying principle driving the implementation of tax exemptions is that private citizens should be able to solve society's problems on a nongovernmental basis (this principle is known as the public policy doctrine).<sup>63</sup> Early American culture preferred private citizen

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<sup>55</sup> *Id.*; see also HYATT & HOPKINS, *supra* note 12, at 215-16.

<sup>56</sup> Treas. Reg. § 1.170A-9(d); see HYATT & HOPKINS, *supra* note 12, at 216.

<sup>57</sup> See HYATT & HOPKINS, *supra* note 12, at 216 (discussing the former iteration of Treasury Regulation § 1.170A-9(c)(1), which is now located within the language of Treasury Regulation § 1.170A-9(d)).

<sup>58</sup> Hyman, *supra* note 12, at 334.

<sup>59</sup> See HYATT & HOPKINS, *supra* note 12, at 14.

<sup>60</sup> *Id.* at 8.

<sup>61</sup> See U.S. CONST. amend. XVI; *U.S. Treasury—Fact Sheet on the History of the U.S. Tax System*, U.S. DEP'T. OF THE TREASURY, <http://www.treasury.gov/education/fact-sheets/taxes/ustax.shtml> (last visited Aug. 26, 2010); see also HYATT & HOPKINS, *supra* note 12, at 8.

<sup>62</sup> HYATT & HOPKINS, *supra* note 12, at 15-17.

<sup>63</sup> See *id.* at 8-9.

action to government intervention, believing that this approach would lead to optimal results.<sup>64</sup> One way in which a government may interfere with the activities of citizens is through taxation. Thus, taxation of nonprofit hospitals is contrary to the public policy doctrine that is part of the founding ideals of the United States.<sup>65</sup>

Most important, the current iteration of the IRC contains no *per se* tax exemption for hospitals.<sup>66</sup> In order to qualify for tax exemption, a hospital needs to do more than be organized under state law as a nonprofit corporation. A hospital receiving tax exemption must qualify as a tax-exempt organization under 501(c)(3) of the IRC.<sup>67</sup> To qualify as a charitable organization (and thus for tax exemption), a nonprofit hospital must be organized and operated exclusively for charitable purposes.<sup>68</sup> This requirement has been interpreted to mean that the organization must be operated “primarily” in furtherance of its charitable purpose.<sup>69</sup>

The following two subparts, Parts I.D.1 and I.D.2., discuss the previous and current standards, respectively, by which nonprofit hospitals qualify for tax-exempt status. The third subpart, Part I.D.3, discusses an important limitation that may disqualify a nonprofit hospital from maintaining its exempt status.

### 1. The Financial Ability Standard

Revenue Ruling 56-185 promulgated the financial ability standard in 1956.<sup>70</sup> In order to qualify for tax exemption under this ruling, hospitals had to provide charity care to the extent of their ability and “not exclusively for those who are able and expected to pay.”<sup>71</sup> This stan-

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<sup>64</sup> The idea, in part, was that citizens would take greater ownership and pride in something they created that was uninhibited by the regulation of government. See JOHN STEWART MILL, *ON LIBERTY* (John W. Parker and Son 2d ed. 1859) (discussing the often antagonistic relationship between individuals in society and the government); GARRY WILLS, *A NECESSARY EVIL: A HISTORY OF AMERICAN DISTRUST OF GOVERNMENT* 17-18 (1999).

<sup>65</sup> HYATT & HOPKINS, *supra* note 12, at 11.

<sup>66</sup> I.R.C. § 501(c)(3) (West 2010); see also JOINT COMM. ON TAXATION, JCX-40-06, *PRESENT LAW AND BACKGROUND RELATING TO THE TAX-EXEMPT STATUS OF CHARITABLE HOSPITALS* 3 (2006). None of the iterations of the Internal Revenue Code included a *per se* exemption. See I.R.C. § 501(c)(3); Hyman, *supra* note 12, at 334.

<sup>67</sup> See Gary J. Young, *Federal Tax-Exemption Requirements for Joint Ventures Between Nonprofit Hospital Providers and For-Profit Entities: Form over Substance?*, 13 ANNALS HEALTH L. 327, 329-33 (2004).

<sup>68</sup> I.R.C. § 501(c)(3).

<sup>69</sup> See also Hyman, *supra* note 12, at 335.

<sup>70</sup> Rev. Rul. 56-185, 1956-1 C.B. 202; see JOINT COMM. ON TAXATION, *supra* note 16, 3-4.

<sup>71</sup> Rev. Rul. 56-185, 1956-1 C.B. 202.

dard was much more rigid than the current standard of qualification for tax-exempt status,<sup>72</sup> as hospitals could only qualify for the exemption through the provision of medical care to the poor.<sup>73</sup> Included within this standard was the hospital's ability to fulfill its obligation by furnishing reduced-rate services at rates below cost.<sup>74</sup>

This standard was relatively short-lived, as the IRS eliminated it in 1969. The primary reason for the elimination of the financial ability standard was a reduction in the number of uninsured patients after the 1965 enactment of Medicare and Medicaid.<sup>75</sup> The rationale was that it would be more difficult to meet a standard based solely on charitable services provided to the poor following a decrease in the number of uninsured patients.

## 2. The Community Benefit Standard

While hospitals originally received their tax exemption based on a charity care standard, Medicare and Medicaid reduced the opportunity to provide significant amounts of charitable care for the poor.<sup>76</sup> The insurance provided by these programs covers many of the people who would otherwise be uninsured. In response, the IRS issued Revenue Ruling 69-545 in 1969, and made significant changes to the rules governing what hospitals must do to qualify for tax exemption.<sup>77</sup> Under this revenue ruling, nonprofit hospitals may qualify for tax exemption in more ways than just the provision of reduced-rate or free care to the poor. This standard remains in force despite the most recent census estimate that 46.3 million Americans are without health care coverage.<sup>78</sup>

This ruling created the "community benefit" standard, which is the current test applied to determine whether a hospital qualifies for

<sup>72</sup> See *infra* Part I.D.2.

<sup>73</sup> By contrast, hospitals now have over a dozen methods of qualification under the current standard. See HYATT & HOPKINS, *supra* note 12, at 166-67.

<sup>74</sup> Rev. Rul. 56-185, 1956-1 C.B. 202.

<sup>75</sup> JOINT COMM. ON TAXATION, *supra* note 16, at 5-8.

<sup>76</sup> The charity care standard reflects the hospital's historical roots as health care providers to the poor, rather than the sick as we use hospitals today. HYATT & HOPKINS, *supra* note 12, at 218-19. In addition to Medicare and Medicaid, other factors decreasing the opportunity for hospitals to provide free care include the prevalence of employer-provided health insurance and the availability of other third-party programs. See JOINT COMM. ON TAXATION, *supra* note 16, at 3-4.

<sup>77</sup> Rev. Rul. 69-545, 1969-2 C.B. 117; see HYATT & HOPKINS, *supra* note 12, at 166-68.

<sup>78</sup> U.S. CENSUS BUREAU, U.S. DEP'T OF COMMERCE, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2008 20 (2009), available at <http://www.census.gov/prod/2009pubs/p60-236.pdf> [hereinafter INCOME, POVERTY AND HEALTH INSURANCE IN THE UNITED STATES].

tax exemption.<sup>79</sup> Under this ruling, the IRS sets out several factors that it considers to determine whether a hospital qualifies as charitable (and thus, exempt from taxation).<sup>80</sup> These factors include: (1) operating a 24-hour emergency room;<sup>81</sup> (2) providing charity care to the extent of the hospital's financial ability;<sup>82</sup> (3) extending medical staff privileges to all qualified physicians in the area, consistent with the size and nature of the facility; (4) accepting patients from Medicare and Medicaid programs on a nondiscriminatory basis; and (5) maintaining a community-controlled board.<sup>83</sup>

In the last couple of decades, the IRS has indicated that the community benefit standard will be the ongoing keystone of hospital activity analysis.<sup>84</sup> Despite its longevity, the community benefit standard is not a static test. Rather, it is dynamic in nature and adapts to changes in the healthcare system.<sup>85</sup> In recent years, the IRS has policed the community benefit standard to ensure that hospitals serve a wide enough class of persons and provide benefits to the community (in some cases even denying an exemption).<sup>86</sup>

However, the IRS recognizes that this standard is imperfect and is currently evaluating levels of compliance, as evidenced by recent reports compiled by its staff as well as interest in obtaining additional information regularly from tax-exempt hospitals. In 2006, the IRS issued a Compliance Check Questionnaire for Tax-Exempt Hospitals to over 500 hospitals to acquire operating information.<sup>87</sup> Additionally,

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<sup>79</sup> See Rev. Rul. 69-545, 1969-2 C.B. 117; JOINT COMM. ON TAXATION, *supra* note 16, at 5-6.

<sup>80</sup> Rev. Rul. 69-545, 1969-2 C.B. 117; see also Young, *supra* note 67, at 330.

<sup>81</sup> Rev. Rul. 69-545, 1969-2 C.B. 117. It is commonly thought that a hospital must operate an emergency room in order to qualify for the tax exemption. While generally required, a nonprofit hospital is not compelled to operate an emergency room "where a state or local health planning agency has found that this would unnecessarily duplicate emergency services and facilities. . . ." It is merely one factor in the analysis. Rev. Rul. 83-157, 1983-2 C.B. 94.

<sup>82</sup> This includes utilizing surplus funds to improve the quality of care, expand facilities, and improve medical training, education and research. Rev. Rul. 69-545, 1969-2 C.B. 117. Revenue Ruling 56-185 was later modified by Revenue Ruling 69-545, removing "the requirements relating to caring for patients without charge or at rates below cost." *Id.*

<sup>83</sup> The members of the independent board of trustees also should be disinterested members of the community as opposed to people who have financial interests in the hospital such as employees. See Rev. Rul. 69-545, 1969-2 C.B. 117; Young, *supra* note 67, at 331.

<sup>84</sup> See HYATT & HOPKINS, *supra* note 12, at 172-74 (discussing the IRS's actions with regard to the community benefit standard).

<sup>85</sup> See *id.* at 168-77.

<sup>86</sup> *Id.*

<sup>87</sup> *Id.* at 172.

the IRS began requiring hospitals to complete Form 990 (Return of Organization Exempt from Income Tax form).<sup>88</sup> The IRS has attempted to improve this form over the last few years in order to increase its relevance and usability.<sup>89</sup> The 2009 version of Form 990 collects information regarding charitable benefits and asks how the hospital serves its community's needs.<sup>90</sup> Of equal importance is the recent IRS Exempt Organizations Hospital Compliance Project Final Report. This report collected useful hospital demographic information that may help refine the community benefit standard in the future and is discussed further in Part IV.<sup>91</sup>

### 3. The Private Inurement Doctrine

In addition to meeting the requirements imposed by the community benefit standard, a hospital may lose its tax-exempt status if it found to have permitted private inurement.<sup>92</sup> Private inurement occurs whenever persons having a personal and private interest in a nonprofit hospital receive benefits disproportionate to their contributions to the entity.<sup>93</sup> Private inurement arises in many circumstances. Examples of such situations are excessive compensation, selling or exchanging property for less than fair market value, and loans whose financial

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<sup>88</sup> See INTERNAL REVENUE SERV., FORM 990 REDESIGN FOR TAX YEAR 2008 BACKGROUND PAPER 1-2 (2007), available at [http://www.irs.gov/pub/irs-tege/background\\_paper\\_form\\_990\\_redesign.pdf](http://www.irs.gov/pub/irs-tege/background_paper_form_990_redesign.pdf).

<sup>89</sup> *Id.*

<sup>90</sup> Form 990 Schedule H, which is specific to hospitals, requests many pieces of financial information regarding community benefits, including the following: (1) charitable care at cost, (2) unreimbursed Medicaid, (3) unreimbursed costs, (4) community health improvement service costs, (5) health professions education, (6) subsidized health services, (7) research, and (8) cash and in-kind contributions to community groups. IRS Schedule H (Form 990), Hospitals (OMB No. 1545-0047) (2009), available at <http://www.irs.gov/pub/irs-pdf/f990sh.pdf>.

<sup>91</sup> See EXEMPT ORGANIZATIONS FINAL REPORT, *supra* note 13.

<sup>92</sup> Treas. Reg. § 1.1501(c)(3)-1(c)(2) (2005).

<sup>93</sup> See Treas. Reg. § 1.501(a)-1(c) (West 2011) (defining "private shareholder[s] or individual[s] . . . [as] persons having a personal and private interest in the activities of the organization). The IRS Office of Chief Counsel has stated that:

[i]nurement is likely to arise where the financial benefit represents a transfer of the organization's financial resources to an individual solely by virtue of the individual's relationship with the organization, and without regard to accomplishing exempt purposes. Conversely, if financial benefit is derived from an individual's participation in an activity which furthers exempt purposes, the benefit may be characterized as merely incidental to the public purposes served.

I.R.S. Gen. Couns. Mem. 39862 (Nov. 21, 1991); see also JOINT COMM. ON TAXATION, *supra* note 16, at 15.



reasonableness is dubious or inadequately secured.<sup>94</sup> IRS agents examine, among other things, the contractual and financial “relationships between the hospital and the members of its board, key staff, and medical staff” to ascertain whether contracts and leases made between the parties were at “arm’s length.”<sup>95</sup>

The gist of the doctrine is to ensure that tax-exempt organizations serve public interests and not private ones.<sup>96</sup> This doctrine does not prevent a hospital from transacting with its physicians and directors.<sup>97</sup> Rather, it requires such transactions to pass a standard of reasonableness.<sup>98</sup>

Most importantly, this doctrine is in direct opposition to the nature of for-profit hospitals. Managers run for-profit entities for the purpose of benefiting stakeholders. Conversely, capital raised from philanthropic donors for nonprofit entities does not entitle the donor to any interest in the hospital. Likewise, the IRS forbids people with close ties to the hospital from financially benefiting in amounts that are not commensurate with their contribution to the hospital.<sup>99</sup> Even small amounts of private inurement can result in the revocation of a hospital’s exempt status.<sup>100</sup> The private inurement doctrine—the principle that no one receives a windfall from a nonprofit hospital—is a primary factor that distinguishes nonprofit hospitals from for-profit hospitals. Thus, nonprofit hospitals can use these excesses to benefit the community and further healthcare efforts.

## II. RATIONALES FOR TAX EXEMPTION

Organizations that are tax exempt range from the traditional and conventional (e.g., schools, private universities, museums, churches and religious organizations) to the controversial and niche (e.g., the

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<sup>94</sup> HOWARD J. BERMAN ET AL., *THE FINANCIAL MANAGEMENT OF HOSPITALS* 61 (8th ed. 1994).

<sup>95</sup> *Id.* Additionally, IRS agents may review the articles, bylaws, meeting minutes, and other communication files to determine whether transactions were not at arm’s length. *Id.*

<sup>96</sup> The IRS Office of Chief Counsel emphasized this doctrine (discussed *supra* note 93) over ten years prior. See HYATT & HOPKINS, *supra* note 12, at 64 (quoting I.R.S. Gen. Couns. Mem. 38459 (July 31, 1980)).

<sup>97</sup> *Id.* at 65 (discussing Private Letter Ruling 8234084, which states “[t]here is no absolute prohibition against an exempt section 501(c)(3) organization dealing with its founders, members, or officers in conducting its economic affairs . . .”).

<sup>98</sup> *Id.*

<sup>99</sup> Amounts paid must be at the “going rate” or in line with what the market price is for a particular good or service. BERMAN ET AL., *supra* note 94.

<sup>100</sup> *Id.*

Ku Klux Klan).<sup>101</sup> Section 501(c)(3) of the IRC establishes which organizations are exempt. It states that the function of exempt organizations is to conduct or further "religious, charitable, scientific . . . or educational purposes."<sup>102</sup> While there may be other avenues of tax exemption, hospitals have historically qualified for the tax exemption based on their charitable services.<sup>103</sup>

There are many rationales for the tax exemption for nonprofit organizations. Among these are political philosophy, lessening the burden of government, fostering volunteerism, inherent tax theory, tradition, and the political process.<sup>104</sup> Some rationales are interrelated while others are more arbitrary in nature, such as tradition, which relies on past exemption as a justification for continued exemption. In short, the rationales for tax exemption are as diverse as the organizations qualifying for them. A few of these rationales are less applicable to hospitals and are not discussed further. The following subsections, Part II.A. through Part II.C., elaborate on some of the most relevant nonprofit hospital tax-exemption justifications.

#### A. Political Policy, Pluralism, and Volunteerism

Political policy (also known as pluralism) is the notion that competition between the government and nonprofit sector is good for society.<sup>105</sup> This philosophy originates in the historic public distrust of government.<sup>106</sup> This ideal's basis, as discussed *supra* in Part I.A., is that private individuals and organizations are efficient allocators of resources to areas of need.<sup>107</sup> The court in *Green v. Connally* artfully articulated the notion of tax-exempt entities' ability to be efficient allocators of resources in society:

[T]he promotion of a healthy pluralism is often viewed as a prime social benefit of general significance. In other words, society can be seen as benefiting not only from the application of private wealth to specific purposes in the public interest but also from the variety of choices made by individual philanth-

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<sup>101</sup> John M. Strefeler & Leslie T. Miller, *Exempt Organizations: A Study of Their Nature and the Applicability of the Unrelated Business Income Tax*, 12 AKRON TAX J. 223, 227 (1996).

<sup>102</sup> I.R.C. § 501(c)(3) (West 2010).

<sup>103</sup> See Potter & Longest, *supra* note 13, at 393-94, 400-04.

<sup>104</sup> Strefeler & Miller, *supra* note 101, at 228-30.

<sup>105</sup> BRUCE R. HOPKINS, *THE LAW OF TAX-EXEMPT ORGANIZATIONS* 12 (9th ed. 2007).

<sup>106</sup> *Id.*; see *supra* note 64 and accompanying text.

<sup>107</sup> HOPKINS, *supra* note 105, at 16 (quoting *Green v. Connally*, 330 F. Supp. 1150, 1162 (D.D.C. 1971)).

ropists as to which activities to subsidize. This decentralized decision-making is arguably more efficient and responsive to public needs than the cumbersome and less flexible allocation process of government administration.<sup>108</sup>

Several notions of the pluralism rationale provide support for the tax deduction for contributions to nonprofit hospitals and for the hospitals' tax exemption. First, the internal processes of government operations tend to be similar no matter what the endeavor—meaning that they often lack experimentation and innovation.<sup>109</sup> Allowing nonprofit organizations to operate independent of government control allows for a diversity of processes to develop.<sup>110</sup> And this diversity of organizational management allows organizations to learn from one another. The Cleveland Clinic's integrated approach to healthcare provides an excellent example.<sup>111</sup> The Cleveland Clinic's approach costs chronically ill patients an average of \$55,000 for the last two years of life, which is tens of thousands less than similar patients pay at other highly-ranked hospitals.<sup>112</sup>

Second, pluralism creates competition between government and the nonprofit sector.<sup>113</sup> This competition presents consumers with alternative providers, thus allowing for increased competition among healthcare organizations. As Adam Smith said, “[m]onopoly . . . is a great enemy to good management . . . .”<sup>114</sup>

In addition, pluralism prevents over-reliance on government.<sup>115</sup> For example, if a city, state, or the federal government decides to reduce spending on governmental hospitals, and thereby reduce capacity, it would not directly change the capacity or funding of nonprofit hospitals. Thus, this rationale protects citizens against heavy-handed, underfunded, or ill-advised governance.

Further, the concept of political policy is complimentary to the idea of volunteerism. Members of the community take ownership of

<sup>108</sup> 330 F. Supp. 1150 at 1162 (citations omitted).

<sup>109</sup> See Strefeler & Miller, *supra* note 101, at 229.

<sup>110</sup> See *id.* (discussing testimony by George P. Shultz, then-Secretary of the Treasury, before the House Committee on Ways and Means).

<sup>111</sup> Many hospitals do not employ their physicians. They remain independent and private practitioners. Contrary to this model, the Cleveland Clinic employs its own physicians and encourages collaboration among its employees. See Vanessa Fuhrmans, *Replicating Cleveland Clinic's Success Poses Major Challenges*, WALL ST. J., July 23, 2009, at A4.

<sup>112</sup> *Id.*

<sup>113</sup> HOPKINS, *supra* note 105.

<sup>114</sup> 1 ADAM SMITH, AN INQUIRY INTO THE NATURE AND CAUSES OF THE WEALTH OF NATIONS 163 (R.H. Campbell & A.S. Skinner eds., 1904).

<sup>115</sup> Strefeler & Miller, *supra* note 101, at 229.

the nonprofit organization and of certain beneficial functions that are essential to the well-being or vibrancy of the community.<sup>116</sup> These community members work for hospitals and fulfill community needs that the government may not be addressing sufficiently because of a lack of locale-specific knowledge. As one scholar noted decades ago, “[i]n no other country has private philanthropy become so vital a part of the national culture or so effective an instrument in prodding government to closer attention to social needs.”<sup>117</sup>

### B. Reducing Government Burden

Another justification for tax exemption is the notion of reducing the burden on government. The services provided by nonprofit hospitals reduce the need for government to fund and administer healthcare for the public.<sup>118</sup> Thus, the government is willing to forego tax revenues it would otherwise receive from hospitals.<sup>119</sup> Completing the *quid pro quo*, the public shoulders the financial and administrative burden to create and maintain the hospital.<sup>120</sup> The public assumes the financial burden by paying taxes that the hospital otherwise would pay in exchange for the services and other benefits that a hospital can provide to the community.<sup>121</sup> Administratively, the hospital employs members of the community and relieves the government of this responsibility.

### C. Tradition

One more rationale for the nonprofit hospital tax-exemption is tradition.<sup>122</sup> The tax exemption for hospitals is older than the country itself, thus it is assumed that Congress found the tax exemption both appropriate and warranted.<sup>123</sup> As discussed throughout this Note, the exemption’s basis was charity.

Over the twentieth century, the hospital’s place and purpose in society has become more multifaceted and complex.<sup>124</sup> Some of these

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<sup>116</sup> *Id.* at 228-30.

<sup>117</sup> Norman S. Fink, *Taxation and Philanthropy—A 1976 Perspective*, 3 J. COLL. & UNIV. L. 1, 6-7 (1975).

<sup>118</sup> HYATT & HOPKINS, *supra* note 12, at 8-11.

<sup>119</sup> *Id.*

<sup>120</sup> *See id.*

<sup>121</sup> *But see* discussion *infra* Parts III.A. and B (discussing the criticisms that hospitals do not provide a fair share of benefits).

<sup>122</sup> Strefeler & Miller, *supra* note 101, at 228.

<sup>123</sup> *Id.*

<sup>124</sup> *See* in general the sources referenced in note 32 (describing the changes in hospitals over the twentieth century and the respective influences).

changes were governmentally encouraged; other changes were a result of improvements in health science and technology; still others were a consequence of changes in the medical profession.<sup>125</sup> The rationale of tradition may be unpersuasive for some observers and appear arbitrary in light of the changes in hospitals over the last century. However, the notion that hospitals have changed significantly does not negate the importance of continuing the tradition of tax exemption. For further discussion of the potential impact of terminating the tax exemption and additional support for the rationale of tradition, see *infra* Part III.D.

### III. THE ONGOING HOSPITAL TAX EXEMPTION DEBATE

Hospitals have received an onslaught of criticism, most of which is directed at their nonprofit status. Public opinion appears to be that hospitals should provide greater benefits than they do at present to the community because they are not taxpayers.<sup>126</sup> Another factor that draws attention to nonprofit hospitals is their dominance—they represent nearly 70 percent of hospital beds in the United States.<sup>127</sup>

Additional criticisms leveled at hospitals are that they engage in essentially the same activities as for-profit hospitals<sup>128</sup> and that they are businesses that reap large profits.<sup>129</sup> The criticisms have intensified in recent decades to the point where states have begun challeng-

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<sup>125</sup> See discussion *supra* Part I.A. and B.

<sup>126</sup> See, e.g., Scott Allen & Marcella Bombardieri, *Much is Given by Hospitals, More is Asked*, BOS. GLOBE, May, 31, 2009, at A1, available at [http://www.boston.com/business/healthcare/articles/2009/05/31/much\\_is\\_given\\_by\\_hospitals\\_more\\_is\\_asking/](http://www.boston.com/business/healthcare/articles/2009/05/31/much_is_given_by_hospitals_more_is_asking/); Mike Colias, *Big Chicago Hospitals See Huge Profit Gains*, CRAIN'S CHI. BUS., Mar. 1, 2010, <http://www.chicagobusiness.com/cgi-bin/article.pl?articleId=33072>.

<sup>127</sup> CONG. BUDGET OFFICE, *supra* note 21, at 3. The basis of this statistic is Medicare-certified community hospitals in the United States. Respectively, 16% and 15% of the beds were located in for-profit and governmental hospitals. *Id.* Based on these figures, it is clear that most hospital care in the United States occurs in nonprofit hospitals.

<sup>128</sup> See, e.g., Robert Pear, *Nonprofit Hospitals Face Scrutiny Over Practices*, N.Y. TIMES, Mar. 19, 2006, at 18.

<sup>129</sup> For the purposes of this Note, the term "profit" is used in the sense of excess revenues over expenses. See Carreyrou & Martinez, *supra* note 12; Colias, *supra* note 126; Jacob Goldstein, *On Top of Tax Breaks, Nonprofit Hospitals Reap Big Profits*, WALL ST. J. HEALTH BLOG (Apr. 4, 2008, 8:29 AM), <http://blogs.wsj.com/health/2008/04/04/on-top-of-tax-breaks-nonprofit-hospitals-reap-big-profits/tab/article/>.

ing the exemption in certain cases.<sup>130</sup> Mark W. Everson, a former Commissioner of Internal Revenue, once said that "tax officials often find little difference between nonprofit and for-profit hospitals in their operations, their attention to the benefit of the community or their levels of charity care."<sup>131</sup> Another source of outrage is the high fees charged by high-profile institutions with substantial net worth.<sup>132</sup>

#### A. The Economic Power of Nonprofit Hospitals

The criticisms against nonprofit hospitals certainly have validity, as it is likely that there are currently nonprofit hospitals unjustifiably receiving the tax exemption (i.e., they receive significantly more in tax benefits than they give in services to the public). It is important to recognize that nonprofit hospitals claim significant advantages compared to their for-profit counterparts.<sup>133</sup> The primary differences between for- and non-profit hospitals lie in the following: (1) nonprofit hospitals generally have a lower cost of capital;<sup>134</sup> (2) nonprofit hospitals' revenues in excess of expenses generally escapes all taxes; (3) nonprofit hospitals are run for the benefit of the community, while for-profits are run for the benefit of their stakeholders;<sup>135</sup> and (4) donors of charitable contributions to nonprofit hospitals receive a deduction.<sup>136</sup> Illustrations 1 through 3 demonstrate the economic advantages of a nonprofit hospital over a for-profit one.<sup>137</sup>

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<sup>130</sup> It should be noted that the state cases are not challenging the respective hospital's federal tax exemption. These cases are attacking other tax exemptions nonprofit hospitals receive by way of property, state and local taxes. *See, e.g., Utah County v. Intermountain Health Care*, 709 P.2d 265 (Utah 1985) (deciding against an exemption from property tax for the hospital because the property was not used exclusively for charitable purposes); *see also* Potter & Longest, *supra* note 13, at 393-94.

<sup>131</sup> Pear, *supra* note 128.

<sup>132</sup> *See* Allen & Bombardieri, *supra* note 126; Carreyrou & Martinez, *supra* note 12; Barbara Martinez & John Carreyrou, *Minority of Tax-Exempt Hospitals Provide Most Charity Care*, WALL ST. J., Feb. 13, 2009, at A3; Joan Mazzolini, *Clinic and UH Worth a Lot, but Taxed a Little*, PLAIN DEALER, Apr. 9, 2006, at A1.

<sup>133</sup> Uwe E. Reinhardt, *The Economics of For-Profit and Not-For-Profit Hospitals*, 19 HEALTH AFFAIRS 178 (2000).

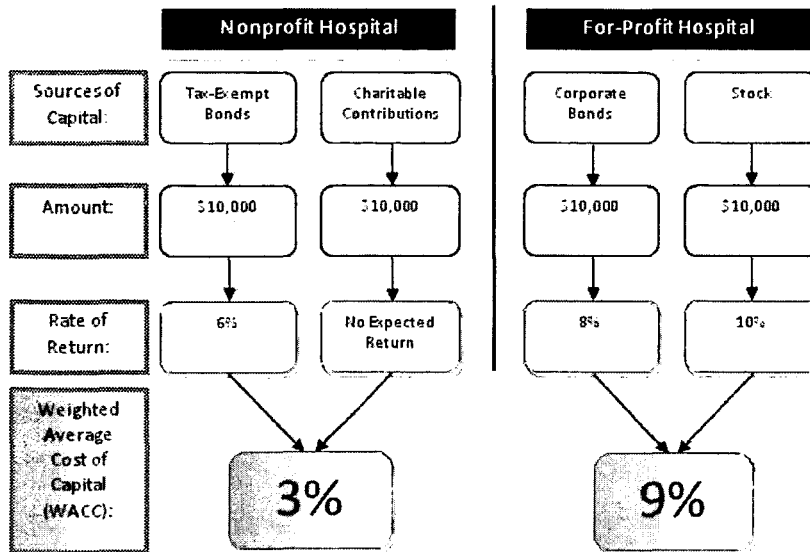
<sup>134</sup> For a discussion of costs of capital and comparison between for-profit and nonprofit hospitals, see *infra* Part III.A. Illustrations 1 through 3. *See* Reinhardt, *supra* note 133, at 179-84.

<sup>135</sup> *See supra* Part I.C. and *infra* Part III.A. Illustrations 1-3.

<sup>136</sup> Reinhardt, *supra* note 133.

<sup>137</sup> For the sake of comparability among the examples, namely Illustrations 2 and 3, the author made all illustrations in a form resembling the financial statements of for-profit entities.

Illustration 1: Weighted Average Cost of Capital Comparison Between Nonprofit and For-profit Hospitals<sup>138</sup>



*Discussion.* The *weighted average cost of capital (WACC)* is the weighted average of an organization's capital component costs.<sup>139</sup> The rate of return derived is the minimum return that an organization must receive on its capital in order to satisfy its stakeholders.<sup>140</sup> In this simplified example, there are four components, or classes, of capital—tax-exempt bonds, charitable contributions, corporate bonds, and stock. All classes are equal in amount. Rates of return (or component costs) for all classes are calculated before tax considerations to the respective organization.<sup>141</sup> The rate of return percentiles reflect the

<sup>138</sup> Author's illustration. The interest rates were arbitrarily selected; however, taxpayers will demand a greater return on equally risky bonds with identical terms if one is tax-preferred (i.e., the interest is not included in the taxpayer's taxable income) and the other is taxed at ordinary income rates. Equity was given an even higher rate of return than the bonds due to the characteristics of equity, including its subordination to the interests of creditors. Simplistic figures were chosen for the sake of illustration clarity.

<sup>139</sup> EUGENE F. BRIGHAM & MICHAEL C. EHRHARDT, *FINANCIAL MANAGEMENT: THEORY AND PRACTICE* 306-08 (11th ed. 2005).

<sup>140</sup> *Id.*

<sup>141</sup> Bond interest is deductible to the for-profit entity. Therefore, the effective interest rate for the bond is 5.6 percent if the for-profit entity is a hypothetical 30 percent bracket taxpayer. Thus, the true WACC in this example is 7.8 percent for the

contributors' minimum expectation of return for that class of contributed capital. In the case of bonds, minimum return is also the maximum return that the bondholders expect to receive. The interest rates of the respective bonds are set at an interest rate where a hypothetical 25 percent tax-bracket taxpayer would be indifferent as to which bond they select.<sup>142</sup>

For the nonprofit hospital, only one of its two classes of capital contributions is received with the expectation of providing a return: the bond. This is simply a loan to the hospital. Donors do not expect any direct economic return and are precluded from otherwise profiting from a nonprofit organization by the private inurement doctrine.<sup>143</sup> Therefore, the WACC for the nonprofit hospital is 3 percent.

The for-profit hospital has two classes of securities: stock and bonds. The bondholders expect to receive a return of their capital contribution as well as annual interest of 8 percent. The holders of stock expect to receive a minimum of a 10 percent return. A corporate hospital would typically provide this return in the form of dividends or capital gains (an increase in the price per share of stock created by an increase in the value of the organization).<sup>144</sup> Combining this into a weighted average, the fictional for-profit hospital has a WACC of 9 percent.<sup>145</sup>

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for-profit entity. I have ignored the effect of taxation for Illustration 1 and discussions referencing Illustration 1.

<sup>142</sup> To calculate the after-tax rate of return, multiply the bond's interest rate by the value derived by subtracting the taxpayer's tax rate from one (e.g.,  $8\% * (1-.25) = 6\%$ ).

<sup>143</sup> For a description of the private inurement doctrine, see *supra* Part I.D.3.

<sup>144</sup> See generally BRIGHAM & EHRHARDT, *supra* note 139, at 313-37 (discussing various approaches to capital cost valuation); see also *id.* at 40 (explaining that capital gains are an increase in the price per share of stock created by an increase in the value of the organization).

<sup>145</sup> No matter what allocation, if the same amount of capital were distributed amongst *each* respective entity, the nonprofit hospital would always have the lower WACC under the assumptions and choices available in this illustration.



Illustration 2: Financial Results of Comparable Nonprofit and For-Profit Hospitals<sup>146</sup>

	<u>Nonprofit Hospital</u>	<u>For-Profit Hospital</u>
Gross Revenue:	\$10,000	\$10,000
Operating Expenses:	7,000	7,000
Gross Income:	<u>3,000</u>	<u>3,000</u>
Bond Interest:	600	800
Earnings Before Taxes:	<u>2,400</u>	<u>2,200</u>
Taxes (@ 30%):	0/ tax exempt	660
Net Income:	<u>2,400</u>	<u>1,540</u>
Dividends:	0	1,000
Retained Earnings:	<u>2,400</u>	<u>540</u>

*Stock/Charitable Contributions.* The for-profit hospital receives \$10,000 worth of capital from investors in exchange for stock in the for-profit hospital. These investors expect a return on the capital contributed for stock. In this example, we will assume that the hospital provides a return to its investors entirely by dividends. Assume that the market rate of return for the investors' capital is 10 percent—this means that the for-profit hospital must provide at least a 10 percent return in order to satisfy its investors' expectation. The nonprofit hospital receives charitable contributions of \$10,000, from which the donors expect to derive no direct financial return. One of the greatest differences between a nonprofit and for-profit institution is seen in the dividend line.<sup>147</sup> The nonprofit does not provide donors with anything in return, resulting in an increase in its retained earnings.

*Bonds.* Both hospitals also have issued \$10,000 worth of bonds. The for-profit and nonprofit bonds pay 8 percent and 6 percent inter-

<sup>146</sup> For simplicity, assume that the two hypothetical hospitals adopted the capital structure discussed in Illustration 1 and that Illustration 2 carries the assumptions from Illustration 1 forward.

<sup>147</sup> The for-profit entity may also choose to not pay dividends and reinvest the capital in other projects, assuming there remain projects with an estimated return greater than the cost of capital.

est, respectively. As previously noted, assuming the bonds are equal in other risk factors, they will never be equal because of the impact of taxation. Investors will demand a higher interest rate on taxable bonds to make up for the tax discrepancy.<sup>148</sup> The nonprofit bonds in this example are tax-exempt.

*Discussion.* Hospitals are primarily fee-for-service entities.<sup>149</sup> In this example, we assume that two virtually identical startup hospitals that are opening each raise capital of \$20,000 through various sources described above in Illustration 1. This initial \$20,000 is enough to lease a building, purchase all equipment, and start operations. Further, this example assumes that operating expenses are 70 percent of revenues.

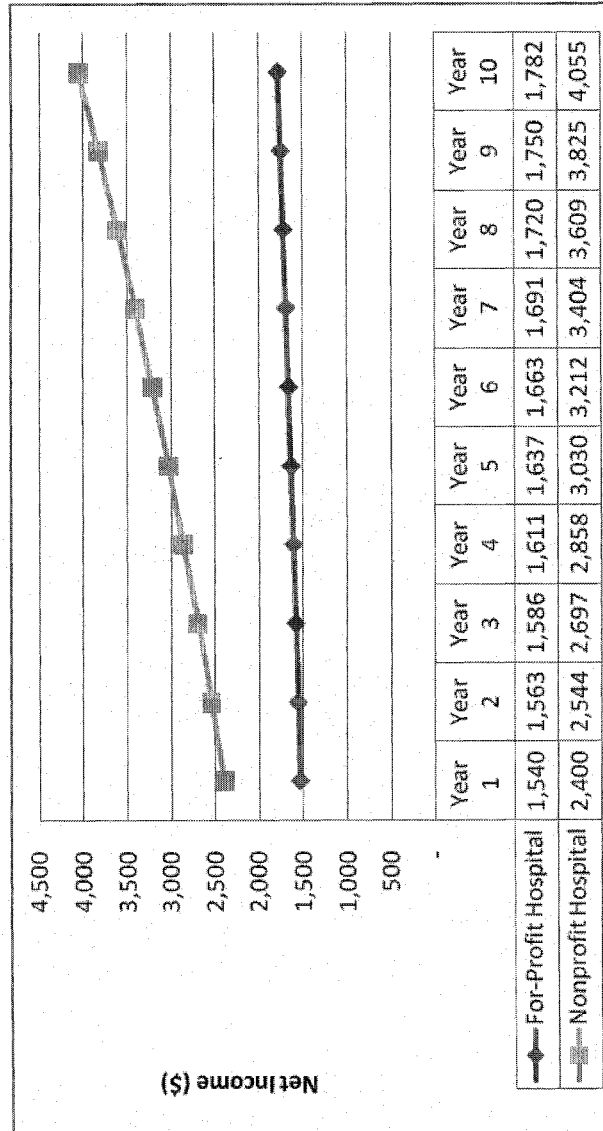
The bottom-line figure, retained earnings, is the amount available to the hospital to reinvest in itself for the following operating year. The hospital will use this money to expand, hire more staff, invest, or purchase new equipment in the hope that reinvesting this money will improve the hospital's following year net income.

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<sup>148</sup> See *supra* pp. 252-53, 253 n.142.

<sup>149</sup> See BERMAN ET AL., *supra* note 94, at 71-72.

Illustration 3: Net Income Over Time of Comparable Nonprofit and For-Profit Hospitals



*Assumptions.* This chart depicts the fictitious hospitals from Illustration 2 as if both operated for ten years. To simplify this comparison, the following assumptions were made:

- Operating expenses equal 70 percent of gross revenue in each year.

- Both hospitals continued to make payments on their bonds without paying off the principal—the nonprofit paying 6 percent and the for-profit paying 8 percent interest annually.
- Both hospitals completely reinvest “retained earnings” into the hospital. The amount invested generates 20 percent of its value in increased revenues.

*Discussion.* Illustration 3 builds upon Illustrations 1 & 2 to demonstrate the relative economic power a nonprofit hospital yields over its for-profit counterparts over time. This chart illustrates how a roughly equivalent nonprofit entity can outpace a for-profit entity as far as financial performance is concerned. As the numbers demonstrate, the nonprofit hospital’s net income is roughly 228 percent greater than the for-profit’s net income by year ten (for comparison, if the for-profit hospital did not pay dividends, the nonprofit hospital’s net income would have been roughly 82 percent greater than that of the for-profit hospital by year ten). It is important to note that both began with an initial \$20,000 worth of capital. Nonprofit hospitals yield significant advantages over their for-profit counterparts in the form of tax savings as well as not providing any direct financial return to charitable donors. Without these factors, the results for both hospitals would have been identical.

#### B. Nonprofit Hospitals’ Competitive Advantages Provide Corresponding Societal Benefits

These benefits to nonprofit hospitals are not without a corresponding benefit to society. In a recent report published by the Congressional Budget Office, “nonprofit hospitals provided higher levels of uncompensated care than did otherwise similar for-profit hospitals.”<sup>150</sup> Further, nonprofit hospitals were more likely than for-profit hospitals to provide specialized healthcare services.<sup>151</sup> However, nonprofit hospitals provided care to fewer Medicaid-covered patients as a proportion of total admitted patients than their for-profit counterparts.<sup>152</sup> Nevertheless, the more affluent locales of nonprofit hospitals may have played an important role in this finding.<sup>153</sup>

Due to the relatively lower cost of capital, nonprofit hospitals are able to take on projects and ventures that for-profit institutions would

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<sup>150</sup> CONG. BUDGET OFFICE, *supra* note 21, at 1.

<sup>151</sup> *Id.*

<sup>152</sup> *Id.*

<sup>153</sup> *See id.*

not be able to undertake.<sup>154</sup> Nonprofit hospitals may invest in projects that yield a lower rate of return than for-profit hospitals because nonprofit hospitals enjoy a lower cost of capital. While a nonprofit hospital can reinvest revenues in excess of cost back into its operations, for-profit hospitals must provide their investors a return through dividends or capital gains (which can also mean reinvesting capital into the hospital in order to expand the business, increase profitability, and drive up the share price).<sup>155</sup>

For example, imagine the two fictitious hospitals in Illustration 1 are approached with a piece of equipment, such as an improved MRI machine. After analysis, the hospitals find this machine will provide each of them with an estimated 4 percent return. Based on their respective WACC's, 3 percent (nonprofit hospital) and 9 percent (for-profit hospital), only the nonprofit hospital actually has a decision to make. The for-profit hospital would probably not purchase this equipment because it does not promise a return in excess of its WACC of 9 percent. However, the WACC of the nonprofit is only 3 percent, so the nonprofit actually will make money on this endeavor.

While one may draw many parallels between nonprofit and for-profit hospitals, there is an important difference between the two. For nonprofit hospitals, "no part of net earnings [may] inure[ ] to the benefit of any private shareholder or individual."<sup>156</sup> The embodiment of this ideal is the private inurement doctrine.<sup>157</sup>

### C. Hospitals Ought Not to Be the Last Stand On Healthcare

Another issue that has fueled the debate more recently is the healthcare reform undertaken by Congress and the Obama Administration.<sup>158</sup> For decades, lawmakers have attempted to create a better healthcare system through legislation and government programs.<sup>159</sup> A

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<sup>154</sup> See Reinhardt, *supra* note 133, at 179-84.

<sup>155</sup> See *id.*

<sup>156</sup> I.R.C. § 501(c)(3) (West 2010); see also *Inurement/Private Benefit - Charitable Organizations*, INTERNAL REVENUE SERV., <http://www.irs.gov/charities/charitable/article/0,,id=123297,00.html> (last updated Nov. 2, 2010).

<sup>157</sup> HYATT & HOPKINS, *supra* note 12, at 6.

<sup>158</sup> See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). The recently enacted Patient Protection and Affordable Care Act is discussed below, *infra* Part IV.D, in light of the standard proposed in this Note.

<sup>159</sup> See STEVENS, *supra* note 31, at 352. This imperfection in the healthcare system is what has sparked the current and ongoing debate on the creation of universal healthcare in the United States. Steffie Woolhandler & David U. Himmelstein, *Paying for National Health Insurance—And Not Getting It*, HEALTH AFF., July-Aug. 2002, at 88.

major problem with the healthcare system is that it is neither universal nor integrated, resulting in high costs without corresponding social benefits.<sup>160</sup> Further exacerbating the imperfection of the system is the growing poverty rate and number of uninsured Americans—currently over forty-six million Americans are without healthcare insurance.<sup>161</sup>

This inefficiency causes public outrage. But who is culpable? The United States hospital system currently operates with significant government subsidies created by the Medicare and Medicaid publicly-funded insurance systems. These government providers and other third-party insurance providers, combined with hospital emergency care,<sup>162</sup> create a patchwork national health system. Yet one problem with relying on hospitals to provide for the uninsured in the current regulatory environment is that most charity care provided to the poor or uninsured is emergency room care.

Hospitals became the last line of defense through the Emergency Medical Treatment and Active Labor Act (EMTALA).<sup>163</sup> This Act requires hospitals to provide emergency treatment to anyone—regardless of insurance, ability to pay, or citizenship status.<sup>164</sup> EMTALA dictates that uninsured persons who require emergency care are entitled to: (1) screening; (2) emergency treatment and care; and (3) appropriate transfers.<sup>165</sup> However, this Act falls short of providing comprehensive care to the uninsured by any measure—it is limited to emergency care.<sup>166</sup>

A partial solution to the problem of the uninsured is to give hospitals greater incentives to provide more charitable care. Nonprofits generally provided higher levels of charitable care than their for-profit

<sup>160</sup> See STEVENS, *supra* note 31, at 352; Woolhandler & Himmelstein, *supra* note 159, at 90.

<sup>161</sup> INCOME, POVERTY AND HEALTH INSURANCE IN THE UNITED STATES, *supra* note 78, at 20. This number may be overstated because some people included in this statistic are able to afford healthcare insurance but choose not to purchase private insurance. See *id.*; Census Bureau: *Number of Americans Without Health Insurance Rises to 46.3 Million*, N.Y. DAILY NEWS (Sept. 10, 2009), [http://www.nydailynews.com/money/personal\\_finance/2009/09/10/2009-09-10\\_number\\_of\\_americans\\_without\\_health\\_insurance\\_rises\\_to\\_463m.html](http://www.nydailynews.com/money/personal_finance/2009/09/10/2009-09-10_number_of_americans_without_health_insurance_rises_to_463m.html).

<sup>162</sup> This is where emergency room care provided by hospitals creates a “catch all” for uninsured and impoverished patients. Hospitals will treat these people but only to the point at which a patient’s condition no longer requires emergency care. This is a major reason why this is an imperfect system if access to healthcare for all is the goal.

<sup>163</sup> 42 U.S.C. § 1395dd (2006).

<sup>164</sup> *Id.*

<sup>165</sup> *Id.*

<sup>166</sup> *Id.*; EMTALA: Overview, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.hhs.gov/emtala/> (last updated Dec. 23, 2010).

counterparts in spite of the fact that the for-profit hospitals are generally located in areas of lesser affluence.<sup>167</sup> The Service reported that the average amount of health services provided to the uninsured by nonprofit hospitals is approximately 7 percent of revenue.<sup>168</sup> This may be an indication that hospitals are able (and potentially willing) to fulfill their obligation as charitable organizations.

#### D. Elimination of the Hospital Tax-Exemption May Have Perverse Effects

Despite criticisms from various sources, denying the tax exemption to nonprofit hospitals could be disastrous. Long before the enactment of the Sixteenth Amendment, the Supreme Court addressed the power of taxation. In *McCulloch v. Maryland*, it recognized that “[a]n unlimited power to tax involves, necessarily, a power to destroy; because there is a limit beyond which no institution and no property can bear taxation.”<sup>169</sup> One outcome of the denial of the tax exemption could be certain death for some hospitals already operating at an annual financial deficit.<sup>170</sup> Another potential outcome is that hospitals will be increasingly reluctant to accept the fiscal burden of providing the indigent with medical care. Thus, it is imperative that nonprofit hospitals maintain their tax-exempt status to preserve the stability of the hospital system in the United States.

Access to capital is crucial to the fiscal integrity of hospitals.<sup>171</sup> If Congress disqualified nonprofit hospitals as public charities, Congress would effectively remove one of the system’s main sources of capital.<sup>172</sup> Organizations must qualify to receive deductible contributions, as explained in detail in Publication 526.<sup>173</sup> This document describes only five primary classifications of organizations that qualify, among

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<sup>167</sup> CONG. BUDGET OFFICE, *supra* note 21, at 1.

<sup>168</sup> EXEMPT ORGANIZATIONS FINAL REPORT, *supra* note 13, at 47. While the mean and median amount of uncompensated care measured as a percentage of revenue provided fluctuates significantly when comparing one classification of hospital to another, it is important to recognize that uncompensated care is not the only way in which a hospital provides a community benefit.

<sup>169</sup> 17 U.S. 316, 327 (1819).

<sup>170</sup> As discussed *infra* Part III.D., the loss of tax exemption to such hospital that would not likely have a federal tax liability may still have other detrimental repercussions (e.g., loss of the ability to issue tax-exempt bonds, and loss of donations from entities or individuals who will only donate to § 501(c)(3) organizations).

<sup>171</sup> Horwitz, *supra* note 12, at 540.

<sup>172</sup> This assumes in part that the deduction allowed under I.R.C. § 170 will no longer apply to donors of capital to hospitals.

<sup>173</sup> I.R.S. Pub. 526, Charitable Contributions (2010), available at <http://www.irs.gov/pub/irs-pdf/p526.pdf>.

which are charitable corporations (the classification of nonprofit hospitals).<sup>174</sup> Therefore, without qualifying under IRC § 501(c)(3), donors to hospitals could no longer deduct their contributions. This is especially problematic as many private foundations pay out excess funds only to IRC § 501(c)(3) organizations. Thus, if a hospital no longer qualifies as a § 501(c)(3) organization, or a tax-exempt entity, many contributors of capital will simply take their money to another organization.

Currently, nonprofit hospitals' primary sources of capital other than patient billing are donor contributions,<sup>175</sup> governmental and private foundation funding,<sup>176</sup> the issuance of tax-exempt bonds, and financial relief received from tax exemption.<sup>177</sup> The removal of the exemption from numerous hospitals at once would create an instant shortage of available capital. The resulting consequences would be a potentially dramatic shift in the demand curve of capital.

Former tax-exempt hospitals would now have to compete with for-profit hospitals for investor money, creating a shift in demand. A shift in demand occurs when the quantity of capital demanded at every given price point increases,<sup>178</sup> while the supply of capital remains relatively constant. An example analogous to this situation occurs when disease or frost destroys a particular crop in a geographic region of the United States. For instance, if strawberry crops are destroyed in Pennsylvania, Pennsylvania buyers of strawberries would likely demand strawberries from surrounding states. This increased demand on other states, while the growers in those states supply the same amount of strawberries, causes prices to increase. Likewise, the increased demand of capital causes the overall cost of that capital to increase because investors can now demand a greater return.<sup>179</sup>

<sup>174</sup> *Id.* These organizations correspond to the organizations qualifying under I.R.C. § 501(c).

<sup>175</sup> These donor contributions are tax deductible by the contributor under I.R.C. § 170.

<sup>176</sup> Hospitals are more likely to receive funding from these sources if they retain their public charity status because of mandatory payouts.

<sup>177</sup> See Horwitz, *supra* note 12, at 540-41.

<sup>178</sup> I make this assertion because disallowing tax-exempt status to nonprofit hospitals would cause them to seek capital from investors (as opposed to donors) and compete with for-profit hospitals that are already demanding capital.

<sup>179</sup> A somewhat attenuated but relevant example is the mortgage industry and the speed at which mortgages were originated in the past decade before the housing crash that occurred in August of 2007. This resulted in a greater percentage of the population owning their homes than at any other time in recent history. See Dirk van Dijk, *U.S. Home Ownership Rates Continue to Fall*, SEEKING ALPHA (Feb. 2, 2010), <http://seekingalpha.com/article/186097-u-s-home-ownership-rates-continue-to-fall> (discussing that home ownership rates rose from 63 percent in 1965 to over 69 per-



Conversely, for-profit hospitals raise their capital in many ways that are not available to nonprofit hospitals.<sup>180</sup> Most important among the advantages is the issuance of stock and its purchase by investors who hope to receive a return on investment through gain in the price per share or dividends.<sup>181</sup>

Despite criticism, when nonprofit hospitals earn revenues in excess of expenses and achieve profitability, the public benefits. A profit indicates that a hospital is efficiently utilizing the capital expenditures and projects undertaken by it. To elaborate, a hospital expends capital when it purchases buildings, medical equipment and supplies, and hires employees. All of these items cost money to maintain or employ. If a hospital cannot cover its expenses, these resources are not in high enough demand by the patient population to cover the cost of supplying or owning them.<sup>182</sup> For example, if a piece of equipment costs \$1,000 and it is only used once per year by a hospital for a fee of twenty dollars, this is not an efficient investment of capital. However, if another hospital in a different location realizes that there is demand for the \$1,000 piece of equipment, purchases it, and uses it hundreds of times per year for the same fee per use, that would be an efficient use of the same capital. Further, a profitable hospital will have resources necessary to expand, to retain a competent staff and suitable equipment, and to purchase new medical technology. Part IV, *infra*, will tie this notion of profitability back into benefits provided to the community.

When a hospital cannot earn enough revenue to continue operating and has to close, society suffers. Because of the large amount of money that goes to healthcare in the United States (approximately

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cent in 2004); see also *Historical Census Housing Tables*, U.S. CENSUS BUREAU, <http://www.census.gov/hhes/www/housing/census/historic/owner.html> (last updated Dec. 2, 2004). As soon as capital stopped flowing into this market, the mortgage market collapsed almost overnight. A complete overhaul of the rules governing a hospital's access to capital would likely result in a similar crash with only the strongest hospitals surviving. Unlike home ownership, where the rental market is an adequate substitute, the closing of hospitals would cause a supply shortage and potentially lead to a spike in healthcare costs because many healthcare services are completely hospital-oriented.

<sup>180</sup> As discussed above, nonprofit hospitals are not allowed to inure a benefit to individuals because of their relationship or interest in the hospital. See *supra* Part I.D.3.

<sup>181</sup> See Horwitz, *supra* note 12, at 540-41.

<sup>182</sup> Hospitals providing free care obviously do not receive any income but incur expenses. In order to effectively evaluate whether the hospital is efficiently utilizing its resources, the hospital should account for the free service at the usual and customary rate for the free service(s) rendered.

\$2.2 trillion),<sup>183</sup> we have demanded efficiency for some time.<sup>184</sup> Once hospitals have pushed towards efficiency, the government should not disrupt something as fundamental as the rules concerning how these hospitals finance their activities by revoking the tax exemption. This demand for efficiency is one reason why for-profit and nonprofit hospitals have begun to look more and more alike.<sup>185</sup>

While many critics look only at the amount of free and uncompensated services given by hospitals to the uninsured, many other types of community benefits are provided by nonprofit hospitals. Besides uncompensated care, hospitals provide medical education and training, medical research, lectures, seminars and training to the public, medical screenings, community newsletters and other publications, immunization programs, and research concerning unmet health-care needs.<sup>186</sup>

Additionally, some hospitals exist primarily to provide necessary healthcare access to rural areas.<sup>187</sup> This group of hospitals, considered critical access hospitals (CAHs), is the most likely type of hospital to operate at a deficit according to the IRS's Hospital Compliance Project Final Report.<sup>188</sup> These hospitals maintain no more than twenty-five inpatient beds.<sup>189</sup> Without these hospitals, people residing in these more remote areas could potentially be without access to critical care when they need it most.<sup>190</sup> These hospitals are important because they are essential to providing basic life-saving care to those who do not live in close proximity to a larger hospital facility.

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<sup>183</sup> Parija B. Kavilanz, *Health Care's Six Money-Wasting Problems*, YAHOO! FINANCE (Aug. 10, 2009), <http://finance.yahoo.com/insurance/article/107498/health-care-six-money-wasting-problems.html?mod=insurance-health>.

<sup>184</sup> See, e.g., Thomas Boyle, *Intersection of Tax-Exemption and Fraud and Abuse Issues: Pitt Health Law Certificate Program 10th Anniversary Symposium February 5, 2007*, 2 PITT. J. ENV'TL. & PUB. HEALTH L. 73, 74 (2007).

<sup>185</sup> *Id.*

<sup>186</sup> EXEMPT ORGANIZATIONS FINAL REPORT, *supra* note 13, at 45.

<sup>187</sup> *Id.* at 14, 17-18.

<sup>188</sup> See *id.* at 9 ("CAHs and the smallest hospitals had the highest percentage of hospitals reporting a deficit.").

<sup>189</sup> *Id.* at 14.

<sup>190</sup> *Id.* Among the requirements for CAHs are that they are located in a rural area (or an area treated as rural) and more than thirty-five miles away from the next nearest hospital facility. *Id.*

#### IV. A NEW PROPOSAL FOR NONPROFIT HOSPITAL TAX-EXEMPT STATUS QUALIFICATION: THE MEASURED COMMUNITY BENEFIT STANDARD

During testimony before the House Committee on Ways and Means, Professor John Colombo noted, “the main problem with the [community benefit] standard is that it lacks accountability.”<sup>191</sup> He proceeded to call the current community benefit standard the “trust me” approach.<sup>192</sup> Mr. Colombo then made several suggestions, including to move to a strict charity care standard,<sup>193</sup> and to improve hospital behavior by making hospitals more accountable.<sup>194</sup> If one were to combine Mr. Colombo’s ideas to create a *measurable* community benefit standard (hereinafter “MCBS”), one could then determine which hospitals qualify for tax exemptions in multiple ways and ultimately achieve better results for the public. Thus, this Note proposes a shift to a MCBS.

The community benefit standard, despite its name, does not provide a definitive standard governing classification as a nonprofit hospital.<sup>195</sup> This standard also does not provide a basis for differentiation between the behaviors and activities of nonprofit and for-profit institutions.<sup>196</sup> For example, nonprofit and for-profit hospitals both may have a community board, open medical staffing, provisions for some level of free service, and care for Medicare/Medicaid patients.<sup>197</sup> These items alone do not justify a tax exemption.

A few recent developments may help facilitate the creation of a new standard, such as a MCBS. One development is the information gathered by the IRS Exempt Organizations Hospital Compliance Project Final Report (hereinafter the “Exempt Organizations Report”).<sup>198</sup> Another development is the revision of Form 990, which sets up a required and standardized method for all nonprofit hospitals

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<sup>191</sup> *The Tax-Exempt Hospital Sector: Hearing Before the H. Comm. on Ways and Means*, 109th Cong. 88 (2005) (statement of John Colombo, Professor, University of Illinois College of Law).

<sup>192</sup> *Id.* at 90.

<sup>193</sup> *Id.* This would mean a strict measureable standard and minimum dictated threshold of required charity services provided by each nonprofit hospital. *Id.*

<sup>194</sup> *Id.* at 91. Mr. Colombo actually called this “Replacing Community Benefit with a More Accountable Standard.” *Id.*

<sup>195</sup> See HYATT & HOPKINS, *supra* note 12, 166-77 (discussing the community benefit standard through commentaries, court rulings, and IRS guidance); see also CONG. BUDGET OFFICE, *supra* note 21, at 4-5.

<sup>196</sup> See CONG. BUDGET OFFICE, *supra* note 21, at 8-9, 12-20.

<sup>197</sup> *The Tax Exempt Hospital Sector*, *supra* note 191, at 88.

<sup>198</sup> EXEMPT ORGANIZATIONS FINAL REPORT, *supra* note 13.

to report financial information.<sup>199</sup> First, this Part will discuss the Exempt Organizations Report, and then explain the significance of Form 990.

#### A. What Can Be Learned From the IRS Exempt Organizations Hospital Compliance Final Report

The Exempt Organizations Report highlights several items that require attention when considering changes to the standard and increasing accountability. Among the most important findings were that:

- (1) a lack of conformity in community benefit reporting from hospital to hospital (some hospitals underreported benefits);
- (2) the potential marked effect of any revisions to the standard between types of hospitals because of the various types, locations, and sizes of hospitals (i.e., if a revised standard only permitted exemption through a narrow set of activities, certain hospitals would either have difficulty or be precluded from qualifying due to the entity's characteristics and location);
- (3) a significant percentage of hospitals would presently fail to satisfy an exemption based on providing at least 3 percent of expenditures or at least 5 percent of revenues in community benefits;
- (4) hospital financial capacities differ significantly based on factors such as locale, size, and community demographics;
- (5) deficits generally decreased as overall revenue increased; and
- (6) critical access hospitals (CAHs)—those that are smaller in size and located in areas of low population—had lower profit margins.<sup>200</sup>

Based on these findings, there are two essential factors to consider when tailoring a standard: a hospital's relative size, and its location. Many hospitals in rural areas would be forced to close their doors if they lost their tax exemption. In addition, some hospitals would not be able to provide any public benefit beyond their continued existence as

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<sup>199</sup> IRS Form 990, Return of Organization Exempt From Income Tax (OMB No. 1545-0047) (2010), available at <http://www.irs.gov/pub/irs-pdf/f990.pdf>.

<sup>200</sup> EXEMPT ORGANIZATIONS FINAL REPORT, *supra* note 13, at 169-71.

they already are operating at a deficit or taking in a relatively low amount of excess revenue.<sup>201</sup> In fact, according to the IRS's latest study, 34% of CAHs<sup>202</sup> had expenses in excess of revenues (hereinafter "operating losses").<sup>203</sup> This suggests that many of these CAHs lack the means to continue to operate without the benefits of tax exemption.<sup>204</sup> Furthermore, the for-profit sector is unlikely to find that running CAHs makes economic sense, as they simply are not profitable. This could effectively deprive many rural areas of acute care.

Therefore, it is important that the MCBS incorporate a lower standard for hospitals with relatively low revenue amounts, as well as CAHs. This would greatly reduce the compliance and administrative burdens for these resource-poor hospital classes. Hospitals exempt from the MCBS standard would still be subject to the community benefit standard to maintain their exempt status.<sup>205</sup> Twenty-five million dollars or less is a reasonable annual revenue threshold at which to exempt nonprofit hospitals categorically—this class made up only 17% of the sampled hospitals and less than 1% of total nonprofit hospital revenues.<sup>206</sup> An additional exemption should exist for entities already operating at a deficit regardless of their revenue size because of their lack of capacity.<sup>207</sup>

## B. Community Benefits Under the MCBS

First, any change to the community benefit standard implemented by the MCBS should provide certain guidance as to what activities qualify as a community benefit. These benefits must be explained along with the measurable community benefit that each hospital must

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<sup>201</sup> *Id.* at 9, 167.

<sup>202</sup> *Id.* at 9.

<sup>203</sup> *Id.*

<sup>204</sup> This statement refers to the CAHs whose revenues only exceed their expenses marginally. For these hospitals, additional financial burdens would likely cause some to close, as 32% of CAHs had revenue excesses of less than 5% of total revenue. *Id.* at 32.

<sup>205</sup> See Rev. Rul. 69-545, 1969-2 C.B. 117.

<sup>206</sup> Of a sample of 488 hospitals, approximately 17% of hospitals had revenues less than \$25 million. EXEMPT ORGANIZATIONS FINAL REPORT, *supra* note 13, at 14. This threshold would eliminate hospitals that would have the least impact in terms of economic value of community benefit provided. However, these hospitals could still lose their exemption based upon the community benefit standard. Additionally, eliminating this class of hospitals from the MCBS would reduce the governmental burden where the marginal gain in potential community benefits from imposing the MCBS is relatively high in comparison to the relative benefit derived.

<sup>207</sup> This exemption would expire in the first year in which the hospital operated at a profit and the hospital would then fall subject to the MCBS given had the requisite revenue amount for the respective tax year.

provide to its community or society at large. The requisite amount should be a percentage of either total revenue or total expenses. Nevertheless, the most abundant data collected in recent years relates community benefit expenditures to percentages of total revenue.<sup>208</sup> One of the findings of the Exempt Organizations Report was that, generally, the greater the revenue, the greater the hospital's profitability.<sup>209</sup> And the more profitable the hospital, the more a hospital benefits from its tax-exempt status. Despite this finding, there was not a perfect correlation between revenue size and profitability due to variations in hospital type and location.<sup>210</sup> Therefore, a progressive system utilizing gross revenue as a basis for calculating how much community benefit a hospital must provide may overreach and harm hospitals without further research.

Borrowing from the current tax rules governing tax-favored activities, the provision or undertaking of any of the following would result in a measurable community benefit under the MCBS:<sup>211</sup>

- Medical research expenditures (hospital-funded and not funded through governmental grants);
- Medical education (practitioner-related);
- The provision of any medical services for free or below cost to persons who are impoverished or have low incomes (these non-emergency-room related services will be recorded at the reasonable and customary rate);<sup>212</sup>
- Emergency room services and any services required by the Emergency Medical Treatment and Active Labor Act (EMTALA) (reported at cost, including overhead, but not recorded at the reasonable and customary amount<sup>213</sup>);

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<sup>208</sup> See CONG. BUDGET OFFICE, *supra* note 21, at 8-9; EXEMPT ORGANIZATIONS FINAL REPORT, *supra* note 13, at 6.

<sup>209</sup> EXEMPT ORGANIZATIONS FINAL REPORT, *supra* note 13, at 9, 22-27.

<sup>210</sup> See *id.* at 169.

<sup>211</sup> This is not intended to be an all-inclusive list of qualifying expenditures or provided benefits.

<sup>212</sup> This would include free screenings, rehabilitative treatment, preventative care, and services designed to treat uninsured and underinsured patients. Some of these services are already provided by hospitals.

<sup>213</sup> The phrase "reasonable and customary" is typically associated with the amount that an insurer will pay for a medical procedure, based upon what is deemed as within the normal range of fees for a specified procedure and not what a specific practitioner or health care provider is charging a patient. See Michael Bihari, *Reasonable and Customary Fee*, ABOUT.COM,

- The provision of typically unprofitable medical services below cost (e.g., specialized services covering rare diseases, AIDS treatments)—the discount, or difference between the cost of providing the services and the amount paid, would be reported;
- Expenditures related to improving access to healthcare, such as free clinics, preventative screenings, and other preventative care (reported at reasonable and customary rate);
- Expenditures related to the education of the public on healthcare matters; and
- Donations to community charities.

As part of the qualifying process, the nonprofit hospital would report some of the services listed at the reasonable and customary rate (or full retail price)<sup>214</sup> to the IRS when completing Form 990.<sup>215</sup> The services that qualify for reporting to the IRS at the full retail rate are those that the hospital is not already legally obligated to provide under EMTALA.<sup>216</sup> However, community education programs and similar activities would simply be reported at cost when calculating the total community benefit provided. Services that *all* hospitals must provide to nonpaying patients are recorded at their cost. This would be known as the for-profit activity presumption. That is, any activity that could be regarded as charitable and is generally undertaken by for-profit entities would be recorded at cost to the hospital under the MCBS. This provides nonprofit hospitals with a greater incentive to provide more preventative and rehabilitative services to people who are unable to afford them.

Although the collection of this information may initially seem administratively burdensome, the IRS has already requested similar information from hospitals in Form 990, starting in 2008.<sup>217</sup> Therefore, the collection of information will not substantially change nonprofit hospital reporting requirements. The significant difference will

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<http://healthinsurance.about.com/od/healthinsurancetermsr/g/Reasonable-And-Customary-Fee.htm> (last updated Aug. 3, 2010).

<sup>214</sup> Another alternative proposition for valuation would be the average amount paid by third-party insurance providers for the respective service within the region. This valuation methodology would provide a built-in check against price gouging practices and improve uniformity in reporting.

<sup>215</sup> Form 990 is referenced in the MCBS proposal because it is an already implemented form. See *supra* notes 88 through 90 and accompanying text.

<sup>216</sup> See 42 U.S.C. § 1395dd (2006).

<sup>217</sup> EXEMPT ORGANIZATIONS FINAL REPORT, *supra* note 13, at 147.

be how the information is used. With modifications to Form 990, hospitals would have a simple and standardized method of reporting various community benefits and metrics to the government and the public. After the IRS collects the information provided by hospitals in Form 990, the data should be maintained in a database and easily accessible to the public for inspection. This would enhance comparability and accountability among hospitals.

### C. Which Hospitals Fall Subject to (or are Exempt from) the MCBS?

The MCBS should initially be a flat benefit system, meaning that the level of benefit a qualifying hospital must provide to the community remains commensurate with its increases or decreases in revenue. The issue that then remains is determining what level of flat benefit is reasonable to impose upon tax-exempt hospitals in order to qualify for tax-exemption.

For all nonprofit hospitals, excess revenues (or profits) as a percentage of total revenue were 4.6%.<sup>218</sup> The flaw with this figure as it applies to this analysis is that there is insufficient data to remove the impact of community benefits provided before the hospitals reached this figure (i.e., hospitals have already deducted expenses incurred from providing community benefits). What is inferable from the excess revenue figure is that hospitals have capacity to provide additional community benefits. This proposal does not suggest that hospitals cannot keep any excesses for purposes other than providing community benefits; it merely suggests that a reasonable threshold will not adversely impact the financial viability of hospitals. In fact, many hospitals will greatly exceed the floor envisioned by the MCBS and would be able to adopt the MCBS with ease.<sup>219</sup>

In the Exempt Organizations Report, the average total community benefit provided by all hospitals was 9.18% of revenue, while the median was 5.5% of revenue. Additionally, the hospitals' mean and median percentages of revenue providing for uncompensated care were 7.21% and 3.88%, respectively.<sup>220</sup> This demonstrates that certain nonprofit hospitals are undertaking a majority of the community bene-

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<sup>218</sup> *Id.* at 32.

<sup>219</sup> The average amount of community benefit provided by all hospitals was 9.18% of revenue while the median was 5.50% of revenue. These percentages are deflated by the inclusion of CAHs, which had respective averages of 6.33% and 2.84%. *See id.* at 60. The disparity between the mean and median percentages indicates that a small percentage of hospitals are providing the majority of community benefits.

<sup>220</sup> *Id.*



fit burdens while all nonprofit hospitals benefit from the tax exemption.

There are additional indications that nonprofit hospitals can provide more services for the public. For example, governmental hospitals dedicated an average of 13% of operating expenses to the provision of uncompensated care.<sup>221</sup> Conversely, nonprofit hospitals allocated 4.7% and for-profit hospitals allocated 4.2% of operating expenses to the provision of uncompensated care.<sup>222</sup> This figure shows that the overall charitable behavior of nonprofit hospitals currently more closely resembles that of for-profit entities than that of the government. This conflicts with many of the rationales for hospital tax exemption. By combining this information with the data from the Exempt Organizations Report, one can conclude that the total community benefit provided by nonprofit hospitals pales in comparison to that provided by governmental hospitals.

After analysis of the IRS's sample of hospitals, the following application of the MCBS is reasonable:

#### Section 1. Hospitals Exempt from the MCBS

- a. qualify as CAHs;<sup>223</sup>
- b. have gross revenues less than \$25 million; or<sup>224</sup>

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<sup>221</sup> CONG. BUDGET OFFICE, *supra* note 21, at 18 fig. 1.

<sup>222</sup> *Id.*

<sup>223</sup> Critical Access Hospitals (CAHs) are designated by the state as such and also are located more than a thirty-five mile drive from another hospital and maintain no more than twenty-five inpatient beds (among other qualifying criteria). *Critical Access Hospitals, CTRS. FOR MEDICARE & MEDICAID SERVS.*, [http://www.cms.hhs.gov/CertificationandCompliance/04\\_CAHs.asp](http://www.cms.hhs.gov/CertificationandCompliance/04_CAHs.asp) (last updated Nov. 29, 2010). CAHs consistently were the least profitable hospital type according to the IRS Exempt Organizations Hospital Compliance Final Report and had the greatest percentage of hospitals whose expenses were in excess of revenues—over one-third of this class had expenses in excess of revenue. EXEMPT ORGANIZATIONS FINAL REPORT, *supra* note 13, at 28. Therefore, it is not reasonable to include entities that would not likely have the resources to follow a more stringent rule of tax-exempt qualification. These organizations contribute to society simply by their existence and providing access to healthcare to those in remote locations—although many provide additional community benefits. *Id.* at 22-32, 39-40.

<sup>224</sup> Hospitals in this revenue class have less excess capital in which to use to benefit the community. These hospitals had an average of \$300,000 of excess revenue. Further, the aggregate revenue collected by these institutions was only 1% of total revenue reported across all hospital classes in the sample collected by the IRS. The additional administrative burdens would likely outweigh any additional benefit derived from holding such hospitals to the MCBS. See EXEMPT ORGANIZATIONS FINAL REPORT, *supra* note 13, at 22-27.

c. have expenses in excess of revenues including expenses arising from charitable activities.<sup>225</sup>

For all other nonprofit hospitals, the following provision of community benefits applies under the MCBS:

### Section 2. Minimum Provision of Community Benefits

a. To qualify for tax-emption, nonprofit hospitals must dedicate 7% of gross revenue to community benefit expenditures, including charitable (uncompensated) care;<sup>226</sup>

b. At least 50% of the community benefit expenditures under the minimum provided for by Section 2.a. must be spent on charitable care, subject to Section 2.c.

c. Amounts in Excess. For community benefits under Section 2.a. in excess of 7% of gross revenue, the amount in excess may be provided to the benefit of the community without regard to the 50% charitable care limitation under Section 2.b.

To safeguard against overburdening hospitals where revenues do not significantly exceed expenses, the following limitations to Section 2 apply:

### Section 3. Limitations

a. Hospitals whose compliance with Section II.a. would cause expenses to exceed revenue must comply with this standard to the extent of its financial ability without regard to the charitable care limitation of Section 2.b. All community benefits provided must be recorded at cost and not at any preferential rate that

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<sup>225</sup> These institutions are already overburdened. Thus, it does not make sense for these institutions to even undertake the burden of reporting results under the MCBS. This represented 21% of the IRS's surveyed hospitals. However, there is overlap between these hospitals and CAHs reporting expenses in excess of revenues. *See id.* at 27.

<sup>226</sup> Based upon the studies reviewed within this Note, 7% is a conservative figure. Furthermore, several studies indicate that governmental hospitals provide greater levels of charitable care to their communities. *See, e.g., id.* at 4, 18-20 (discussing prior studies' findings, and also finding that, on average, hospitals provided 7% of revenues in uncompensated care alone).

the hospital would be entitled for services if the hospital were able to comply with Section 2 in its entirety. “Extent of financial ability” is defined by Section 3.b.

b. Extent of financial ability—the extent of financial ability is satisfied if a hospital provides at least 50 percent of its earnings in excess of revenue for the purpose proscribed.

#### Section 4. Exempt Hospitals

All hospitals exempt under Section 1 must comply with the community benefit standard created by Revenue Ruling 69-545.

The minimum thresholds in this proposal should be reasonable and conservative in light of several aspects that the proposed iteration of the MCBS incorporates.

- Nonprofits hospitals will receive credit for several services, not at the amount it costs to provide the service, but rather at the reasonable and customary amount (full retail it would charge to paying customers). All other figures listed throughout this Note were based on the cost, not the retail price. Therefore, this builds in a cushion for hospitals.
- 7% of gross income is 23% less than the average amount hospitals currently contribute (i.e., it will only impact the hospitals not providing a fair contribution of community benefit).
- The majority of hospitals have revenues in excess of expenses.<sup>227</sup>
- The proposed MCBS has built-in safeguards to ensure the financial viability of nonprofit hospitals in Section 3.
- Section 2 of the proposed MCBS provides flexibility that is necessary because of the diversity of hospital types as well as the varying needs of the localities in which hospitals are located. The maximum required charitable care any hospital would have to provide is 3.5% of gross revenue.

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<sup>227</sup> Of all nonprofit hospitals surveyed, 21% had expenses exceeding revenue. *Id.* at 27.

Finally, hospitals must be at risk of losing their tax-exempt status if they choose to simply increase their expenses in order to avoid being subject to the MCBS (in part or whole). Thus, some sort of bad faith provision should be either implied or explicitly contained within the MCBS. The MCBS should favor and incentivize both hospital efficiency as well as the provision of community benefits.

#### D. Considerations for the Patient Protection and Affordable Care Act

The recently enacted Patient Protection and Affordable Care Act (PPACA) greatly influences the future matrix in which hospitals operate.<sup>228</sup> Among the Act's sections are provisions that affect patient insurance, hospital reporting requirements, charitable status review intervals, and community needs assessments.<sup>229</sup> Nevertheless, because the individual mandate<sup>230</sup> of PPACA does not come into effect until 2014,<sup>231</sup> a significant portion of PPACA's impact on reducing the uninsured patients will remain unknown for some time.

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<sup>228</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). PPACA was enacted into law on March 23, 2010. Note that PPACA does not come into full effect at its inception.

<sup>229</sup> Title I (patient insurance) and Section 9007 (charitable status review intervals and community needs assessments) of PPACA primarily cover these provisions. *Id.*

<sup>230</sup> The so-called "individual mandate" is the requirement under PPACA that "every individual either buy health insurance or pay a fine." Steve Chapman, *A Conservative Defense of ObamaCare*, CHI. TRIBUNE, Apr. 17, 2011, at 23, available at [http://articles.chicagotribune.com/2011-04-17/news/ct-oped-0417-chapman-20110417\\_1\\_individual-mandate-obamacare-health-insurance](http://articles.chicagotribune.com/2011-04-17/news/ct-oped-0417-chapman-20110417_1_individual-mandate-obamacare-health-insurance).

<sup>231</sup> § 1501, 124 Stat. 119, 842-49 (to be codified at 26 U.S.C. § 5000A). Many other provisions of the PPACA will also have a considerable impact on the U.S. healthcare system but will not be discussed within this Note. At the time of this publication, there has been much congressional opposition to PPACA, which may result in the repeal of some relevant provisions or the entire statute. See Felicia Sonmez, *Boehner: Budget Office "Entitled to Their Opinion" on Health Care Repeal's Deficit Impact*, WASH. POST (Jan. 6, 2011, 3:40pm), <http://voices.washingtonpost.com/44/2011/01/boehner-budget-office-entitled.html> (indicating that the 112th Congress may work to repeal the PPACA). There is also much discussion over litigation to repeal the PPACA through litigation. See generally Glenn Adams, *Maine to Challenge Federal Health Care Law*, ASSOCIATED PRESS, Jan. 11, 2011, available at <http://www.bloomberg.com/news/2011-01-11/maine-to-challenge-federal-health-care-law.html>; Aly Van Dyke, *Kansas, Missouri Political Forces Begin Pushing Back on Health Care Reform*, KAN. CITY BUS. J. (Jan. 12, 2011), <http://www.bizjournals.com/kansascity/news/2011/01/12/kansas-missouri-health-care-reform.html>; Russ Ferguson, *Healthcare Reform Opponent May Rue a Victory*, CBS NEWS (Jan. 16, 2011),

While PPACA will undoubtedly affect how a hospital would implement the MCBS proposed in this article, PPACA only further supports the proposition advanced by this Note—that the current community benefit standard needs reform. The broad impetus for reform created by PPACA is two-pronged and briefly discussed in the immediately following subpart. The subpart following that, Part IV.D.2., briefly highlights some of the additions to IRC § 501 that change enforcement and requirements for nonprofit hospitals.

### 1. Reduction in the Uninsured and Augmentation of the “Nonprofit” Hospital Debate

PPACA greatly reduces the number of uninsured Americans—the first prong of reform impetus.<sup>232</sup> As discussed in this Note, the traditional method through which a hospital provided community benefits was free care to the poor.<sup>233</sup> While PPACA largely eliminates much of this traditional “poor” constituency, there will still be approximately fourteen million uninsured Americans, not including illegal aliens, after full implementation of PPACA.<sup>234</sup> PPACA additionally excludes the provision of insurance coverage and additional services to illegal aliens, many of whom will likely continue to receive free hospital care through emergency room service.<sup>235</sup> Thus, while there will still be opportunity for nonprofit hospitals to provide charitable care to the indigent, uninsured, and underinsured, hospitals will have to find new ways in which to provide a community benefit. The provision of free care through emergency services and so-called reactive care<sup>236</sup> may no longer be adequate to achieve the nonprofit hospital’s end of the tax exemption bargain.

Thus, while the MCBS still encourages free care to the poor, it also incentivizes hospitals to provide greater levels of preventative or proactive care.<sup>237</sup> These incentives seem to be missing from the current community benefit standard, at least in practice. Without the

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<http://www.cbsnews.com/stories/2011/01/16/sunday/commentaries/main7251883.shtml>.

<sup>232</sup> See Jessica Wilen Berg, *What is Left of Charity Care After Health Reform?*, HASTINGS CTR. REP., Jul.-Aug. 2010, at 12, 12.

<sup>233</sup> See discussion *supra* Parts I.A. and I.D.

<sup>234</sup> See Berg, *supra* note 232.

<sup>235</sup> See *id.*

<sup>236</sup> See Janice L. Clarke, *Preventive Medicine: A Ready Solution for a Health Care System in Crisis*, 13 POPULATION HEALTH MGMT. S-3, S-5 (2010) (discussing the traditional model of health care in the United States with a reactive care focus).

<sup>237</sup> Several commentators have discussed the past and present state of our health care system, as well as the benefits of moving to a proactive/preventative care model. See, e.g., *id.*

proper incentives to care for patients on a proactive basis, it is likely that we will continue to see merely more of the same reactive care and no new radical change in the way that medicine is practiced in the United States. Reform to the community benefit standard could be the force that causes hospitals to once again change the way in which we view and deliver our healthcare.<sup>238</sup>

If legislators and regulators do not adequately address the underlying issue, nonprofit hospitals will inevitably come under greater scrutiny than ever before.<sup>239</sup> This is the second prong of reform impetus—PPACA further reducing the uninsured population. It seems that the greatest criticism of nonprofit hospitals stems from the perception that hospitals receive more than they give in return.<sup>240</sup> By the time PPACA comes into full effect, this discussion will likely intensify. Even without new regulation or legislation, hospitals could voluntarily begin to comply with a system similar to the MCBS that addresses the concerns of transparency, fairness, and the provisions of benefits to the community. This would be a proactive approach to stave off criticism. However, hospitals are only likely to adopt such policies if they are adopted by a critical mass of participants and enforced by the industry. Thus, such reform is unlikely in the absence of legislation. In addition, hospitals are less likely to report unflattering accounts of their operations without some form of independent oversight.

## 2. Amendment to the Tax-Exempt Status Section of the Code (IRC § 501)

As part of the PPACA's package, legislators added provisions to the IRC to address some of the concerns mentioned above surrounding the nonprofit hospital exemption. Section 9007 of the PPACA amends IRC section 501<sup>241</sup> to add new subsection 501(r).<sup>242</sup> There are several provisions within § 501(r) that affect nonprofit hospitals, namely the addition of several requirements for nonprofit hospitals to qualify as a charity, including:

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<sup>238</sup> See discussion, *supra* Part I.A., discussing how historically most people received care at home, rather than at a medical facility. If the hospitals take a more proactive approach, it may over time lead to patients taking a more active role in their care and patients' healthcare focus could shift from reactive/preventative care to wellness treatment.

<sup>239</sup> See discussion, *supra* Part III., about the ongoing critique of hospitals' nonprofit status.

<sup>240</sup> See *supra* Parts III.A. and B.

<sup>241</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9007, 124 Stat. 119, 855-57 (codified at 26 U.S.C. § 501(r) (2010)).

<sup>242</sup> *Id.*

- meeting the community needs assessment;
- meeting the financial assistance policy requirements;
- limiting the fees charged to individuals for emergency or necessary care who qualify under the financial assistance policy;
- limiting the collection practices of hospitals;
- conducting a community health needs assessment in the current or preceding two tax years; and
- implementing a strategy to meet its community health needs identified through the assessment.<sup>243</sup>

However, the measures included within the PPACA appear to act merely as a band-aid to the problem created by it. Besides *potential* denial of tax-exempt status for failure to comply, these provisions provide little teeth. If a hospital fails to complete its community needs assessment and implementation strategy required under IRC § 501(r)(3), a tax of \$50,000 may be assessed on the organization.<sup>244</sup> Nevertheless, to many of the largest hospitals, the potential negative publicity would far outweigh this seemingly small monetary assessment and, if the hospital's noncompliance is not publicized, render the assessment virtually moot if undiscovered.

PPACA does not modify the community benefit standard, it merely modifies the matrix in which tax-exempt hospitals must operate. While PPACA implements some useful tools that hospitals may use to decide which services to provide based on community needs, such as the community needs assessments, it does little to actually change hospital behavior or provide incentives for fundamental changes. Until the government imposes changes similar to the ones advanced in this Note, we are likely to see much of the same out of our tax-exempt hospitals. Essentially, while Congress increased the burden of these entities, it has given far too vague of a direction to fundamentally change the way the American public views the role of hospitals in the twenty-first century—and certainly nothing parallel to the radical changes seen from the mid-nineteenth through the twentieth centuries. Because the public view is unlikely to shift favorably, tax-exempt hospitals will only increasingly become scrutinized as PPACA comes into full effect.

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<sup>243</sup> *Id.*

<sup>244</sup> § 9007, 124 Stat. 119, 857-59 (to be codified at 26 U.S.C. § 4959).

## CONCLUSION

While the continuation of the tax-exemption for nonprofit hospitals is important to our overall healthcare system, the community benefit standard is far too vague and difficult to enforce. Varying levels of hospital compliance under the community benefit standard has likely left taxpayers shouldering some of the financial burden of continuing the nonprofit tax exemption. Only through improved reporting and the creation of a measurable standard of tax-exempt entity qualification will hospital behavior change.

Nonprofit hospitals have their historical foundations in care for the indigent and should continue to provide care for the disadvantaged. However, the view that hospitals can only provide charitable care to keep up their end of the tax-exemption bargain is outdated because of the diversity of expertise, locale, and size of hospitals in the United States.

The framework of the MCBS advanced in this Note offers a plethora of qualifying services from which a hospital may select to provide benefits to its community and achieve the minimum level of benefit. If the MCBS is implemented, the public would receive greater accountability, higher levels of charitable service, and improvements in the quality and diversity of projects undertaken by the hospitals that can most afford to do so.



