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NONPROFIT HOSPITALS AND THE FEDERAL TAX EXEMPTION: A FRESH PRESCRIPTION

Helena G. Rubinstein[†]

I. INTRODUCTION

THE AMERICAN LAW'S TREATMENT of charity has a long history. Its modern expression derives from the English Statute of Charitable Uses,¹ enacted in 1601, which contained the first extensive definition of charitable purposes. The statute's aim was public benefit, expressed principally by the relief of poverty.² Over time, charitable public benefit was seen as a broad mantle, including not only the relief of poverty, but also advancement of education, religion, and health. This attitude came over to the New World with the colonists,³ and was incorporated into federal⁴ and then state tax

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1. An Act to Redress Misemployment of Lands, Goods and Stocks of Money Heretofore Given to Charitable Uses, 43 Eliz., ch. 4 (Eng. 1601) [hereinafter Statute of Charitable Uses]. In *Commissions for Special Purposes of Income Tax v. Pemsel*, 61 Q.B. 265, 290 (1891) Lord McNaughton analyzes the definitions of charity that were the foundation for the Statute of Charitable Uses. Lord McNaughton states the following:

'Charity' in its legal sense comprises . . . trusts for . . . purposes beneficial to the community. [They] . . . are not the less charitable in the eye of the law, because incidentally they benefit the rich as well as the poor, as indeed, every charity that deserves the name must do either directly or indirectly.

Id. at 290. See also *Bob Jones Univ. v. United States*, 461 U.S. 574, 588 (1983) (quoting Lord McNaughton's opinion from *Commissioner for Special Purposes of Income Tax v. Pemsel*).

2. See GARETH JONES, HISTORY OF THE LAW OF CHARITY 1532-1827, at 26-27 (1969).

3. See generally HOWARD S. MILLER, THE LEGAL FOUNDATIONS OF AMERICAN PHILANTHROPY 1776-1844 (1961) (discussing the English law of charity).

4. Section 501 of the Internal Revenue Code provides exemption from income taxation

codes,⁵ which provide tax exemptions and benefits⁶ to a cer-

for organizations described in subsections (c) or (d) or section 401(a). Subsection (c)(3) includes "[c]orporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary or educational purposes . . ." I.R.C. § 501(c)(3).

5. See generally ALA. CONST. art IV, § 91 (1996) (holding charitable organizations exempt from property taxation); ARIZ. REV. STAT. ANN. § 43-1201 (West 1996) (exempting charitable organizations from property taxation); ARK. CODE ANN. § 26-51-303 (Michie 1987) (exempting charitable nonprofit organizations from property taxation); ALASKA CONST. art. IX, § 4 (1995) (exempting from taxation nonprofit charitable corporations); CAL. REV. & TAX. CODE § 214 (West 1996) (exempting from state taxation property used, organized, and operated exclusively for hospital purposes); COLO. REV. STAT. § 30-3-111.5 (1996) (stating that property used for charitable purposes is exempt from taxes); CONN. GEN. STAT. ANN. § 12-88 (West 1995) (exempting from taxation real property owned by nonprofit charitable institutions); DEL. CODE ANN. tit. IX § 8105 (1996) (exempting from local taxation property owned by nonprofit charitable institutions); D.C. CODE ANN. §§ 29-1002, 47-1802 (1995) (providing property and income tax exemptions for nonprofit charitable institutions); FLA. STAT. ANN. § 196.001 (West 1996) (exempting charitable organizations from taxation); GA. CODE ANN. § 48-5-41 (1996) (exempting nonprofit hospitals' property from taxation); HAW. REV. STAT. ANN. § 246-32 (Michie 1996) (exempting from taxation property owned by a corporation engaged in charity, and organized and operated for such purpose); IDAHO CODE § 63-105K, *repealed* by S.L. 1996, ch. 98 § 1 (effective Jan. 1, 1997); 35 ILL. COMP. STAT. ANN. 5/205 (West 1996) (exempting from taxation property used exclusively for charitable purposes); IND. CODE ANN. § 6-1.1-10-16 (West 1996) (exempting from taxation land and buildings used for charitable purposes); IOWA CODE ANN. § 427.1(9) (West 1995) (exempting charitable organization from property taxation); KAN. CONST. art. XI, § 1 (1995) (exempting charitable institutions from taxation); KY. REV. STAT. ANN. § 136.395 (Banks-Baldwin 1996) (providing an exemption from premium tax); KY. REV. STAT. ANN. § 139.495 (Banks-Baldwin 1996) (extending the exemption from sales tax to resident-nonprofits qualified for the income tax exemption under section 501(c)(3) of the Internal Revenue Code); KY. REV. STAT. ANN. § 141.040 (Banks-Baldwin 1997) (exempting charitable institutions from income tax); LA. REV. STAT. ANN. § 305 (West 1996) (providing exclusion and exemptions from state taxation to charitable organizations); ME. REV. STAT. ANN. tit. 22, § 2067 (West 1992) (exempting hospitals from taxation); MD. CODE ANN., TAX-PROPERTY § 7-202 (1996) (providing for property tax exemption for charitable organizations); MASS. GEN. LAWS ANN. ch. 176A, § 19 (West 1996) (exempting from state, city, county, district, and municipal taxes nonprofit charitable hospitals); MICH. COMP. LAWS ANN. § 205.54 (West 1996) (exempting hospitals and other institutions from taxation); MINN. STAT. ANN. §§ 272.02, 290.05 (West 1996) (exempting charitable institutions from property, income, and franchise taxation); MISS. CODE ANN. §§ 27-7-29, 27-13-63 (1996) (providing for exemption from income and franchise taxation for charitable institutions); MO. ANN. STAT. § 137.101 (Vernon 1996) (holding charitable institutions exempt from property taxation); MONT. CODE ANN. § 15-6-201 (1995) (providing exemption from property taxation); NEB. REV. STAT. § 21-1903 (1995) (providing exemption from property taxation); NEV. REV. STAT. § 361.140 (1995) (creating exemption from property taxes); N.H. REV. STAT. ANN. § 72:23 (1988) (exempting charitable institutions from property taxation); N.J. STAT. ANN. § 54:4-3.6 (West 1996) (providing exemption from property taxation to nonprofit charitable organizations); N.Y. REAL PROP. TAX LAW § 420-a (McKinney 1996) (exempting from taxation real property owned by charitable corporations); N.M. STAT. ANN. §§ 57-22-11, 7-2A-4 (Michie 1996) (providing exemptions from state, local, corporate income, and franchise taxes); N.M. CONST. art. VIII, § 3 (1995) (providing a property tax exemption); N.C. GEN. STAT. §§ 105.278.8, 105.130.11 (1995) (exempting nonprofit hospitals from property tax, and classifying those corporations that are exempt from federal income taxation as also exempt from state income taxes); N.D. CENT. CODE § 57-38 (1995) (providing exemption to those organizations exempt from federal taxation); OHIO REV. CODE ANN. § 140.08 (Baldwin 1995) (exempting hospitals from all taxes); OKLA. STAT. ANN. tit. 68, § 2359 & tit. 36, § 2617 (West 1996) (exempting from

tain class of nonprofit corporations.⁷

Although hospitals are not specifically mentioned, nonprofit hospitals are exempt from federal taxation under section 501(c)(3) of the Internal Revenue Code under the general heading of charity, and have received the benefits conferred upon exempt organizations. These benefits, however, have not come without a price.⁸ Since there is no theoretical construct to explain empirically why the tax law of charitable nonprofits is structured as it is,⁹ there has been no clear rationale guiding

income tax those organizations that are exempt from federal income taxation, and exempting nonprofit hospitals from state, county, district, and municipal taxation); OR. REV. STAT. §§ 307.130, 317.080 (providing property tax exemption to charitable organizations and exemption from corporation excise tax to organizations that are exempt from federal taxation); 72 PA. CONS. STAT. ANN. § 5020-204 (1996) (providing exemption from property taxation); 1996 R.I. PUB. LAWS § 252 (to be codified at R.I. GEN. LAWS § 44-3-3) (exempting any incorporated public charitable institution from property taxation); S.C. CODE ANN. § 44-7-1890 (Law Co-op. 1995) (exempting hospitals from property and income taxes); S.D. CODIFIED LAWS ANN. §§ 10-4-9.3, 10-45-14.1, 10-46-15 (1996) (exempting property owned by nonprofit healthcare organizations from property taxation and nonprofit hospitals from sales and use taxation); TENN. CODE ANN. §§ 67-5-212, 67-2-104, 67-6-322 (1996) (exempting charitable organizations from property, income, and sales taxation); TEX. TAX CODE ANN. § 11.18 (West 1995) (exempting charitable organizations from property taxation); UTAH CODE ANN. § 59-2-1101 (1996) (exempting charitable organizations from property taxation); VT. STAT. ANN. tit. 32, § 3802 (1995) (exempting charitable organizations from property taxation); VA. CODE ANN. § 58.1-609.8 (Michie 1996) (exempting from property taxation organizations exempt from federal taxation under section 501(c)(3)); WASH. REV. CODE ANN. § 84.36.040 (1996) (exempting nonprofit hospitals from property taxation); W. VA. CODE § 11-3-9 (1996) (exempting nonprofit healthcare organizations from property taxation); WIS. STAT. ANN. § 71.26 (West 1996) (exempting charitable corporations from income taxation); WYO. STAT. ANN. § 39-1-201 (Michie 1996) (providing exemption from property taxation for charitable institutions).

6. Benefits include the ability to offer tax exempt bonds in order to raise capital, the ability to attract grants from private foundations, and eligibility for preferential second and third-class postal rates. See THOMAS K. HYATT & BRUCE R. HOPKINS, *THE LAW OF TAX-EXEMPT HEALTHCARE ORGANIZATIONS* 21-23 (1995).

7. Tax exemption is granted to nonprofit organizations that are organized and operated for the public benefit. See I.R.C. § 501. See also note 8 *infra* (explaining conditions for establishing tax exempt status).

8. Section 501(c)(3) requires that exempt organizations be organized and operated for the public benefit, rather than for private interests. To do this, organizations must observe the non-distributional constraint, which requires that no part of the exempt entity's net earnings inure to the benefit of any private shareholder or individual. Further, no substantial part of the activities of the exempt organization may include propagandizing, or otherwise attempting to influence legislation, nor may the exempt organization participate in, or intervene in, any political campaign. See I.R.C. § 501(c)(3); Treas. Reg. § 1-501(c)(3)-1(a-c) (outlining organizational and operational tests for exemptions for charitable organizations).

9. The legislative history accompanying the promulgation of the federal income tax is curiously silent on the reasons for granting tax exemption to particular types of organizations. Theorists have since attempted to articulate coherent theories. Under the traditional public benefit subsidy theory, charitable tax exemption is justified on the basis of the public benefit conferred by the exempt organization, and is offered in order to "encourage activities that were recognized as inherently meritorious and conducive to the general welfare." Chauncey Belknap, *The Federal*

Income Tax Exemption of Charitable Organizations: Its History and Underlying Policy, in IV RESEARCH PAPERS SPONSORED BY THE [FILER] COMMISSION ON PRIVATE PHILANTHROPY AND PUBLIC NEEDS 2025, 2039 (1977).

The capital subsidy theory views exemption as a needed device that enables nonprofits to gain access to capital markets otherwise foreclosed to them by virtue of the nondistributional constraint and the inadequate availability of debt financing. See Henry Hansmann, *The Rationale For Exempting Nonprofit Organizations From Corporate Income Taxation*, 91 YALE L.J. 54, 72-75 (1981). A nonprofit organization's "ability to accumulate retained earnings is of substantial importance as a means of capital expansion." *Id.* Retained earnings can be used to finance capital improvements, and are tied, to some degree, to the amount of debt financing a nonprofit can obtain. This is because "capital purchased with such earnings provides an extra margin of security for the debt, and [because] the cash flow from such earnings is evidence to lenders that interest payments on the debt can be covered." *Id.* An income tax on nonprofits would substantially erode these retained earnings, "further crippl[ing] a group of organizations that is already capital-constrained." *Id.* Moreover, the subsidy is justified because nonprofits are more efficient than their for-profit analogues in providing those services characterized by contract failure. Contract failure occurs in instances where, because of the type of goods or services, "the cost of capital subsidy provided by corporate tax exemption may be more than compensated for by the efficiency gains deriving from the expansion of nonprofit producers that the subsidy encourages." *Id.*

Arguing for the donative theory, Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307, 390 (1991) [hereinafter *Charitable Status*], declare that "the primary rationale for the charitable exemption is to subsidize those organizations capable of attracting a substantial level of donative support from the public." By attracting public donations, the entity demonstrates its deservedness, incorporating notions of worthiness and neediness, through the entity's need to seek donations and the "willingness of the public to contribute" to the entity. Mark A. Hall & John D. Colombo, *The Donative Theory of the Charitable Tax Exemption*, 52 OHIO ST. L.J. 1379, 1381-89 (1991) (suggesting a charitable exemption test based on institutions' dependence on public donations) [hereinafter *Donative Theory*]. Thus, "the existence of substantial donative support from the public at large signals the need for an additional . . . subsidy," and the exemption represents the subsidy required "to take up the donative slack." *Id.* at 1385 (emphasizing the relationship between public dependence and the need for subsidization).

Observing that some charitable giving can be explained by the psychological effect that giving has on the donor, Rob Atkinson, *Altruism in Nonprofit Organizations*, 31 B.C.L. REV. 501, 501 (1990) argues that tax exemption is warranted by the nonprofit organizations' founders decision to forego all profits. As long as a nonprofit organization's assets are used for the benefit of someone other than those who control the organization, the organization should qualify for a tax exemption, free from any inquiry about the measure of public benefit derived. For Atkinson, the "metabenefit of altruistic production would suffice." *Id.* at 619.

Finally, the income measurement theory rejects the idea that the exemption is a subsidy, and instead argues that public benefit organizations are exempt because they are improper targets for taxation. Boris I. Bittker & George K. Rahdert, *The Exemption of Nonprofit Organizations From Federal Income Taxation*, 85 YALE L.J. 299, 307 (1976) (arguing that the appropriate tax base and "computing their 'net income' would be a conceptually difficult, if not self-contradictory task").

In *Regan v. Taxation with Representation of Washington*, 461 U.S. 540, 544 (1983), Justice Rehnquist, in his dissent, wrote that "tax exemptions . . . are a form of subsidy . . . administered through the tax system . . . [having] much the same effect as a cash grant to the organization of the amount of tax it would have to pay on its income." This statement cannot be reconciled with his dissent the same year in *Bob Jones University v. United States*, 461 U.S. at 574. In *Bob Jones*, Justice Rehnquist argued that since Congress did not explicitly enumerate a public policy requirement in the language of section 501(c)(3), and since in all other respects, Bob Jones University, a nonprofit private school having racially discriminatory admissions standards,

what such organizations must do to earn this benefit.¹⁰ In addition, the definition of the term “charitable” has not been constant.¹¹ Over the years, the Internal Revenue Service (the Service) has required hospitals, in order to qualify for the exemption, to behave in certain ways regarding the public. In 1956, the Service proffered the first of its Revenue Rulings dealing directly with exempt hospitals, requiring them to provide, to the extent they were able, free or below cost care to indigent patients.¹² The most recent major pronouncement came in 1969,¹³ when the Service, responding to the advent of Medicare¹⁴ and Medicaid,¹⁵ redefined the hospitals’ responsibility toward the community. The “charity standard,” articulated in 1956, was supplanted by the “community benefit” standard, which recognized that the promotion of healthcare may be a charitable purpose, and required that an exempt hospital provide benefits to a broad class of individuals within the community.¹⁶

Since 1969, changes in the fabric of society and within the landscape of healthcare have had an impact on who delivers

qualified as a tax-exempt organization, then it should not have its exemption withdrawn. *Id.* at 612-13, 623.

But if a tax exemption is a subsidy, how could this grant be extended, under the U.S. Constitution, to a racially discriminatory institution? Further, if the exemption is a subsidy, would not the exemption for a church, upheld in *Walz v. Tax Commission*, 397 U.S. 664 (1970), violate the Establishment Clause? Justice Rehnquist recognized this conundrum himself, and addressed it in a footnote to *Regan v. Taxation with Representation of Washington*. There, he indicated that “[i]n stating that exemptions and deductions . . . are like cash subsidies, . . . we do not mean to assert that they are in all respects identical.” *Regan*, 461 U.S. at 543, n.5.

10. For if the exemption is a traditional subsidy, then it would follow that the government could insist upon *quid pro quo* from those accepting the exemption. If, however, the exemption is rooted in an income measurement problem, then extracting anything in exchange is less defensible.

11. “Charitable” went from meaning relief of poverty to a broader definition of charitable purposes, including the promotion of health. *See* Rev. Rul. 69-545, 1969-2 C.B. 117 (defining charitable to include the promotion of health and hospitals).

12. *See* Rev. Rul. 56-185, 1956-1 C.B. 202.

13. Rev. Rul. 69-545, 1969-2 C.B. 117 was further refined in 1983 by Rev. Rul. 83-157, 1983-2 C.B. 94, which granted exempt status to specialized hospitals that, because they offer care for special conditions that are unlikely to require emergency treatment, have no emergency rooms.

14. The Medicare program, entitled Health Insurance for the Aged Act, was created by the Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 290 (1965).

15. *See* Social Security Amendments of 1965, Pub. L. No. 89-97, § 1902(13)(B), 79 Stat. 343 (1965) (stipulating that state plans for medical assistance must pay reasonable costs for inpatient hospital services).

16. *See* Rev. Rul. 69-545, 1969-2 C.B. 117 (setting forth new requirements for granting exemptions to hospitals). *See also* Section IIB *infra*.

care,¹⁷ how it is delivered,¹⁸ what is delivered,¹⁹ and the cost of what is delivered.²⁰ There have been corresponding changes with respect to access to healthcare. It is now estimated that there are forty million Americans²¹ without the health insurance that is often the threshold for access to healthcare,²² forty to sixty percent of whom are ineligible for Medicaid.²³

17. The healthcare industry has undergone striking transformation. This is demonstrated by the rise in for-profit hospital entities and urgent care centers.

18. Equally dramatic are changes in the method of healthcare delivery. Beginning October 1, 1982, Medicare utilized a prospective payment system based upon diagnostic related groups (DRGs) to reimburse hospitals for inpatient services. This has led to a reduction in inpatient days. In addition, managed care entities like health maintenance organizations (HMOs) have changed the way healthcare is delivered by offering capitated payments for insureds. Since a single payment is rendered for a given period, irrespective of the amount of service rendered, then the incentive exists to limit the amount of service rendered.

19. Coaxial Tomography, Positron Emissions Tomography, Dual Energy X-Ray Absorptiometry, and Magnetic Resonance Imaging perform diagnostic feats beyond the capacity of the traditional X-Ray. The use of light amplification by stimulated emission of radiation (LASER) makes delicate brain surgery possible.

20. In 1965, healthcare expenditures accounted for 5.9% of the Gross Domestic Product (GDP). See FRANCES R. HILL & BARBARA L. KIRSCHTEN, FEDERAL AND STATE TAXATION OF EXEMPT ORGANIZATIONS § 3.01[1], at 3-3 (1994) (observing that by 1994, national healthcare expenditures rose by almost four times the rate of inflation). Unique features of U.S. healthcare, such as "the predominance of the FFS payment system, extensive third-party insurance coverage, a fragmented multipayer system . . . and rapid diffusion of new technologies, contributed to growth." Nancy DeLew et al., *A Layman's Guide to the U.S. Healthcare System*, 14 HEALTH CARE FIN. REV. 151, 159 (1992). In 1994, healthcare expenditures accounted for 13.9% of the GDP, and by the year 2005 are expected to reach \$2.2 trillion, an amount equal to 17.9% of the GDP. See Sally T. Burner & Daniel R. Waldo, *National Health Expenditure Projections*, 16 HEALTH CARE FIN. REV. 221, 221 (1995).

21. See, e.g., U.S. BUREAU OF THE CENSUS, CURRENT POPULATION SURVEY (1984); INTERNATIONAL TRADE ADMIN., U.S. DEPT. OF COMMERCE, U.S. INDUSTRIAL OUTLOOK 1993, at 42-1 (1993); GENERAL ACCOUNTING OFFICE, NON-PROFIT HOSPITALS: BETTER STANDARDS NEEDED FOR TAX EXEMPTION, H.R. DOC. NO. 90-84, at 12 (1990) [hereinafter GAO/H.R. DOC. 90-84]; David Bowermaster & Bruce B. Auster, *There They Go Again: This Year's Battle Over Health Care Reform is a Political Barometer*, U.S. NEWS & WORLD REP., Apr. 8, 1996, at 23 (stating there are 40 million Americans without health insurance in the country today); David M. Flynn, *Hospital Charity Care Standards: Reexamining the Grounds for Exempt Status*, 3 J. TAX'N. EXEMPT ORG. 13, 13 (1992) (observing that the increase in uninsured patients has put more pressure on the ability of exempt hospitals to provide adequate levels of healthcare in their communities).

22. See generally Charles B. Gilbert, *Health-Care Reform and the Nonprofit Hospital: Is Tax-Exempt Status Still Warranted?*, 26 URB. LAW. 143, 143 (1994) (arguing that being uninsured is a significant obstacle to receiving healthcare because many uninsured individuals have no access to medical care except in emergencies); Anne M. Murphy & Tecla A. Murphy, *Using the Emergence of Primary Health Care in Hospital Strategy and Community Reform, Part I*, 25 J. HEALTH & HOSP. L. 321, 321 (1992) (stating that an increasing number of citizens are effectively denied access to healthcare because they lack health insurance).

23. See Charles J. Milligan, Jr., *Provisions of Uncompensated Care in American Hospitals: The Role of the Tax Code, The Federal Courts, Catholic Health Care Facilities, and Local Governments in Defining the Problem of Access for the Poor*, 31 CATH. LAW. 7, 14 (1989) (explaining the role of Catholic health facilities in connection with issues of access for the poor,

The number of uninsureds is expected to grow to sixty-seven million by the year 2002.²⁴ Congress, alarmed by the rising healthcare costs and concerned about the economic barriers to access, has within the last few years attempted to require nonprofit hospitals to deliver greater amounts of uncompensated care²⁵ in exchange for the exemption.²⁶ To date, these efforts have failed. But they have not quieted the debate about what a nonprofit should be required to return to the community. Indeed, a healthy debate exists as to whether the nonprofit hospital form should continue to exist at all.²⁷ What seems

underinsured, and uninsured). See also Murphy & Murphy, *supra* note 22 (discussing how employed low-income individuals comprise a large segment of the uninsured).

24. See Bowermaster & Auster, *supra* note 21, at 23.

25. On February 4, 1991, Representative Edward R. Roybal (D-CA) introduced H.R. 790, the Charity Care and Hospital Tax-Exempt Status Reform Act of 1991, [hereinafter Charity Care Act], which would require, *inter alia*, tax exempt hospitals to render an amount of charity care equal to 50% of the value of the exemption, and other unreimbursed qualified community benefits equal to 35% of the value of the exemption. On March 12, 1991, Representative Brian Donnelly (D-MA) introduced H.R. 1374, which would require exempt hospitals to satisfy criteria of charity care. Neither of these bills passed into law, but the issue did not die.

In 1994, as an amendment to The Health Security Act, H.R. 3600, 103d Cong. (1994), Representative Richard Gephardt, House Majority Leader, proposed to amend section 501 of the Internal Revenue Code to include a new subsection. The proposed subsection 501(n) would apply to 501(c)(3) or 501(c)(4) organizations that were primarily devoted to providing healthcare services. The provision would have required exempt organizations to assess community healthcare needs, to prepare written plans to meet those needs, to perform qualified outreach services, and to provide medically necessary services without regard to ability to pay. This provision, like the rest of the Health Security Act, was not enacted. See Section IIC *infra*.

26. The estimated 1994-98 revenue costs to the federal government of allowing tax-exempt healthcare providers to receive deductible contributions and to issue tax-exempt bonds are \$8.8 billion and \$10.8 billion respectively. See Robert A. Boisture, *Health Reform Speeds Shift To Tax-Exempt Integrated Managed Care Plans*, 11 HEALTHSPAN 3, 3 (1994) [hereinafter *Health Reform*]. Boisture offers no figures for the value of the exemption from income taxation, arguing that its value might be relatively small, on the assumption that hospitals are basically break-even operations that would have relatively little taxable income. *Id.* However, by another analysis, the value might be sizable, given "the substantial capital reserves accumulated by many tax-exempt hospitals." *Id.* Another view estimates the collective value of nonprofit hospitals' tax advantages at 7.8% of net revenues, of which the income tax exemption comprises 1.5% of hospitals' net revenues, or \$1.6 billion. See John Copeland & Gabriel Rudney, *Federal Tax Subsidies for Not-For-Profit Hospitals*, 3 EXEMPT ORG. TAX REV. 161, 162, 167 (1990) (discussing the income tax exemption for hospitals).

27. John D. Colombo argues that tax exemption for hospitals/healthcare providers is an anachronism that should be ended. He reasons that services that society greatly values should be subsidized directly, through funds saved from eliminating healthcare organizations' tax exemption. See John D. Colombo, *John Colombo Says Tax the Hospitals*, 9 EXEMPT ORG. TAX REV. 1294, 1295 (1994).

In contrast, Robert A. Boisture observes that the market cannot provide patient-oriented healthcare services, creating a very real risk that if nonprofit hospitals are deprived of tax-exemption, patient interests will be sacrificed to provider profit. See generally Robert A. Boisture, *Tax Treatment of Nonprofit Organizations Providing and Financing Health Care Services*, 968 ALI-ABA 195 (1994).

clear is that nonprofit hospitals will be involved in the effort to address the problem of unequal access to healthcare. Notwithstanding the failure of the recent national health reform initiative, "both Congress and the IRS are moving once again in the direction of instituting a specific requirement that healthcare organizations provide some level or type of charity care services in order to retain their tax exemption."²⁸ Representative Pete Stark (D-CA), in hearings before the Subcommittee on Oversight of the House Committee on Ways and Means, challenged the definition of charity care and proposed strict qualifications and harsh penalties for violations thereof.²⁹ But ending the subsidy, or redefining the community benefit to require greater amounts of charity care in exchange for the subsidy will likely have unfortunate consequences. It will result in less charity care, as formerly exempt hospitals may close their doors or convert to for-profit status, where they will be under no obligation to provide any charity care at all.

This Note explores the continued viability of the prevailing definition of community benefit, presently the Service's measuring stick for a nonprofit hospital's expression of its charitable purpose. As currently interpreted, the community benefit standard is an inadequate measure of the benefits the community derives from a special class of hospitals, which by the very nature of what they do, provide a benefit not calculated in numbers of indigents treated nor easily measured against the value of the exemption. This Note proposes that a different measure be taken to define community benefit, reflecting both the wider scope of the community, and the greater and more diverse scope of the benefit. For such hospitals, whose research and innovation reach well beyond local boundaries, the community benefit standard, as currently defined by the Service, is too narrow to encompass the many ways in which medicine, as practiced by these hospitals, has become nationalized.

Section II of this Note will present background material. Specifically, Section IIA will discuss the history of hospitals,

28. HYATT & HOPKINS, *supra* note 6, at 437.

29. See *Tax-Exempt Status of Hospitals and Establishment of Charity Care Standards: Hearing Before the Committee on Ways and Means: H.R. 790 and H.R. 1374*, 102nd Cong. 94-6 (1991) (statement of Representative Fortney Pete Stark).

and will demonstrate that the place occupied by nonprofit hospitals within section 501 of the Internal Revenue Code is a function of history. Section IIB reviews the history of the exemption as applied to healthcare organizations. Section IIC examines recent congressional initiatives aimed at linking the exemption to provision of a required amount of uncompensated care, thereby limiting the definition of what constitutes "charitable." Section IID looks at state actions to revoke the exempt status of hospitals by examining the standards the courts have articulated.

Next, Section III of this Note will critique current efforts at reforming the exempt status of nonprofit hospitals, including both the charity care and community benefit standards. This Section will evaluate the articulated standards of Revenue Ruling 69-545, the Service's last major pronouncement, and will demonstrate that although Revenue Ruling 69-545 articulated a community benefit standard, the actual elements deal more with charitable benefit than community issues, leading to the confused expectations society has of nonprofit hospitals.

Next, Section IV proposes that hospitals whose research has had ramifications beyond the borders of the hospital and its patients be deemed per se charitable for purposes of tax exempt status, without regard to either a charity or community benefit test of charitability. Further, Section IV illustrates that the greater community will benefit from such a policy.

Finally, Section V suggests criteria against which the Service can determine which hospitals can qualify for this treatment.

II. BACKGROUND

This Section will address the history of the exemption, juxtaposed against the history of hospitals. It will illustrate that the rationale under which hospitals are categorized in the tax code as charitable organizations is explained by the position of hospitals in England when the Statute of Uses was enacted, and in America when the tax exemption was first articulated. This Section will also illustrate that religion and charity were intertwined in early healthcare, and notions of charity infuse the debate when viewing the hospitals' obligation under the tax code. But given the modern state of hospitals and medicine, a

different rationale is needed, for “[a]pplying an 84 year old statute to today’s nonprofit hospitals, . . . is [a practice] that is screaming out for examination.”³⁰ Also screaming out for examination is the application of a twenty-six year old pronouncement, Revenue Ruling 69-545, to a hospital industry whose changing paradigms³¹ the Service could not have envisioned when promulgated.

A. History of American Nonprofit Hospitals

Hospitals have not always been viewed as the “most visible embodiment of medical care in its technically most sophisticated form.”³² From their “earliest origins in preindustrial societies, hospitals were primarily religious and charitable institutions for tending to the sick, rather than medical institutions existing for their cure.”³³ Spiritual care, prayer, and “religious provision for the dying predomina[ted].”³⁴ Medieval European hospitals, “one branch of a family of institutions of religious charity or social relief,”³⁵ were tended by clerical or knightly orders.³⁶ Even when, in the later Middle Ages, hospitals were taken over from the religious orders by municipali-

30. James J. McGovern, *Transcript of the Winter ABA-EO Committee Meeting: Panel Three: Significant Issues in the Office for the Associate Chief Counsel for Employee Benefits and Exempt Organizations*, 7 EXEMPT ORG. TAX REV. 539, 556 (1993).

31. See generally John D. Golenski, *Paradigm Shift in American Health Care: Are We Ready for a Comprehensive System?*, 1 HEALTH MATRIX 259, 259 (1991). This article suggests that society has undergone a paradigm shift in terms of its social metaphor for healthcare, going from the paternalism model to the model of “medicine as science.” *Id.* Rising healthcare costs, having reached “proportions threatening to other social goods,” unleashed forces that created another paradigmatic shift, to a model merging “the medicine as science metaphor with the image of the competitive free market in healthcare services.” *Id.* Sadly, this merger “may have created a monster” in terms of the staggering numbers of uninsureds and underinsureds, which in turn is prompting another paradigmatic shift, to a “public utility model,” wherein healthcare is recognized as a basic human need and equitably distributed. *Id.*

32. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 145 (1982).

33. *Id.* at 145. See also ROTH A MARY CLAY, *THE MEDIEVAL HOSPITALS OF ENGLAND* at xvii-xviii (1909) (noting that medieval hospitals were “ecclesiastical, not medical institution[s],” whose preeminent goal was not “the relief of the body, . . . but . . . the refreshment of the soul”).

34. George Rosen, *The Hospital: Historical Sociology*, in *THE HOSPITAL IN MODERN SOCIETY* 1, 10 (Eliot Freidson ed., 1963).

35. Eduard Seidler, *Medieval Western Hospitals: Social or Health Care Facilities?*, in *HISTORY OF HOSPITALS: THE EVOLUTION OF HEALTH CARE FACILITIES* 5, 5 (Yosio Kawakita et al. eds., 1986) (discussing proceedings of the 11th International Symposium on the Comparative History of Medicine - East and West).

36. See NICHOLAS ORME & MARGARET WEBSTER, *THE ENGLISH HOSPITAL 1070-1570*, at 26 (1995).

ties, hospitals were not secularized but were "religious house[s] in which the nursing personnel had united as a vocational community under a religious rule."³⁷ Thus, the medieval hospital was a "*locus religiosus*"³⁸ from an ecclesiastical viewpoint, and legally a *pia causa*,³⁹ and as such, enjoyed such privileges as tax-exemption.⁴⁰

The colonists brought the tradition of charitable giving with them to the New World. As in Europe, almshouses, the forerunners of American hospitals, "serv[ed] general welfare functions and only incidentally car[re]d for the sick,"⁴¹ housing them together with the elderly, the insane, and the orphaned.⁴² But in the eighteenth century, the almshouse "metamorphosed into the modern hospital, first by becoming more specialized in its functions and then . . . more universal in its use."⁴³ In the mid-eighteenth century, the first hospitals built specifically to care for the sick (termed voluntary because they were funded by voluntary charitable donations rather than by grants from the public fisc)⁴⁴ were opened.⁴⁵ But the medical care practiced within these walls was, at best, primitive.⁴⁶ The emergence of these hospitals did not bring an end to the almshouse.

37. Rosen, *supra* note 34, at 10.

38. Translated from the Latin, it means a place devoted to and serving the purposes of the clergy.

39. Translated from the Latin, it means a noble cause affected by a sense of obligation or duty.

40. See Rosen, *supra* note 34, at 10.

41. See STARR, *supra* note 32, at 149.

42. See *id.* at 149.

43. *Id.* at 150.

44. See *id.* at 151. Donations, however, did not cover all of the costs of care, and voluntary hospitals required their nonindigent patients to pay a portion of the costs of treatment. See MORRIS J. VOGEL, *THE INVENTION OF THE MODERN HOSPITAL* 14-15 (1980).

45. In Philadelphia, Pennsylvania Hospital was opened in 1752. Likewise, New York Hospital opened in 1791 and Boston's Massachusetts General Hospital opened in 1821. See STARR, *supra* note 32, at 150.

46. See, e.g., ERWIN H. ACKERKNECHT, *A SHORT HISTORY OF MEDICINE* (1968) (stating that the germ theory of disease was not fully developed until after the American Civil War; not until the Crimean War did the relationship of good hospital hygiene and reduced mortality become apparent); L. EARLE ARNOW, *HEALTH IN A BOTTLE* (1970) (observing that the first antibiotic, heralding the conquest of medicine over bacteria, was penicillin, discovered in 1928; tetracycline became available in 1948); HERBERT BUTTERFIELD, *ORIGINS OF MODERN SCIENCE* (1965) (noting that in 1872, the first patient was anesthetized with an injected solution of chloral hydrate). See also STARR, *supra* note 32, at 156 (concluding that control over infection achieved by antiseptics and asepsis, control over pain achieved by use of anesthesia, and "[i]mprovements in diagnostic tools, particularly the development of X-Rays in 1895, spurred the advance" of surgery); VOGEL, *supra* note 44, at 5.

As the colonial period ended, so did the preference for providing assistance to the poor within their homes. The almshouse became, rather than an option of last resort, the only option, as state legislatures abolished home aid, hoping to restrict disbursement for public relief by making the almshouse the only source of governmental assistance to the indigent.⁴⁷ Thus, the almshouse, out of whose infirmaries public hospitals evolved,⁴⁸ operated in conjunction with voluntary hospitals, which attempted to distinguish themselves not only by separating the sick from the indigent, but by maintaining conditions conducive to attracting "the more respectable poor with curable illnesses, as well as . . . occasional well-to-do people."⁴⁹

Discrimination furthered the association between religion, charity, and hospitals. As hospitals became more important, so too did staff positions. Physicians did not gain access to these positions on an equal basis, for "[b]lack and foreign-born doctors . . . were almost completely unrepresented on hospital staffs, [and] appointment decisions depended largely on . . . social background."⁵⁰

47. See STARR, *supra* note 32, at 145. The shift from home relief to the almshouse has been explained as an effort to rehabilitate dependents, just as the penitentiary and asylum were designed to rehabilitate the criminally and the mentally ill. See DAVID J. ROTHMAN, *THE DISCOVERY OF THE ASYLUM*, 180-205 (1971).

However, an award-winning essay, written in 1876 by Dr. W. Gill Wylie, argues against this interpretation. Dr. Wylie wrote that, while hospitals were necessary to deal with victims of contagious epidemics and accident casualties, "to extend hospitals any further was to encourage pauperism, idleness, and the breakup of the family . . . by separating the sick from their homes and their relatives, who are often too ready to relieve themselves of the burden of the sick." W. GILL WYLIE, *HOSPITALS: THEIR HISTORY, ORGANIZATION, AND CONSTRUCTION* 57-66 (1876), *quoted in* STARR, *supra* note 32, at 151. In eliminating home relief, state legislatures may not have been addressing the indigents as much as other members of their communities, "forcing the immigrant communities to come up with their own institutions for the poor and the sick." STARR, *supra* note 32, at 466.

48. Philadelphia General Hospital resulted from the Philadelphia Almshouse. Similarly, Baltimore County Almshouse grew to become a part of Baltimore City Hospitals, and Bellevue Hospital evolved from New York Almshouse. See generally STARR, *supra*, note 32. Bellevue is America's oldest public hospital and is New York's premiere institution for major emergencies. See Katherine E. Finkelstein, *Bellevue's Emergency*, N.Y. TIMES, Feb. 11, 1996, § 6 at 45 (stating that Bellevue "is the designated receiving hospital for policemen, firemen and visiting dignitaries from President Clinton to the Pope").

49. STARR, *supra* note 32, at 145.

50. *Id.* at 167. In a 1940 study of appointment decisions in Providence, Rhode Island, one administrator admitted that competitive examinations for appointment slots had to be discontinued, for "the persons who did best on the written examinations [were] Jewish." Oswald Hall, *The Stages of a Medical Career*, 53 AM. J. SOC. 327, 331 (1948), *cited in* STARR, *supra* note 32, at 168.

Prospective patients, too, had reasons for concern. Open discrimination against black individuals required that separate hospitals be formed.⁵¹ Catholic patients feared they would not receive last rites, and Jewish patients feared both ridicule of their practices and the unavailability of kosher food. Both Catholics and Jews worried that efforts would be made to convert them.⁵² Therefore, about 1850, a new type of hospital was formed, primarily religious or ethnic. Once the religious denomination of these hospitals was established, it was soon submerged and the hospitals served patients of all faiths.⁵³ These denominational hospitals, like the earlier voluntary hospitals, relied on charitable contributions, although they received far fewer large endowments than the older, primarily Protestant voluntaries.⁵⁴

By the time the first federal income tax was promulgated in 1894 with the enactment of the first corporate income tax,⁵⁵ legislators were accustomed to a society in which, both through history and contemporary practice, hospitals were closely associated with charity and religion. Thus, it is not difficult to see why hospitals were classified as charitable, and swept into the first corporate income tax's exemption for "corporations, companies or associations organized and conducted solely for charitable, religious or educational purposes."⁵⁶ It would have required vision to posit in 1894, or even in 1913,⁵⁷ that non-profit hospitals should be granted an exemption premised on a societal benefit not necessary related either to charity or religion.

51. [The] Home For Worthy, Aged, Indigent, Colored People opened in New York in 1842, funded by charitable donations. In 1882, it became the Colored Home and Hospital. Subsequently, it began admitting white people, and in 1902, its name was changed to the Lincoln Hospital and Home. In 1925, it became a municipal hospital "providing acute care to the poor of all descriptions." STARR, *supra* note 32, at 158.

52. *See id.* at 173-74.

53. *See id.* at 175.

54. *See id.* at 171.

55. *See* Rev. Act of 1894, ch. 349, § 32, 28 Stat. 556. The U.S. Supreme Court declared portions of the tax law to be unconstitutional, and the Act did not become effective. It was reenacted in 1913, by the Income Tax Act of 1913, ch. 16, § II(G)(a), 38 Stat. 114, 166-81.

56. Rev. Act of 1894, ch. 349, § 32, 28 Stat. 556.

57. *See id.*

B. The Service, Hospitals, and the Federal Tax Exemption

Early case law concerning hospitals and the tax exemption demonstrates "a struggle to rationalize an exemption to apply to a rapidly developing institution . . . reflect[ing] the IRS' and courts' struggles with the growing pains of a slowly maturing institution."⁵⁸ Many of these cases "focused more on a physician's or medical group's relationship to a small hospital than on establishing any meaningful, affirmative requirements for exemption."⁵⁹ These cases raised issues about private benefit and inurement with which we still grapple today. One Court, however, *Southern Methodist Hospital and Sanitarium v. Wilson*,⁶⁰ considered what a charitable institution owes the public. The state of Arizona had acted to revoke a hospital's tax exemption because the hospital had not rendered sufficient charity care. The Court upheld the hospital's exemption, finding that "the position that the test of a charitable institution is the extent of the free services rendered . . . is difficult of application and unsound in theory."⁶¹ The *Southern Methodist* Court articulated a test for defining a charitable institution, concluding that a hospital whose purpose:

[I]s recognized in law as charitable, and . . . is not maintained

58. Douglas M. Mancino, *Income Tax Exemption of the Contemporary Nonprofit Hospital*, 32 ST. LOUIS U. L.J. 1015, 1038 (1988). See, e.g., *Income Tax Ruling 2421*, VII-2 C.B. 150 (1928) (denying tax-exempt status to a corporation organized and operated exclusively by a physician, based upon the court's skepticism that the corporation was formed for any purpose other than to obtain capital through deductible charitable contributions); *Commissioner v. Battle Creek Inc.*, 126 F.2d 405, 405 (5th Cir. 1942) (upholding tax exemption of sanitarium, although its articles of incorporation authorized it to "conduct any other lawful business," in violation of section 501(c)(3)'s requirement that an exempt organization be organized and operated exclusively in pursuit of the exempt purpose); *Goldsby King Mem'l Hosp. v. Commissioner*, 3 T.C.M. (CCH) 693, 694, 697 (1944) (upholding the exemption of a 72-bed hospital, reasoning that "organization for such exclusively charitable purposes is not precluded by the fact that petitioner's charter authorized it to engage in all businesses that would be usual and profitable in the operation of a hospital"); *Davis Hosp., Inc. v. Commissioner*, 4 T.C.M. (CCH) 312, 315 (1945) (upholding the exemption of a hospital which, prior to incorporation as a nonprofit, had been run as a for-profit hospital, and, when incorporated as a nonprofit, charged patients who were financially able to pay).

Douglas Mancino argues that since the litigated cases involve not large urban hospitals, but only small hospitals with low bed counts, in expanding areas of the country, "there was very little concern regarding the criteria generally applicable to 'established' nonprofit hospitals in the more urban midwest, east, and northeast." Mancino, *supra*, at 1040.

59. Mancino, *supra* note 58, at 1039.

60. 77 P.2d 458, 462 (Ariz. 1938).

61. *Id.*

for the private gain . . . of its organizers, . . . directly or indirectly, . . . [may be] properly characterized as . . . charitable . . . , notwithstanding the fact that it charges for most, if not all, of the services which it may render, so long as its receipts are devoted to the necessary maintenance of the institution and the carrying out of the purpose for which it was organized.⁶²

The Service did not adopt the *Southern Methodist* standard for hospitals. In 1956, the Service released Revenue Ruling 56-185, which set forth, for the first time, the criteria that nonprofit hospitals had to satisfy in order to establish themselves as exempt under section 501(c)(3) of the Internal Revenue Code.⁶³ Revenue Ruling 56-185 established an organizational test for hospitals, requiring that exempt hospitals "be organized as a nonprofit charitable organization for the purpose of operating a hospital for the care of the sick."⁶⁴ Further, it included an open staff provision, mandating that exempt hospitals not restrict use of their facilities to particular groups of physicians or surgeons, to the exclusion of other qualified physicians. Paralleling statutory language of section 501(c)(3) regarding private inurement and private benefit, the ruling forbade "net earnings to inure directly or indirectly to the benefit of any private shareholder or individual."⁶⁵ Finally, it adopted the financial ability standard, requiring that an exempt hospital be "operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay."⁶⁶ An exempt hospital could no longer "refuse to accept patients in need of hospital care who cannot pay for such services."⁶⁷ Bad debts would not count toward the provision of charity care; if full payment for services was expected, a hospital would not be deemed to "dispense charity merely because some of its patients fail to

62. *Id.*

63. *See* Rev. Rul. 56-185, 1956-1 C.B. 202 (modified by Rev. Rul. 69-545, 1969-2 C.B. 117).

64. *Id.* *See also* Treas. Reg. § 1.501(c)(3)-1(b) (defining a corporation organized exclusively for one or more exempt purposes as one whose articles of incorporation limit the purpose of the corporation to the exempt purpose or purposes, and do not empower the corporation to engage in activities not in furtherance of the exempt purpose or purposes).

65. Rev. Rul. 56-185, 1956-1 C.B. 202 (modified by Rev. Rul. 69-545, 1969-2 C.B. 117).

66. *Id.*

67. *Id.*

pay for the services rendered."⁶⁸ By requiring exempt hospitals to act as charitable institutions, Revenue Ruling 56-185 "embrac[ed] the relief of poverty theory of exemption . . . consistent with the then-applicable definition of charitable contained in the pre-1959 Treasury regulations."⁶⁹

As the *Southern Methodist* Court predicted twenty years earlier, the financial ability standard proved more difficult to implement than to describe, since the inquiry was factual in nature,⁷⁰ and "created potential conflicts between the judgments of revenue agents and those of hospital [administrators]."⁷¹ As a result, "some hospitals were in danger of losing their tax-exempt status because they failed to provide sufficient levels of free or below cost care."⁷²

The administrative difficulties associated with the application of the financial ability test were growing, and non-profit hospitals sought a means by which they would be treated as tax exempt per se. Several attempts were made to legislatively recognize hospitals as exempt per se, but were unsuccessful.⁷³ The creation of Medicare and Medicaid in 1965 had a fundamental effect on hospitals, in that "[a] substantial portion of the free care previously subsidized by tax-exempt hospitals [under Revenue Ruling 56-185] now was reimbursed through these programs."⁷⁴ The Service came to recognize that the concept of charity was evolving, and that its own definition of charity was too narrow.⁷⁵ Medicare and Medicaid, as well as improvements in medical technology, wrought fundamental changes in the hospital, taking it "from an almshouse to a

68. *Id.*

69. Mancino, *supra* note 58, at 1041.

70. *See id.* at 1046 (observing that the financial ability test entailed an analysis of a hospital's charity care policies, its bad debts, charity care, contractual allowances, allowances for capital expenditures, medical education and research, and community health programs).

71. ROBERT R. BROMBERG, 1 TAX PLANNING FOR HOSPITALS AND HEALTH CARE ORGANIZATIONS § 7.26-7.27 (1977).

72. Mancino, *supra* note 58, at 1041.

73. *See, e.g.*, H.R. Rep. No. 413, 91st Cong. (1969) (proposing that hospitals that otherwise meet the requirements set forth in section 501(c)(3) be deemed exempt, even though they do not fulfill the financial ability test of Rev. Rul. 56-185, 1956-1 C.B. 202).

74. HILL & KIRSCHTEN, *supra* note 20, at § 3.02[1][c] 3-7 & 3-8 (describing the change from reimbursement for free care by tax-exempt hospitals to reimbursement through Medicare and Medicaid).

75. *See* MARY JO SALINAS ET AL., EXEMPT ORGANIZATIONS TECHNICAL DIVISION, INTERNAL REVENUE SERVICE, EVOLUTION OF THE HEALTH CARE FIELD 157, 158-59 (1992).

modern [medical center], . . . warrant[ing] a change in the rationale for a hospital's tax exempt status."⁷⁶ Hence, in 1969, the Service promulgated Revenue Ruling 69-545.⁷⁷

Revenue Ruling 69-545 announced a change in the rationale for hospitals' exempt status. Citing the general law of charity,⁷⁸ Revenue Ruling 69-545 recognized:

[T]he promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes . . . that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community.⁷⁹

Thus, Revenue Ruling 69-545 set in motion the shift from the charity care standard set by the financial ability test to the community care standard, in "recognition of the fact that hospitals were designed and operated to serve all classes of society, not only the sick poor."⁸⁰

Revenue Ruling 69-545 compared two hospitals, only one of which qualified for an exemption. The most important factors the Service articulated in finding that the first hospital qualified for exemption were the following:

1. Whether the hospital is governed by a board of trustees composed of prominent citizens in the community.⁸¹
2. Whether medical staff privileges are available to all qualified physicians in the area, consistent with the size and nature of its facilities.⁸²
3. Whether the hospital provides care to all those in the community who could pay, either by themselves or through private

76. Mancino, *supra* note 58, at 1043. See also BROMBERG, *supra* note 71, at 7-17 to 7-26.

77. Rev. Rul. 69-545, 1969-2 C.B. 117 (explaining the rationale for hospitals' tax exempt status).

78. See RESTATEMENT (SECOND) OF TRUSTS §§ 368, 372 (1957) (defining the nature of charitable purposes and actions).

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

80. Mancino, *supra* note 58, at 1048.

81. See Rev. Rul. 69-545, 1969-2 C.B. 117. In late 1996, the IRS released its Continuing Professional Education Instruction Textbook for Exempt Organizations for Fiscal Year 1997. Under this new text, the IRS relaxed its policy restricting physician participation on the board of exempt hospitals. Physicians now may constitute a majority of the board of directors without jeopardizing the hospital's exempt status, provided the hospital is controlled by a parent corporation which itself is controlled by non-physician directors.

82. See *id.*

health insurance or through a public program such as Medicare.⁸³

4. Whether the hospital operates a full time emergency room treating all persons requiring emergency care, regardless of ability to pay.⁸⁴

5. Whether transactions between the hospital and members of its medical staff are conducted at arms' length and reflected fair market value.

6. Whether the hospital applies its surplus of receipts over disbursements to improvements in patient care; medical training, education, and research; expansion and repair of facilities; and amortization of indebtedness.

Shortly after Revenue Ruling 69-545 was introduced, it was challenged by health and welfare advocates as well as several private individuals. In *Eastern Kentucky Welfare Rights Association v. Simon*,⁸⁵ the Court of Appeals, reversing the District Court's holding that Congress intended to restrict the term charitable to its narrow sense of relief of the poor,⁸⁶ held that the term charitable as used in section 501(c)(3) was capable of a broader definition.⁸⁷ The Court stated that:

[Although] in the past Congress and the federal courts have conditioned a hospital's charitable status on the level of free or below cost care that it provided for indigents, there is no authority for the conclusion that the determination of 'charitable' status was always to be so limited. Such an inflexible construction fails to recognize the changing economic, social and technological precepts and values of contemporary society⁸⁸

The Court concluded that Revenue Ruling 69-545 did not overrule Revenue Ruling 56-185. Instead, it afforded an alternative

83. Although Medicaid was not mentioned in this regard, the Service applies this condition equally to Medicaid. See HILL & KIRSCHTEN, *supra* note 20, at § 3.02[1][c] 3-8 (citing SALINAS ET AL., *supra* note 75, at 157, 159).

84. See Rev. Rul. 69-545, 1969-2 C.B. 117 which states the following:

[B]y operating an emergency room open to all persons and by providing hospital care for all those persons in the community able to pay the cost thereof either directly or through third party reimbursement, [an exempt hospital] is promoting the health of a class of persons that is broad enough to benefit the community.

Id. at 118.

85. 506 F.2d 1278 (D.C. Cir. 1974).

86. *Eastern Ky. Welfare Rts. Org. v. Schultz*, 370 F. Supp 325, 338 (D.D.C. 1973) (finding that Revenue Ruling 69-545 was improperly promulgated and is without effect).

87. *Simon*, 506 F.2d at 1287.

88. *Id.* at 1287-88.

method whereby a hospital could qualify for exemption as a charitable institution.⁸⁹

Specialty hospitals, however, such as cancer institutions or children's hospitals, raised questions about Revenue Ruling 69-545's applicability to themselves. Children's hospitals rarely, if ever, involved Medicare patients; eye and ear hospitals rarely involved emergency situations, and consequently, such hospitals often did not have emergency rooms. The Service released Revenue Ruling 83-157,⁹⁰ which further relaxed the obligation of hospitals. It extended exempt status to specialized hospitals offering care for special conditions unlikely to require emergency treatment, thus having no emergency facilities.⁹¹ Revenue Ruling 83-157 has been interpreted to mean that "participation in Medicare and similar programs, as well as the operation of an open emergency room, were not absolute requirements of exemption, but merely illustrated the types of activities that would evidence the existence of sufficient community benefit to warrant tax-exempt status."⁹² The Service, however, has not endorsed this interpretation. It maintains that "Revenue Ruling 83-157 should not be interpreted to suggest that operation of a full-time emergency room open to all regardless of ability to pay is not a requirement for exemption, but is merely illustrative of the types of activities that demonstrate community benefit."⁹³ The Service goes on to depict the

89. See *id.* at 1289.

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

91. The Ruling stated:

[C]ertain specialized hospitals, such as eye . . . and cancer hospitals, offer medical care limited to special conditions unlikely to necessitate emergency care and do not, as a practical matter, maintain emergency rooms. These organizations may also qualify under section 501(c)(3) if there are present similar, significant factors that demonstrate that the hospitals operate exclusively to benefit the community.

Id. at 95. Furthermore, Revenue Ruling 83-157 announced that operation of an emergency room was not an absolute requirement in cases where a state planning agency made an independent determination that the emergency services would be duplicative and unnecessary. *Id.* at 94. As of 1996, Judith E. Kindell, of the Exempt Organizations Branch of the Internal Revenue Services, repeated that no state agency had ever made such a determination. (Personal communication with author).

92. Mancino, *supra* note 58, at 1048.

93. INTERNAL REVENUE SERVICE, INTRODUCTION TO THE HEALTH CARE INDUSTRY 216 (1995). In testimony before the House Select Committee on Aging, the Service explained that the operation of an emergency room and participation in Medicare and Medicaid are the two most important factors demonstrating community benefit. See *Hospital Charity Care and Tax Exempt Status: Restoring the Commitment and Fairness Before the House Select Committee on Aging*, 101st Cong. 58 (1990) (statement of James J. McGovern, Assistant Chief Counsel, Employment

operation of a full-time emergency room open to all regardless of ability to pay as a “virtual requirement to demonstrate community benefit.”⁹⁴

C. Congressional Initiatives

Despite the Service’s view, by 1990, there were growing concerns that nonprofit hospitals, in response to increasing pressure to control costs, were not delivering sufficient medical care to the indigent. In 1989, Representative Brian Donnelly (D-MA), introduced a bill linking a specified level of charitable care to the availability of tax-exemption.⁹⁵ The Donnelly bill was not enacted, but it sparked interest. Representative Edward R. Roybal (D-CA), then Chairman of the House Select Committee on Aging, held a hearing on June 28, 1990 to explore the amount and type of charity care provided by hospitals and the type of legislation needed to ensure that exempt hospitals shoulder their share of burdens.⁹⁶ At that meeting, a General Accounting Office (GAO) report,⁹⁷ commissioned by Representative Roybal, was released. The report found that “the link between tax-exempt status and the provision of charitable activities for the poor or underserved is weak for many nonprofit hospitals,”⁹⁸ and recommended that “[t]o the extent that one of the goals of the tax exemption is to continue or expand current levels of charity care and other services to the poor in an increasingly competitive hospital environment, changes in tax policy may be needed.”⁹⁹

In response, Representative Roybal introduced the Charity

Benefits and Exempt Organizations, Office of Chief Counsel, Internal Revenue Service).

94. James J. McGovern, *McGovern Reviews Hospital Developments Leading to July 10 Ways and Means Hearing*, 4 EXEMPT ORG. TAX REV. 446, 446-48 (1991) (transcribing the remarks of James J. McGovern, Assistant Chief Counsel (Employee Benefits and Exempt Organizations) to a Joint Assembly of the Canadian and U.S. Health Associations).

95. See H.R. 2207, 101st Cong. (1989) (providing that hospitals that provide insufficient service to low-income individuals would be subject to a 150 million dollar limitation on outstanding bonds).

96. HILL & KIRSCHTEN, *supra* note 20, at § 3.02[1][e] 3-11 (describing Representative Roybal’s efforts to ensure that tax-exempt hospitals bear their share of the burdens of providing charity care).

97. GAO/H.R. DOC. 90-84, *supra* note 21, at 12 (recording the General Accounting Office’s Report to the Chairman, Select Committee on Aging, and House of Representatives).

98. *Id.* at 44.

99. *Id.*

Care and Hospital Tax-Exempt Status Reform Act of 1990.¹⁰⁰ Representative Roybal intended, not to eliminate the tax-exempt status of hospitals, but to redirect the use of the exemption for the benefit of the indigent and near-indigent.¹⁰¹ The Charity Care Act proposed a substantive test for hospitals to meet in order to obtain and keep their exemption. In addition to satisfying the requirements of section 501(c)(3), hospitals would have to serve a reasonable number of Medicare and Medicaid patients in a nondiscriminatory manner, and would have to provide, in an equally nondiscriminatory manner, ample qualified charity care and qualified community benefits. To satisfy the qualified charity care requirement, a hospital would have to expend fifty percent or more of the value of the hospital's tax exemption for the tax year on unreimbursed charity care. Charity care was defined to include bad debt expenses, care to indigents or near-indigents, costs in excess of Medicaid reimbursements, and if the community had too few charity patients requiring charity hospital care, the costs associated with providing health services designed to improve the health of underserved members of the community. To satisfy the qualified community benefit condition, a hospital would have to expend thirty-five percent of the value of its exemption on qualified community benefits. Such benefits would include charity care costs exceeding the amount required under the qualified charity care arm of the test, or those uncompensated and not ordinarily provided by nonexempt hospitals. The bill defined the value of the exemption as the "national target percentage" of the hospital's gross revenues for the tax year, as follows:

[T]he percentage estimated by the [Service] which, when applied to the estimated average gross receipts of tax exempt hospitals in the United States for such taxable years, will yield an amount equal to the average Federal, State, and local tax revenues which are foregone by reason of their exempt sta-

100. Hospital Charity Care Act, H.R. 5686, 101st Cong. (1990), reintroduced the following year as H.R. 790, 102d Cong. (1991) [hereinafter Charity Care Act].

101. See 136 CONG. REC. E2949-01 (daily ed. Sept. 21, 1990). Representative Roybal remarked that "[w]ith the value . . . of hospital . . . tax-exempt status estimated at over \$8 billion annually, we must once again target this vital federal resource at providing hospital care to uninsured, underserved, and disadvantaged Americans." 137 CONG. REC. E396.23 (daily ed. Feb. 4, 1991).

tus.¹⁰²

Essentially, this meant that “the IRS would pick a number.”¹⁰³

Soon thereafter, Representative Donnelly introduced a bill under which a hospital would be denied exemption from federal income tax if a substantial portion of its activities was involved in operating a “nonqualified hospital.”¹⁰⁴ A qualified hospital was one which provided emergency services to all regardless of ability to pay,¹⁰⁵ treated Medicaid patients, and met one of five community benefit standards. Tests under the community benefit standard included treating a disproportionate share of low income Medicaid or Medicare patients; being a sole community hospital, as defined by Medicare; expending at least five percent¹⁰⁶ of gross revenues to provide charity care;¹⁰⁷ and expending at least ten percent of gross revenues to provide outpatient clinics in medically underserved areas.¹⁰⁸

These bills were considered on July 10, 1991, during the House Ways and Means Committee hearings to review the tax-exempt status of nonprofit hospitals, at which time a Treasury Department Assistant Secretary presented the Bush Administration’s preference for the community benefit standard.¹⁰⁹ No action was taken on either legislative proposal.

102. Charity Care Act, *supra*, note 100.

103. Richard Bove, *When Should a Hospital be Treated as a Charity?*, 3 J. TAX’N. EXEMPT ORG. 10, 12 (1991) (commenting on the valuation of a hospital’s exemption).

104. See H.R. 1374, 102d Cong. (1991) (requiring hospitals to provide certain emergency medical care in order to be exempt from income tax).

105. This condition adhered closely to the spirit of Rev. Rul. 83-157, in that the requirement to provide emergency care would not be applicable if the appropriate state agency determined that operating an emergency room would be unnecessary or duplicative, or if the nature of the hospital is such that, because of its specialty, it does not operate an emergency room and is not paid under Medicare’s prospective payment system.

106. Unlike the Roybal bill, the Donnelly bill sought to merge the charitable benefit standard with that of community benefit. The five percent target Donnelly utilized harkens back to Rev. Rul. 56-185, under which Internal Revenue Service agents determined the sufficiency of hospitals’ charitable care against a five percent target amount. See Hospital Charity Care and Tax Exempt Status, Hearings Before the Select Committee on Aging, 101st Cong., 2d Sess. 62-63 (1990) (statement of James J. McGovern, Internal Revenue Service Associate Chief Counsel).

107. For purposes of the Donnelly bill, charity care was defined as excluding bad debts.

108. See H.R. 1374, 102d Cong. (1991) (stating the requirements that are necessary for classification as a qualified hospital under the proposed bill).

109. Michael Graetz, the Treasury Deputy Assistant Secretary for Tax Policy, said that the “community benefit standard is a more appropriate standard for evaluating the tax-exempt status

In 1994, Representative Richard Gephardt, (D-MO), proposed an amendment to section 501(c)(3), as part of the Clinton Health Plan. He introduced section 501(n), adding a new exemption requirement that called for a community planning process, whereby tax-exempt healthcare organizations would be required to conduct annual assessments of the community's needs for healthcare and outreach services, and to develop a written plan stating how the organization would meet those needs. Like the rest of the Clinton Health Care Plan, it died on the vine. However, the question of indigent care and hospital tax exempt status remains very much alive on a federal, state, and municipal level.

D. State and Local Governments Lead the Way

Over the last ten years, state and local governments actively have challenged the exemption of hospitals.¹¹⁰ Some states have enacted legislation requiring hospitals to provide a set amount of uncompensated care in order to qualify for exemption from state and municipal taxes.¹¹¹ However, to date, no consensus has emerged from the courts that might inform the federal debate.¹¹² On the federal level, by 1991, the Ser-

of hospitals than the proposed charity-care standards" because it "recognizes the potential for a variety of means" of expressing the charitable purpose of the institution. *Tax Exempt Status of Hospitals and Establishment of Charity Standards: Hearings on H.R. 790 and H.R. 1374 Before the Comm. on Ways and Means, 102d Cong.* (1991).

110. In at least twelve states, local officials have sought to end nonprofit hospitals' charitable status and property tax exemption. Additionally, at least seventeen states have contemplated or enacted legislation to prevent unfair competition, and some municipalities are contemplating charging nonprofits a fee for the services they use. *See* GAO/H.R. DOC. 90-84, *supra* note 21, at 16.

111. *See, e.g., TEX. HEALTH & SAFETY CODE ANN. § 311.043* (West 1996) (stating that a hospital must provide charity care in order to qualify as a charitable organization). This section was enacted in response to the State Attorney General's attempt to force Houston's Methodist Hospital to increase its provision of charity care. *See State v. Methodist Hosp. Sys., No. 494212* (126th J. Dist., Travis Cty., Tex., filed Nov. 26, 1990). The effort may have motivated the state legislature to enact a bill requiring nonprofit hospitals to meet one of several tests involving minimum expenditures for charity care and community benefits. *See* Gary Taylor, *Charity Begins in Court? Hospital Sued in Novel Lawsuit*, NAT'L. L.J., Feb. 18, 1991, at 3 (describing a lawsuit brought by the Texas Attorney General against the nation's largest private non-profit hospital).

112. *See, e.g., Rideout Hosp. Found., Inc. v. Yuba*, 10 Cal. Rptr. 2d 141, 149 (Cal. Ct. App. 1992) (upholding hospital's property tax exemption from challenge by municipality; holding that a nonprofit hospital earning surplus revenue in excess of 10% could still qualify as charitable under the State Revenue and Taxation Code as long as it was organized and operated for an exempt purpose and operated under the nondistributional constraint); *Callaway Community Hosp. Ass'n. v. Craighead*, 759 S.W.2d 253, 255, 257 (Mo. Ct. App. 1988) (upholding hospital's

vice announced that it would "initiate coordinated examinations of large hospitals utilizing the services of income tax agents, exempt organization agents, computer audit specialists, and members of the Office of Chief Counsel."¹¹³ The Service expected to strip as many hospitals of their exempt status in 1991 as had lost their exemption in the prior ten years.¹¹⁴

III. CRITIQUE

The effort to link charity care to hospitals' tax exemption does not occur in a vacuum. Indeed, it occurs in an atmosphere where government has set health-care policy on a course that is antithetical to the provision of increased amounts of charity care. The result of government actions has been to increase the

eligibility for exemption from *ad valorem* taxation, despite the fact that the hospital, operating at a loss of approximately \$700,000, allocated only 4.9% of its operating expense to services for indigent patients); *Erie Sch. Dist. v. Erie Hamot Med. Ctr.*, 602 A.2d 407 (Pa. Commw. Ct. 1992). The court upheld the county board of assessment's determination that Hamot Medical Center was not exempt from property taxes, finding that the hospital, although it would provide emergency healthcare to individuals without regard to ability to pay, aggressively attempted to collect payment from uncompensated care patients not poor enough to qualify for Medicaid. Although the hospital provided emergency care, the court weighed heavily the fact that the hospital was compelled to do so as a condition of its licensure, determining that if the hospital was compelled to have an open emergency room by law, it could not be deemed to be performing this function voluntarily or charitably. *See also West Allegheny Hosp. v. Board Property Assessment*, 455 A.2d 1170, 1171 (Pa. 1982) (holding that the hospital properly fell under the state statute conferring an exemption on hospitals founded, endowed, and maintained by public and private charity, notwithstanding that public and private charity covered only a small portion of the hospital's costs, and that costs were passed along to the hospital's paying patients, whose fees covered approximately 80% of the amounts billed); *Downtown Hosp. Ass'n v. Tennessee Bd. of Equalization*, 760 S.W.2d 954, 957 (Tenn. Ct. App. 1988) (upholding lower court's reversal of a state board of equalization's determination that the nonprofit hospital was not entitled to exemption because the hospital received "substantial" payment for its services); *Arkansas Hosp., Inc. v. Arkansas Pass Indep. Sch. Dist.*, 521 S.W.2d 685, 691 (Tex. Civ. App. 1975) (finding that the hospital was not charitable in operation where only 1.9% of its admissions in a five year period were charitable cases); *Utah Bd. of Equalization v. Intermountain Health Care, Inc.*, 709 P.2d 265, 265 (Utah 1985) (upholding board of equalization's withdrawal of exemption, arguing that exempt status requires a sufficient measure of charity care, reflecting the view that healthcare delivery is not *per se* a charitable enterprise); *Medical Ctr. Hosp., Inc. v. Burlington*, 566 A.2d 1352, 1352 (Vt. 1989) (holding the hospital to be exempt from property taxation, although the hospital did not dispense an amount of free care in excess of the amount of care it gave to the paying public, nor did it derive its funds mainly from public and private charity).

A number of other hospitals, in exemption challenges from their states, have agreed to pay settlements in order to prevent revocation of the exemption. *See David Burda, Pa. Files More Challenges to Tax Exemptions*, MOD. HEALTHCARE, Feb. 18, 1991, at 2; Michele L. Robinson, *Via Donation or Tax, Cities Want More Revenues*, HOSP., Mar. 20, 1989, at 55.

113. Bove, *supra* note 103, at 11 (describing IRS' actions to initiate coordinated examinations at large hospitals).

114. *See id.*

numbers of uninsureds or underinsureds while decreasing the reimbursements to hospitals.

Perhaps the trend away from charity and toward commercialism began even before government enactments. As the hospital evolved into a medical institution controlled by physicians, it became not "a well of sorrow and charity but a workplace of the production of health."¹¹⁵ But the government has become a vast shaper of medical policy and is largely responsible for having created the conditions under which nonprofit hospitals render less uncompensated care than some would like.¹¹⁶

The passage of Medicare and Medicaid unleashed forces that had a great impact on nonprofit hospitals. As the government became an important third-party payor of medical services, hospitals moved "toward becoming . . . commercial nonprofits — organizations that generate most of their revenues from the sale of services rather than from charitable donations."¹¹⁷ Indeed, donations currently equal less than five percent of hospitals' revenues,¹¹⁸ due both to the size of the revenue, and to the belief that hospitals are less in need of donations in an era of third-party payors and government pro-

115. STARR, *supra* note 32, at 146.

116. In Congress' major effort to eliminate the barriers to employment, transportation, and public services faced by the disabled, it specifically omitted one major barrier - the preexisting condition barrier to obtaining medical insurance. The *Americans with Disabilities Act of 1990* provides that no portion of the Act shall be "construed to prohibit or restrict . . . an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law. 42 U.S.C. § 12201(c)(1) (1993) [hereinafter ADA].

In April 1996, the House (H.R. 3063) and Senate (S. 1698) each passed a version of the Health Insurance Reform Act of 1996. This Act was proposed by Senators Kennedy (D-MA) and Kassenbaum (R-KS) and won committee approval. However, several conservative Republican senators, opposing the measure, utilized an arcane procedural device, a "hold," to anonymously delay action. Only when the media attention created adverse publicity was this bill brought before the House and Senate for a vote. *See Bowermaster & Auster, supra* note 21, at 23. The Health Insurance Reform Act became the Health Insurance Portability and Accountability Act, and was passed in August, 1996. *See Health Insurance Portability and Accountability Act of 1996*, Pub. L. No. 104-191, 110 Stat. 1936, 1936 (1996). This legislation prevents insurers from denying coverage to individuals with preexisting conditions. Insurers will still be able to impose up to twelve month waiting periods before having to pay for medical treatment associated with the preexisting condition. *See id.* However, future insurers will not be able to exclude coverage for the same condition. *See Bowermaster & Auster, supra* note 21, at 23-24.

117. Bradford H. Gray, *Why Nonprofits? Hospitals and the Future of American Health Care*, 6 EXEMPT ORG. TAX REV. 729, 733 (1992).

118. *See id.* at 738.

grams.¹¹⁹

Medicare had an even greater influence, because it included reimbursement for capital expenses. Prior to the advent of Medicare, the Hill-Burton program¹²⁰ provided for hospitals' capital needs, in exchange for provision of uncompensated care.¹²¹ But in the 1960s, the Hill-Burton program was being phased out, requiring hospitals to develop their own funding sources. Unlike the for-profits, which could raise funds through shareholders, nonprofits were, by the terms of section 501(c)(3), under a nondistributional constraint. Therefore, the nonprofits had no shareholders from whom to obtain funding. Medicare's capital expense reimbursement program made it possible for hospitals to go to the debt market to replace funds they could no longer get through Hill-Burton and could not get in sufficient quantity through charitable contributions or through fees charged for services. But the debt market is less generous than Congress. It demands that "hospitals' credit worthiness be subject to careful evaluation and ranking on the scale used for bond rating."¹²² Questionable credit worthiness would result in lower bond ratings and higher interest costs. Financially weak hospitals were foreclosed from the debt market by virtue of their poor balance sheets. So it was important for hospitals to present a "good" bottom line in order to obtain funds. While "[e]valuations of credit worthiness depend on many factors . . . there is a negative correlation with such

119. See generally LESTER M. SALAMON, *AMERICA'S NONPROFIT SECTOR* (1992).

120. *Hospital Survey and Construction Act*, 42 U.S.C. § 291 (1964) [hereinafter Hill-Burton]. The Hill-Burton Act forged an alliance between federal and state governments, whereby federal money was allocated to the states according to a formula based on relative population and per capita income. From 1947 to 1974, the Hill-Burton program built forty percent of the beds in 6,000 of the country's nonprofit and public hospitals, costing four billion dollars in federal grants and loans, and \$10.4 billion more in state and local matching funds. See Milligan, *supra* note 23, at 12-13 (explaining the role of the Hill-Burton Act as it relates to federal and state governments).

121. Although Hill-Burton funds were distributed with the proviso that accepting hospitals provide a reasonable amount of free care to indigents, its mission has not always been marked with success. Compliance was tenuous at best, with hospitals having to be forced by legal action to render indigent care. See *American Hosp. Ass'n v. Schweiker*, 721 F.2d 170, 181 (7th Cir. 1983) (interpreting Hill-Burton's uncompensated care obligation to require that, for a period of twenty years after receiving Hill-Burton funds, hospitals must annually provide a prescribed amount of free or reduced-rate care to indigent patients), *cert denied*, 466 U.S. 958 (1984). See also 1 PRESIDENT'S COMMISSION STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *SECURING ACCESS TO HEALTH CARE 90-92* (1983) (commenting on how the ability to pay influences accessibility to healthcare services).

122. Gray, *supra* note 117, at 733.

factors as amount of bad debt and serving large numbers of Medicaid and Medicare patients."¹²³ Access to capital is critical in the healthcare industry, which is "capital-intensive due to the competition between hospitals to have the most modern facilities and the latest technology."¹²⁴ Foreclosure from the capital market could be detrimental to the future of a hospital. Thus, nonprofit hospitals were encouraged to minimize uncompensated care in order to gain access to the capital necessary for survival.

Medicare's prospective payment system revised the original terms of the Medicare program wherein reimbursement for hospital services was made on a reasonable cost basis. Given the dramatic rise in healthcare costs, jeopardizing the fiscal stability of the Medicare program, the prospective payment system reimbursed hospitals a set amount based upon the patient's diagnostic related grouping (DRG). The prospective payment system encouraged hospitals to become efficient, by virtue of its rationale that efficient hospitals could keep the difference between what Medicare reimbursed and what it actually cost the hospital to provide the care. This "led to immediate interest in hospitals' profitability,"¹²⁵ an interest inimical to rendering vast amounts of uncompensated care.

The government has also influenced hospital behavior with respect to its manipulation of the Medicaid program. Unlike the Medicare program, which is federal, "Medicaid is a cooperative federal-state program through which the Federal Government provides financial assistance to States" for the provision of indigent medical care.¹²⁶ But Medicaid has "failed to uphold the promise it offered,"¹²⁷ because states have "enjoy[ed] wide latitude in designing the specific eligibility requirements that will apply within their boundaries; being poor in and of itself is not enough."¹²⁸ Further, state-set reimbursement rates are precipitously low, creating an economic barrier for Medic-

123. *Id.*

124. Hansmann, *supra* note 9, at 54.

125. Gray, *supra* note 117, at 733.

126. See *Wilder v. Virginia Hosp. Ass'n.*, 496 U.S. 498, 501 (1990) (challenging administration of the state's Medicaid program).

127. Milligan, *supra* note 23, at 14.

128. *Id.* (citing Georgia's policy of denying coverage to families where both parents are in the home).

aid recipients when seeking medical care. Partially as a result of low reimbursement, few physicians are willing to treat Medicaid patients.¹²⁹ Some healthcare providers have challenged unreasonable reimbursement rates. In one such challenge, *Wilder v. Virginia Hospital Association*,¹³⁰ a nonprofit corporation of public and private hospitals filed suit, contending that the state's reimbursement plan violated the Boren Amendment.¹³¹ The Boren Amendment required the state to set rates:

[That it] finds, and makes assurances satisfactory to the Secretary, . . . [are] reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, and to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality.¹³²

The Court held that the language of the statute that gives states the obligation to set reimbursement levels is not satisfied by setting an arbitrary rate determined by budget considerations. Rather than increase the overall budget for indigent medical care, states have responded by limiting eligibility. Further, since Medicaid rates are set on a different scale than are those for Medicare, Medicaid rates remain well below those set for Medicare.

In addition, the modern healthcare landscape itself is hostile to increasing levels of charity care. Gunshot and knife wounds, AIDS, and illicit drug use have created an increased

129. See *id.* (stating that "twenty percent of all physicians have no Medicaid patients at all, and just six percent of all doctors care for one-third of all Medicaid patients").

130. See 496 U.S. at 498 (noting that the Boren Amendment creates a substantive federal "right").

131. See Pub. L. 96-499, 94 Stat. 2650 (1980) (changing the standard reimbursement of nursing and intermediate care facilities when Congress enacted the Boren Amendment).

132. 42 U.S.C. § 1396a(a)(13)(A) (1982 & Supp. 1988). When Medicaid was originally adopted, the Act provided for reimbursement based upon the reasonable cost of services actually performed. In 1972, the Act was amended in order to provide states with additional flexibility to develop standards for reimbursement, although Congress retained the requirement that states reimburse on a 'reasonable cost' basis for inpatient hospital services provided. See Social Security Act of 1972 § 232(a), 42 U.S.C. § 1396(a) (1972). Regulations promulgated by the Secretary of Health and Human Services, however, "had essentially forced states to adopt Medicaid rates based on Medicare 'reasonable cost' principles." *Wilder*, 496 U.S. at 506. Thus, in response to swiftly climbing Medicaid costs, Congress extended the Boren Amendment to hospitals in 1981, giving states greater flexibility to implement different reimbursement methodologies. The Boren Amendment changed the "reasonable cost basis" reimbursement provision to "reasonable and adequate" language. In so doing, Medicaid reimbursements would be smaller than those for Medicare.

demand for intensive hospital services, which in turn has placed "a new cost squeeze on hospitals."¹³³ Gunshot violence alone now adds approximately 4.5 billion dollars per year to healthcare expenditures.¹³⁴ It is more expensive to treat than are other forms of violence. In 1992, an average stab wound would cost approximately \$6,446 to treat, while an average gunshot case cost \$14,541.¹³⁵ For a gunshot into the spinal cord, the costs dramatically increase. In 1992, the National Spinal Cord Injury Statistical Center estimated the first year's medical costs of a gunshot wound to the upper cervical vertebra to be approximately \$417,067, plus \$74,707 each succeeding year.¹³⁶ For a gunshot wound to the lower spinal column, first year costs were estimated at \$152,395, plus \$15,507 for each year thereafter.¹³⁷ Spinal cord gunshot injuries are now so common that "some healthcare providers suspect gunmen are deliberately aiming for the neck."¹³⁸ Approximately seventy-five percent of all spinal cord gunshot victims are under thirty years of age,¹³⁹ portending "many costly years ahead."¹⁴⁰ But who bears these costs? Eighty percent of gunshot victims are either Medicaid recipients or are uninsured.¹⁴¹ Traditionally, hospitals have shifted the costs of treating uninsured and underinsureds onto the bills of paying patients. But both HMOs and traditional fee-for-service insurers have become more cost sensitive, making it difficult for hospitals to "pawn off on anyone the costs of the uninsured."¹⁴² Hospitals have responded to this cost squeeze by closing sixty urban trauma centers within the past ten years, leaving "less than one quarter of the nation's population resid-

133. Bove, *supra* note 103, at 11 (describing the impact of intensive hospital care). See also EUGENE RICHARDS, *THE KNIFE AND GUN CLUB: SCENES FROM AN EMERGENCY ROOM* (1989); GAO/H.R. DOC. 90-84, *supra* note 21, at 14-15.

134. See Susan Headden, *Guns, Money & Medicine*, U.S. NEWS & WORLD REP., Jul. 1, 1996, at 34 (noting the nine-fold increase in medical costs over the past decade).

135. *See id.*

136. *See id.* at 38.

137. *See id.*

138. *Id.* (speculating about why spinal cord injuries from gun shot wounds have become more common).

139. *See id.* at 40.

140. *Id.*

141. *See id.* at 31-32 (explaining why the public bears the cost of caring for gunshot victims).

142. *Id.* at 37.

ing anywhere near top flight trauma care.”¹⁴³ These centers all cited the “growing burden of [providing] uncompensated services—millions of dollars of which resulted from treating indigent victims of handgun violence.”¹⁴⁴

Further, there exist fundamental flaws in both the community benefit standard, and the charity care standard as articulated in the recent legislative efforts.

If, as the Roybal, Donnelly, and Gephardt bills suggest, the exemption is linked to the requirement that exempt hospitals render charity care, then the exemption, regardless of what tax theorists will argue,¹⁴⁵ is a subsidy of one form or another.¹⁴⁶ And if the exemption is a subsidy given to promote indigent care, then why should nonprofits receive it if for-profits, which also provide uncompensated care, do not?¹⁴⁷ Further, given that the tax exemption has been premised on its contribution to the promotion of pluralism by virtue of the social innovations provided by exempt nonprofits,¹⁴⁸ it would be a strange expression of pluralism to condition the hospital exemption on only one expression, that of charity care. This would render the exemption a mechanical quid pro quo that would fail to recognize new methods of increasing the community’s health.

The community benefit standard, too, contains flaws which render it mechanistic and archaic in an era where hospitals are combining and healthcare is being delivered in ever growing new forms.

Several indicia of community benefit, as articulated in Revenue Ruling 69-545, are duplicative of the statutory language in section 501(c)(3). Revenue Ruling 69-545’s requirements that the hospital be governed by prominent community

143. *Id.*

144. *Id.*

145. *See supra* note 9.

146. And in fairness, Congress, hospitals, and tax planners do assume it to be a subsidy. But calling it a subsidy does not in turn decide what that subsidy is or should be about when applied to hospitals.

147. *See, e.g.,* John D. Colombo & Mark A. Hall, *The Future of Tax-Exemption for Non-profit Hospitals and Other Health Care Providers*, 2 HEALTH MATRIX 1, 16 (1992) [hereinafter *Tax-Exemption*].

148. *See SALAMON, supra* note 119, at 9 (explaining that tax exemption for nonprofits is premised, in part, on the role they play in freedom and pluralism through encouraging initiatives for the public good).

citizens; that the hospital make medical staff privileges available to all qualified area physicians, space permitting; and, that transactions between the hospital and members of its medical staff be conducted at arms' length, reflecting fair market value, all speak to the requirement under section 501(c)(3) that the organization's assets not inure to the benefit of any private party. They have nothing to do with community benefit directly, except that the community does benefit when an exempt organization's funds are dedicated to the community, and not passed to insiders.¹⁴⁹ The requirement that the hospital apply its surplus of receipts over disbursements to hospital improvements is a straightforward ban against the distribution of exempt assets to a private interest. So only two elements of the community benefit test, the requirement that the hospital operate an open emergency room and that it provide care equally to those who pay by themselves, through private third-party payors, or through government programs like Medicare and Medicaid, really speak to the direction of the hospital's assets toward the community. But how relevant are they today?

Today, many hospital beds remain empty.¹⁵⁰ In an era of increasing competition, and in a desire to generate cash flow, hospitals are, if not courting Medicare and Medicaid recipients, far more eager to have them. This is due to the government payment that accompanies them,¹⁵¹ the theory being that a small payment is better than none at all, which is what an empty bed generates.

Finally, exempt hospitals are required to maintain an emergency room open to all regardless of ability to pay. Emergency departments, unlike physicians' offices, provide "24-hour staff coverage and highly technical procedural capabilities."¹⁵²

149. The term "insider" is defined in Treas. Reg. § 1.501(c)(3)-1(d)(ii) to include "designated individuals, the creator or his family, shareholders of the organization, or persons controlled, directly or indirectly, by such private interests." This definition is extremely broad, encompassing many who are excluded from the definition of insiders under the body of corporate law prohibiting "insider" trading.

150. Both the number of hospital beds, and the percentage of those beds occupied, fell from 1.7 million beds, of which 80% were occupied in 1965, to 1.2 million beds, of which 70% were occupied in 1992. James Kunen, *The New Hands-Off Nursing*, TIME, Sept. 30, 1996, at 57.

151. Finkelstein, *supra* note 48, at 48 (commenting on hospital dependence on government reimbursement for medical care). See also, GAO/H.R. Doc. 90-84, *supra* note 21, at 12.

152. John S. Dickhudt et al., *Emergency Room Use and Abuse: How it Varies With Payment Mechanism*, 70 MINN. MED. 571, 571 (1987).

Emergency department visits have been on the rise, increasing by nineteen percent from 1985 to 1990, a year which marked 99.6 million visits.¹⁵³ Those visitors have included victims of accidents, heart attacks, strokes, violence and drug abuse. The emergency room also receives victims of poverty, the uninsured and underinsured. The poor come for urgent and nonurgent care, for this is often the only place where care will be dispensed without regard to their ability to pay. Between 1985 and 1990, emergency department visits by Medicaid recipients increased by thirty-four percent.¹⁵⁴ But is the emergency department the most efficient place to provide primary care for such ailments as headaches, sprains, or other symptoms best addressed by a primary care physician?¹⁵⁵ Some research suggests that it is not.

One study,¹⁵⁶ utilizing data from the 1987 National Medical Expenditure Survey,¹⁵⁷ examined the ratio of emergency department to nonemergency department costs for nonurgent care.¹⁵⁸ The study, viewing approximately 2,100 visits to

153. See Robert M. Williams, *The Costs of Visits to Emergency Departments*, 334 NEW ENG. J. MED. 642, 642 (1996) (noting a 34% increase in visits by Medicaid patients, a 29% increase by Medicare patients, and a 15% increase by uninsured patients).

154. See The Medicaid Access Study Group, *Access of Medicaid Recipients to Outpatient Care*, 330 NEW ENG. J. MED. 1426, 1426 (1994) (citing U.S. GEN. ACCOUNTING OFFICE, EMERGENCY DEPARTMENTS: UNEVENLY AFFECTED BY GROWTH AND CHANGE IN PATIENT USE 93-4 (1993)).

155. It is likely that because the indigent cannot obtain access to private physicians, they resort to the always available emergency room for routine medical treatment. *Id.* at 1428. See also U.S. GEN. ACCOUNTING OFFICE, EMERGENCY DEPARTMENTS: UNEVENLY AFFECTED BY GROWTH AND CHANGE IN PATIENT USE 93-4 (1993) (stating the General Accounting Office identified the absence of a primary physician as the chief reason people use hospital emergency departments for minor medical problems); Judith S. Gavalier & David H. Van Thiel, *The Non-Emergency in the Emergency Room*, 72 J. NAT'L. MED. ASS'N. 33, 33 (1980) (stating that "the urban poor, who very often do not have a personal physician, use the hospital emergency room as a family physician, or as a source of ongoing medical care"); Richard I. Haddy et al., *Nonemergency Emergency Room Use in Patients With and Without Primary Care Physicians*, 24 J. FAM. PRAC. 389, 389, 392 (1987) (confirming the hypothesis that "patients who have personal physicians use emergency services less often for non-emergency reasons," and concluding that if individuals had access to personal physicians, "nonemergency emergency room use would decrease").

156. Laurence C. Baker & Linda Schurman Baker, *Excess Cost of Emergency Department Visits for Nonurgent Care*, HEALTH AFF., Winter 1994, at 162, 169.

157. The National Medical Expenditure Survey is a national survey of approximately 35,000 people in 4,000 American households. Survey items address the use of healthcare services and healthcare expenditures by individuals within the family, as well as the financing of these expenditures.

158. Nonurgent conditions were defined in this study to include superficial injuries, sore throats, diaper rash, eczema, corns, callouses, ingrown nails, conjunctivitis, earwax, hiccoughs, heartburn, headaches and backaches, gastroenteritis, upper respiratory tract infections, and

emergency departments and nonemergency departments, tested the hypothesis that use of emergency services for nonurgent situations is a source of excess healthcare expenditure. The study found that charges for emergency department visits were two to three times higher than those for visits in non-emergency department settings.¹⁵⁹ Based upon estimates of the total number of nonurgent cases being treated in an emergency department setting, the study theorized that the excess cost of such visits was five to seven billion dollars.¹⁶⁰

Another study reviewed medical record and billing information for a sample of twenty thousand emergency department visits in three Los Angeles, California hospitals deemed "representative of large and medium-sized urban [emergency departments] in which physician services were provided primarily by full-time board-certified or board-prepared emergency physicians."¹⁶¹ Of the initial sample, approximately nine thousand visits involved nonurgent conditions. The cost of providing such care in an emergency department setting was found to be almost twice the cost of its provision in a nonemergency department setting.¹⁶²

A recent report published in the *New England Journal of Medicine* challenged these findings.¹⁶³ This study examined six Michigan community hospitals' emergency departments, centering on the average and marginal costs of providing care.¹⁶⁴ Visits were classified as urgent, semiurgent, and non-

uncomplicated fractures of any digit or metacarpal. Baker & Baker, *supra* note 156, at 163.

159. *See id.* at 166-67. For all episodes, the difference between actual emergency department charges and those projected in non-emergency department settings was \$93.85, a ratio of 2.882:1.

160. These figures were determined by assuming that 55.4% (approximately 50 million) of 1992 emergency department visits were nonurgent, and multiplying this number by the \$93.85 differential in charges observed between emergency and non-emergency department costs. The resulting number, \$4.7 billion, was multiplied by the medical consumer price index (CPI), which indicated 54.8% growth between 1987, the year in which the data from the National Medical Expenditure Survey was obtained, and 1993, the year in which the study was prepared for publication. The resulting number is \$7.2 billion (1993 dollars). *See id.* at 169, 171.

161. Larry J. Baraff et al., *Direct Costs of Emergency Medical Care: A Diagnosis-Based Case-Mix Classification System*, 20 ANN. EMERG. MED. 1, 2 (1991).

162. *See id.* at 5.

163. *See Williams, supra* note 153, at 642-45 (indicating that the costs of nonurgent care in emergency departments is considerably less than previous studies conclude).

164. Marginal cost was defined as the extra cost for one additional visit. For instance, the cost for "squeezing in" a visit by a 12-year-old patient with acute asthma in a private physician's office at 4 p.m. would be relatively small. *See id.* at 642. In contrast, the cost of seeing the same

urgent.¹⁶⁵ The study found that, contrary to widely held belief,¹⁶⁶ “[t]he . . . costs of [providing] nonurgent care in the emergency department are relatively low.”¹⁶⁷ However, the study is flawed by the fact that it omitted hospitals located in the Detroit metropolitan area. Detroit is a large urban center whose problems of poverty, violence, and drug abuse require that emergency departments be highly sophisticated. This in turn calls for higher staffing, more intensive machinery, and consequently, higher costs associated with the provision of care.¹⁶⁸ Thus, this study provides little in the way of information that can be transferrable to large urban medical centers.¹⁶⁹ Further, even if the study’s conclusion is transferable, it suggests that there is some quantifiable cost to providing nonurgent care in an emergency room setting in excess of that associated with the provision of care in a primary care setting. Further, “although the potential savings from a diversion of nonurgent visits to private physicians’ offices would be less

patient by the same physician at 4 a.m. would be relatively high, due to the expense and inconvenience entailed in opening an office at a time when it is ordinarily closed. *See id.* Conversely, a 4 a.m. visit to an emergency room would be highly convenient, because the department is usually enjoying a slack period at that time, but, due to the nature of emergency departments, the cost is high because the department is fully staffed. *See id.* at 642, 644.

165. Urgent visits were defined as ones requiring immediate attention in the emergency department. It included patients who were admitted to the hospital, had conditions assigned critical care codes, or required special treatment for such conditions as burns, lacerations requiring sutures, fractures, or medical conditions requiring extensive evaluation in the emergency room. *See id.* at 642. Semi-urgent visits were defined as ones involving moderately serious injuries or medical conditions. *Id.* Nonurgent conditions were defined as “minor medical problems, such as acute pharyngitis, otitis media, upper respiratory tract infection, or first-degree burns.” *Id.*

166. *See id.* at 642 & n.2 (referring to federal government findings that nonurgent visits to emergency rooms by Medicare and Medicaid recipients cost considerably more than the same visits to physicians’ offices).

167. *Id.* at 642 (arguing that the actual marginal costs of nonurgent care at hospital emergency departments are far less than other studies suggest).

168. This cycle was recognized in a study by Robert M. Saywell, Jr. et al., *An Analysis of Reimbursement for Outpatient Medical Care in an Urban Hospital Emergency Department*, 10 AM. J. EMERG. MED. 8, 12 (1992) (illustrating how the demand placed on hospitals because of the “national trend of increasing [emergency department] visits,” necessitates increased staffing levels, thus increasing the emergency department’s payroll, which in turn increases the cost of providing care in an emergency department). *See also* Headden, *supra* note 134, at 36 (observing that more than half of the victims of gunshot violence require costly emergency procedures, such as laparotomies and thoracotomies).

169. Dr. Williams, the study’s author, acknowledges that the study’s hospitals were not randomly selected, but rather, the emergency departments in the study “contracted with physicians who used a common billing company,” and that “[t]he results [of the study] may not be applicable to other hospital settings or locations.” Williams, *supra* note 153, at 644-45 (providing further evidence that urgent care service is not a reliable standard for exempted status).

than is widely believed," some savings would be effected.¹⁷⁰

Another study, proceeding from the position that the "[u]se of the emergency department for nonemergency care is frequent and costly,"¹⁷¹ examined the effect of a copayment on utilization of emergency department services. This study followed 30,276 subjects who were members of the Northern California Kaiser Permanente Plan, a group-model HMO. The HMO introduced a copayment of \$25 to \$35 for the use of emergency department services, payable by cash, check, or credit card at the time the services were provided. The study found a 14.5% reduction in the number of nonemergency visits.¹⁷² However, the reduction in emergency visits¹⁷³ was deemed "small and not significant,"¹⁷⁴ resulting in no adverse events as a consequence of the copayment.

Thus, even if, *arguendo*, we cannot reliably conclude that the provision of nonemergency services in an emergency room setting costs more per visit, there is reliable evidence that the system pays more because absent responsibility for payment, services may be utilized in excess of what is reasonably necessary. And, if exempt healthcare dollars are inefficiently spent, the expenditure does not benefit the community, any more than does private inurement, which is barred by the statutory language of section 501(c)(3). In short, the emergency care requirement is not a sound basis on which to predicate tax-exempt status.

IV. PROPOSAL

As the foregoing has suggested, both the charity care and community benefit standards are flawed. They lack the flexi-

170. *See id.* at 642 (acknowledging that some cost savings would result from referring nonurgent patients in hospital emergency rooms to doctors' offices).

171. Joe V. Selby et al., *Effect of a Copayment on Use of the Emergency Department in a Health Maintenance Organization*, 334 NEW ENG. J. MED. 635, 635 (1996).

172. The study defined nonemergency conditions to include musculoskeletal sprain, strain, or pain, soft-tissue injury, vaginitis, wound infection, upper respiratory infection, cough, constipation, nasopharyngitis, arthritis, and headache. *See id.* at 640.

173. The study defined emergency conditions to include cardiac arrest, ventricular tachycardia or fibrillation, coma, myocardial infarction, respiratory failure, stroke, cerebral aneurysm, congestive heart failure, poisoning, drug overdose, fracture, gunshot or knife wound. *See id.*

174. *Id.* at 638.

bility to capture the ways in which some exempt hospitals provide benefit to the national community. For such hospitals, termed here "meta-hospitals," this Note proposes to create a categorical exemption, wherein the exempt hospitals would be bound by the requirements of section 501(c)(3), including the nondistributional constraint, but would not be bound by mechanistic yardsticks of community benefit.

Measuring community benefit in a more global setting is an idea whose time has come. Forces of technology and business are pushing medical information across the country into areas where it had not gone before, and furthering the concept of nation as community.¹⁷⁵ As telemedicine continues to allow hospitals to "reach out and touch someone,"¹⁷⁶ the someones they are touching are often patients in rural communities, for whom healthcare had previously been unavailable because of the community's remote location.¹⁷⁷

Indeed, nationalization of medicine is already recognized, as the strict locality standard¹⁷⁸ in malpractice has in many jurisdictions given way to a national rule,¹⁷⁹ recognizing the

175. See Rhonda Bergman, *Letting Telemedicine Do the Walking: Rural Project Uses Video Communications to Enhance Access to Care*, 67 HOSP. 46, 46 (1993) (quoting Scott Parisella, one of the organizers of the Rural Health Networking Project of Western New York, who observed that "[i]t is no longer the paradigm of transporting the expert knowledge worker, but transporting the knowledge worker's expertise," which produces "immediate access to medical expertise no matter where the patient is, and more timely diagnoses and treatment").

176. More than twenty states currently have telemedicine projects. See *id.* at 46-47 (reporting that an Austin, Texas nephrologist, who formerly had to travel three hours to visit his dialysis patients in Giddings, a rural Texas community, now is "available to patients [in Giddings] on a continuous basis").

177. *Model Act Would Create Special Licenses For Physicians Practicing Telemedicine*, 49 BNA HEALTH CARE POL'Y. REP., Dec. 11, 1995, at D-40 (noting that the impetus to developing the Telemedicine Model Act was the interest in telemedicine, stemming from the "demand for high quality healthcare irrespective of location").

178. The strict locality standard for examining the performance of physicians was "developed to protect the rural and small town practitioner, who was presumed to be less adequately informed and equipped than his big city brother." *Shilkret v. Annapolis Emerg. Hosp. Ass'n.*, 349 A.2d 245, 248 (Md. 1975). The standard recognized that "[i]n the smaller towns and country, those who practice medicine . . . do not enjoy . . . opportunities of daily observation and practical operations, where the elementary studies are brought into every day use." *Tefft v. Wilcox*, 6 Kan. 33, 43 (1870).

179. See, e.g., *Favalora v. Aetna Cas. & Sur. Co.*, 144 So.2d 544, 551 (La. Ct. App. 1962) (determining that "[t]o relieve a member of the medical profession from liability for injury to a patient on the ground that he followed a degree or standard of care practiced by others in the same locality is . . . unthinkable when the . . . standard of care in question is shown to constitute negligence because it fails to meet the test of reasonable care and diligence required of the medical profession"); *Shilkret*, 349 A.2d at 245 (observing that "the development of the strict locality

reality that medical school education, journals, cable programs, continuing medical education seminars, and the advent of telemedicine, allow healthcare providers throughout the country to be educated with the latest information. Currently, computer databases are providing instant information on advances in medical knowledge irrespective of the physician's geographic location. MEDLINE, the largest medical computer database, offers more than "five million references and articles from 4,000 journals."¹⁸⁰ Thus, in the realm of malpractice, the nation is the community benefitting from research and discoveries performed in localities far from that in which the medical treatment at issue occurs.

By recognizing meta-hospitals as categorically exempt from taxation, the Service would be doing no more than acknowledging the reality of the national reach of these hospitals currently. Even smaller hospitals are participating in research that will yield benefits to the many. For example, multi-centered clinical trials allow a given hypothesis to be tested on a large and diverse sample population. By testing on large and diverse populations, results can be more reliably generalized.¹⁸¹

But it is the amount and importance of the research done by these meta-hospitals that commends them for this special tax treatment. Research patterns differ between for-profit and not-for-profit hospitals, and between teaching and community hospitals.¹⁸² The importance of exempt hospitals' research can

rule a century ago was grounded in the manifest inequality existing in that day between physicians practicing in large urban centers and those practicing in remote rural areas," and determining that the rule could not be justified in light of the realities of modern medical practice, which made "[n]ew techniques and discoveries . . . available to all doctors within a short period of time through medical journals, closed circuit television presentations . . . medical literature, and . . . correspondence courses"; *Pederson v. Dumouchel*, 431 P.2d 973, 977 (Wash. 1967) (holding that "[n]egligence cannot be excused on the ground that others in the same locality practice the same kind of negligence"). See also John Kimbrough Johnson, Jr., Comment, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 732 (1970); Samuel J. Stoia, Case Brief, *Vergara v. Doan: Modern Medical Technology Consumes the Locality Rule*, 2 J. PHARM. & LAW 107, 107-12 (1993).

180. BARRY R. FURROW ET AL., HEALTH LAW § 6-2, at 240 (1995).

181. See Rebecca Dresser, *Wanted: Single, White Male for Medical Research*, 1992 HASTINGS CTR. REP. 24, 24 (finding that "despite a 1986 federal policy to the contrary, women [minorities and the elderly] continue to be seriously under-represented in biomedical research study populations . . . [resulting] in significant gaps in . . . knowledge").

182. See, e.g., GAO/H.R. DOC. 90-84, *supra* note 21, at 39 (finding that exempt hospitals engage in approximately twice as much scientific and clinical research as do investor-owned

be seen through the paradigm of the disease model, AIDS. In the early years of the epidemic, when research might have yielded the information essential to informing the public about conforming its behavior, neither government nor private funds were being amply distributed to researchers interested in the disease.¹⁸³ It was not until several years into the epidemic that the federal government began to dedicate more substantial sums for AIDS research.¹⁸⁴ But hospitals, which faced the beginning of the epidemic as the first patients entered their doors, performed fundamental research. This research begins, not with a grant proposal, a grant, an Institutional Review Board's analysis, but with the anecdotal evidence borne of the observation that one, then two, then another, then a group of patients have a cluster of unusual symptoms. Such research, funded by the hospitals themselves when the patients were uninsured or underinsured, revealed information that greatly benefitted the community, information without which a contaminated blood supply would have continued to be used for transfusion purposes.¹⁸⁵ Because discrimination and cutbacks in funding affect the rate at which research is undertaken,¹⁸⁶ the value of the exemption can be expressed as providing funding for important research that might otherwise find no other source of financial support.

Recognizing these special hospitals as categorically exempt will not decrease access to healthcare. It is unlikely that even one emergency room will close its doors as a result of the adoption and application of this proposal. Whether efficient or

hospitals).

183. See RANDY SHILTS, AND THE BAND PLAYED ON: POLITICS, PEOPLE, AND THE AIDS EPIDEMIC 91, 139, 144, 175, 190, 214, 232-33, 235, 283 (1987).

184. See *id.* at 288-98, 328.

185. See *id.* at 220-26, 307-09, 432-34, 477-78, 514-15, 539-43 (recording the difficulty encountered by officials at the Centers for Disease Control in compelling the blood banking industry to stop the potential spread of AIDS by recognizing that the disease could be transmitted through blood, and by taking prudent measures to screen donated blood).

186. See, e.g., *id.* at 91. Shilts observed that in 1981, scientists were not eager to begin research on the disease that would later be termed AIDS "because there was little glory, fame, and funding to be had in this field; there wasn't likely to be money or prestige as long as the newspapers ignored the outbreak and the press didn't like writing about homosexuals." *Id.* at 144. In 1982, during hearings by the Congressional Subcommittee on Health and the Environment, a representative from the National Cancer Institute announced it would release one million dollars for multi-centered Kaposi Sarcoma research, a sadly inadequate figure because "[a] grant to a single research center for one project often ran beyond ten million." *Id.*

not, the emergency room serves several functions in the hospital. The emergency room is a point of entry through which much desired hospital admissions are made. Further, by offering an emergency room open without regard to ability to pay, the indigent ill appear, sometimes presenting medical mysteries that challenge medical science and that untreated, may threaten the greater community.¹⁸⁷ As many of the indigent themselves suspected almost two hundred years ago,¹⁸⁸ they are valuable to hospitals because of the training ground they provide to the interns and residents who staff emergency rooms.

Adoption of this proposal may mean, however, that categorically exempt hospitals will refer screened and clearly stable nonemergency cases¹⁸⁹ to other local public or nonprofit hospitals that are better equipped to handle these patients.¹⁹⁰ Or, perhaps, it may mean that categorically exempt hospitals will require a token payment, which may reduce the number of nonurgent cases, while not deterring those in need of emergency care, from coming to the emergency department.¹⁹¹ By reducing inefficient and unnecessary healthcare expenditures, the funds are redirected toward more efficient utilization, the national fisc is protected, and the community benefit is advanced.

Ironically, requiring hospitals to render greater levels of uncompensated care may result in unintended consequences.

187. The gay men who first appeared at hospitals with what became known as AIDS were generally affluent and had, at least at the beginning of the crisis, health insurance. The I.V. needle-users, however, typically had no health insurance, and were indigent. If they had not had access to an emergency room at hospitals like Montefiore in New York City and San Francisco General in California, the transmissibility of AIDS from mother to fetus would have gone undiscovered for a longer period of time, as would the discovery that AIDS operates in a fundamentally different manner in I.V. injectors than in gay men. See SHILTS, *supra* note 183, at 103-04. Further, history has shown the inexorable connection between poverty and illness. See generally CHARLES E. ROSENBERG, *THE CHOLERA YEARS* (1962).

188. STARR, *supra* note 32, at 152 (stating that the sick poor were distrustful of hospitals because of the fear that they would be used for surgical experimentation, or, still worse, once dead, used for anatomical dissection).

189. Nothing in this proposal would undermine the obligations of meta-hospitals under the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (1995).

190. At Maine Medical Center's Emergency Department, a free mini-van transports such patients to Brighton First Care, with whom Maine Medical is affiliated. Tux Turkel, *Maine Med's Grand Plan*, PORTLAND (MAINE) PRESS HERALD, Jan. 19, 1997, at 1A. Patients are better served because they are treated sooner. *Id.* Maine Medical is pleased because routine illnesses can be treated more economically at Brighton. *Id.* As a result of this program, Maine Medical can reduce the number of employees needed in its emergency room. *Id.*

191. See *supra* notes 174-77 and accompanying text.

Currently, competition from for-profits, lower reimbursement from third-party payers, increased bad debt and empty beds, and increased cost control mechanisms from managed care organizations have all resulted in decreased hospital profitability. Financially vulnerable, some nonprofit hospitals have closed, or will be closing, their doors.¹⁹² Other nonprofits are finding salvation in conversions¹⁹³ and sales to for-profit corporations.¹⁹⁴ One healthcare economist has observed:

[T]he instability, bankruptcies, and falling profits of the 1980s have given way to a new wave of consolidations in the 1990s [in which] [i]n 1995 alone, there were 447 community hospitals in play in takeover negotiations, as well as several hundred more that had been sold in four large corporate mergers.¹⁹⁵

This will have profound repercussions, not only for charity care, but for healthcare in general.¹⁹⁶

As conversions and sales of non-profit hospitals to for-

192. See generally Finkelstein, *supra* note 48, at 45. See also Elizabeth Rosenthal, *Groups Predict New York Hospital Closings*, N.Y. TIMES, Apr. 7, 1996, at A1 (reporting that the "managed care revolution steamrolling through New York City," would result in the closure of at least fifteen hospitals in New York City, with the most likely targets being those that serve large numbers of uninsured or patients on Medicare).

193. See Sandy Lutz, *VHA Joins Effort to Aid For-Profit Conversions*, MOD. HEALTHCARE, Nov. 6, 1995, at 3 (reporting that "the need for capital, coupled with an increasing openness to the for-profit form," has spurred conversion to for-profit status"); Arlan R. Yoder, *Is Being Tax-Exempt Really Better?*, 32 HOSP. FIN. MGMT. 8, 8 (1978) (observing that changes in healthcare have encouraged many hospitals to convert to for-profit status). See also Robert Kuttner, *Columbia-HCA and the Resurgence of the For-Profit Hospital Business, Part I*, 335 NEW ENG. J. MED. 362, 362 (1996) (reporting that conversions of nonprofit hospitals to for-profit status have risen from 34, in 1994 to 58, in 1995).

194. See, e.g., Pamela Gaynor, *Sale of Non-Profits Raises Questions*, PITTSBURGH POST-GAZETTE, Dec. 22, 1995, at B11 (reporting that "[s]ales of non-profit hospitals to for-profit companies have been occurring at a breakneck pace"); Jay Greene, *Charity Care Falls After Oklahoma Hospital's Sale*, MOD. HEALTHCARE, Mar. 13, 1995, at 36 (reporting that in the year after Hospital Corporation of America acquired Presbyterian Hospital, a 311-bed Oklahoma City nonprofit hospital, charity care dropped from \$1.9 million to \$165,000); Charles Stein, *Healthy Competition? Possible Sale of Hospital to For-Profit Chain Raises Concerns*, BOSTON GLOBE, May 25, 1995, at 47 (reporting that MetroWest Medical Center, in Framingham, Massachusetts, was soliciting bids from at least one for-profit chain, widely rumored to be Columbia/HCA Healthcare Corporation).

195. Kuttner, *supra* note 193, at 363.

196. See, e.g., Gaynor, *supra* note 194, at B11 (reporting that the continued sale of nonprofit hospitals to for-profit chains will likely result in "the largest redeployment of charitable assets in history, potentially involving tens of billions of dollars"). The concern is that these charitable assets not be redeployed in ways that will serve private interests. See Louise Kertesz, *California Group Adopts Policy on For-Profit Conversion*, MOD. HEALTHCARE, Jan. 22, 1996, at 12 (reporting that the California Healthcare Association has adopted a policy "on the rights and charitable obligations of not-for-profit healthcare organizations when they convert to for-profit status," resolving to impress with a charitable trust the assets of nonprofits).

profit chains continue to reduce the number of nonprofit hospitals, uncompensated care will likely decrease. For-profit hospitals do render uncompensated care, of both the charitable and bad debt variety.¹⁹⁷ But how much of it they render is hotly debated.¹⁹⁸ One report indicates that 3,440 nonprofit hospitals rendered \$8.4 billion in uncompensated care in 1988; 1,149 for-profits provided only \$1.4 billion during the same period.¹⁹⁹ This averages out to approximately \$2,441,860.46 per nonprofit hospital, and \$1,218,450.84 per for-profit. These figures suggest that, on average, nonprofits render twice as much uncompensated care as is offered by for-profits.²⁰⁰ However, these figures may “overstate the contribution of for-profits somewhat, because their charges are higher.”²⁰¹ Furthermore, other figures indicate that in some regions, for-profit hospitals render far less charity care. In Florida, for-profit hospitals, accounting for fifty-six percent of the institutions and thirty-four percent of the beds, rendered only eight percent of the charity care and twenty percent of uncompensated Medicaid care. In Tennessee, where for-profits account for forty-four percent of hospitals and thirty-five percent of beds, for-profit hospitals “provide only three percent of charity care.”²⁰²

But since for-profits do render some measure of charitable care, and if, as has been claimed, the exemption is a subsidy given to promote indigent care, then why do for-profits not

197. See GAO/H.R. DOC. 90-84, *supra* note 21, at 12. See also Regina E. Herzlinger & William S. Kraker, *Who Profits from Nonprofits?*, HARV. BUS. REV. Jan.-Feb. 1987, at 93 (finding that, as compared with nonprofit hospitals, for-profit hospitals make their services available to as many, if not more, patients).

198. See Milligan, *supra* note 23, at 23 (concluding that “for-profit hospitals are financially successful not because they are intelligently managed, but rather, because they systematically exclude the uninsured poor”); Barbara Arrington & Cynthia Carter Haddock, *Who Really Profits From Not-For-Profits?*, 25 HEALTH SERV. RES. 291, 303 (1990). Responding to Herzlinger & Kraker, *supra* note 197, Arrington & Haddock examined data from the same time period, but viewed a larger data set and utilized a different statistical technique. They found that nonprofits return more social benefit, as defined by, *inter alia*, access to care, than do nonprofits. See also Jan P. Clement, et al., *What Do We Want and What Do We Get From Not-For-Profit Hospitals?*, 39 HOSP. & HEALTH SERV. ADMIN. 159, 159 (1994) (explaining data of how not-for-profit hospitals offer benefits to the community); Greene, *supra* note 193, at 36.

199. See GAO/H.R. DOC. 90-84, *supra* note 21, at 12.

200. See also Kuttner, *supra* note 193, at 365 (citing a report by the Georgia State Health Planning Agency that found that in 1993, nonprofit hospitals rendered “twice as much charity care per bed as for-profits”).

201. *Id.* at 366.

202. *Id.*

receive a subsidy for their provision of charitable care? The short answer is the nondistributional constraint, which differentiates nonprofits from for-profits. But this answer is only satisfying if the exemption for hospitals can be justified. Although a detailed discussion regarding the continued viability of non-profit hospitals' tax exemption is beyond the scope of this Note, and is available elsewhere,²⁰³ some brief statement is in order.

Certainly, under the Bittker and Rahdert income measurement theory,²⁰⁴ the exemption requires no justification. If the exemption is not a subsidy, but rather a matter of administrative convenience, then no *quid pro quo* could be required. And under Atkinson's altruism theory,²⁰⁵ the exemption is premised on the funders, controllers, and beneficiaries all being nonidentical, which entitles complying organizations to the exemption, regardless of the merits of their product or the public benefit derived therefrom. But Congress, the Service, and hospitals themselves assume the exemption is a subsidy, whether traditional or for capital. Given hospitals' ability to raise capital through tax exempt bonds, arguably Hansmann's capital subsidy theory is inapplicable. Then justification must rest upon a traditional subsidy. And in a world in which for-profits render good quality healthcare, is there still a justification for the exemption?

The nondistributional constraint, which prevents nonprofit hospitals from distributing their profits, may be more important now than ever before, because market failure still exists within hospitals, in that there continue to be "disparities of information and bargaining power between 'seller' and 'consumer.'"²⁰⁶ These disparities of information can become critical.

Entrepreneurs, by directly imposing market principles on hospitals, overturn the explicit understandings that have allowed doctors and hospitals to balance professionalism, profitability, and service [B]y weakening the professionalism that has traditionally served as a counterweight to the profit motive in

203. See Colombo, *supra* note 27 and accompanying text (arguing that tax exemption for hospitals/healthcare providers is an anachronism that should be ended).

204. See Bittker & Rahdert, *supra* note 9, at 307-16.

205. See Atkinson, *supra* note 9, at 501.

206. Kuttner, *supra* note 193, at 363.

medicine, the investor-owned chains risk undercutting clinical care as they relentlessly pursue cost savings. In theory, the competitive marketplace prevents any deterioration in quality, because dissatisfied customers are free to take their business elsewhere. But the healthcare system is rife with well-known asymmetries of information and "customers" who are essentially captive. By attracting the doctor and the insurance plan or HMO, the for-profit chain brings along the patient. Insofar as the investor-owned chains initiate a cost-cutting "race to the bottom" among hospitals, effective consumer choice is precluded, because rival hospitals pursue essentially similar economies.²⁰⁷

Further, managed care organizations, by virtue of their "gag provisions" and economic credentialing, which create additional monetary incentives for physicians and hospitals to deliver less care, have inserted a new fear factor into what is already a complicated decision. It is difficult to know which hospitals render the best care, and unfortunately, few of us research this question until we find that we need the answer in a hurry. By then, because we are ill, there is no time to research. Depending upon how ill we become, we may be highly compromised and vulnerable, and certainly not in any appropriate position to evaluate critically such complex issues.

Further, if lowered reimbursements and increased empty beds have created incentives to render less care, tort reform threatens to remove the last patient protection against such acts, by capping medical malpractice damages.²⁰⁸ But in an era when many economic incentives are presented to hospitals to do less, the threat of a large malpractice judgment remains a serious incentive to do at least enough, if not more. By removing or reducing the threat of liability for medical wrongs, legislators will be removing a very powerful patient weapon to

207. *Id.* at 363-64.

208. Early examples of state tort reform legislation include California's Medical Injury Compensation Reform Act of 1975, CAL. CIV. CODE § 3333.2 (West 1996) (placing a \$250,000 cap on non-economic injuries in medical malpractice cases); FLA. STAT. ANN. § 766.202 (West 1995). For more recent tort reform legislation refer to ALA. CODE §§ 6-5-544, 6-5-547 (1996) (limiting non-economic losses to \$400,000 and total judgment to \$1 million in medical malpractice cases); KAN. STAT. ANN. § 60-3407 (1995) (limiting compensatory damages in medical malpractice actions to \$250,000 and total amount recoverable to \$1 million); VA. CODE ANN. § 8.01-581.15 (Michie 1996) (capping recovery in medical malpractice actions to a total of \$1 million); WIS. STAT. ANN. § 893.55 (West 1997) (limiting total non-economic damages to \$350,000).

induce high, or at least acceptable quality medical care.²⁰⁹ Managed care, tort reform, and a competitive market are all forces that will act to reduce care. Nonprofits, by virtue of the nondistributional constraint embodied in section 501(c)(3), have one less incentive to do so.

Thus, the short answer to why for-profits that render charity care do not get the exemption subsidy is because they distribute their profits, creating an incentive to charge more and do less, in an environment where that incentive already exists, and threatens to become greater. And the incentive to do less is why for-profits render less charity care than do nonprofits, for "in a purely for-profit enterprise . . . there is no place for uncompensated care, unprofitable admissions, research, education, or public health activities—all chronic money losers from a strictly business viewpoint."²¹⁰ Thus, by linking the exemption to a requirement that nonprofit hospitals engage in more redistributive care, the result likely will be that hospitals will continue, at possibly an accelerated rate, to convert or sell themselves to for-profit entities, which ultimately will result in less redistributive care than currently exists.

Adoption of the categorical exemption may have an effect on the trend toward conversion and sale. If exempt meta-hospitals are strengthened as a result of this proposal, they may be in a stronger position to present "capital-starved, debt-laden community hospitals"²¹¹ with an alternative to accepting an offer from a for-profit institution. If nonprofits join to form strategic alliances with each other, they, like for-profits, can take advantage of economies of scale, which will enable them to purchase more for less. Further, both meta-hospital and smaller exempt hospitals may benefit from such alliances.

209. Speaking of Florida's Medical Malpractice Reform Act, one writer observed that "the Act has protected the wrong-doer at the expense of the innocent victim." Jessica Fonseca-Nader, Note and Comment: *Florida's Comprehensive Medical Malpractice Reform Act: Is It Time For a Change?*, 8 ST. THOMAS L. REV. 551, 552 (1996). For information about tort reform in general, refer to Steven M. Weiner & Marc Reibman, *Doctors Will Get More Immunity for Mistakes*, N.Y. TIMES, Mar. 22, 1995, at A18 (observing that "[t]he proposed tort reforms that seek to further limit damages for pain and suffering in medical malpractice lawsuits will dilute whatever minimal safeguards exist to prevent malpractice").

210. Kuttner, *supra* note 193, at 363.

211. Alex Pham, *Hospital Against Hospital: When Columbian/HCA Began a New Orleans Buying Spree, Nonprofit Institutions Joined Forces*, BOSTON GLOBE, Sept. 10, 1995, at A69.

Smaller hospitals can offer a patient stream to the meta-hospital for specialized services, while the smaller hospitals can benefit by being able to offer their patients better referrals and access to clinical trials, thereby reducing their costs by sharing administration functions with the larger hospital.²¹²

In the end, it is likely that the categorical exemption will represent for exempt hospitals a brass ring that, if not as attractive as that of the for-profit form, is at least more attractive than financial dissipation. The categorical exemption, if adopted, is likely to be a brass ring for which many nonprofit hospitals will reach.

V. PROPOSED SELECTION CRITERIA

Clearly, not all nonprofit hospitals fit the model envisioned in the proposal. Consequently, adoption of the proposal will create a two-tiered exemption structure for hospitals, wherein traditional hospitals will continue to be guided in their exemption by Revenue Ruling 69-545, and categorical nonprofits will be guided only by the explicit terms of section 501(c)(3). The distinction proposed in this Note is not beyond the ability of the Service, which is accustomed to making such distinctions.²¹³ However, it is necessary to develop criteria against which the Service can evaluate the applications from various hospitals eager to receive this categorical exemption.

Currently, in order to be recognized as exempt from federal taxes, organizations must submit a Form 1023, an elaborate application through which entities prove their eligibility. As part of that application process, hospitals wishing to apply for the categorical exemption should be required to complete a

212. Susan Pearsall, *A Hospital Winds Up With an Out of State Partner*, N.Y. TIMES, Jan. 28, 1996, at 9 (writing about the benefits of the alliance between New York City's Columbia Presbyterian hospital, "the country's oldest academic medical center," and New Milford hospital, "one of Connecticut's smallest hospitals"); New Milford will join "seven New York and New Jersey hospitals in the Columbia-Presbyterian Regional Network, which share information systems, clinical programs and trials, continuing education, and managed-care contracts." *Id.* In particular, Columbia-Presbyterian will not only receive referrals from Connecticut, a bedroom suburb of New York City, but will be able to provide several services at lower cost by providing them at the Connecticut site. *Id.*

213. The Service must determine whether an entity is entitled to an exemption, whether it falls within the religious exemption, in which case it is relieved of many reporting requirements, and whether it has engaged in more than an "insubstantial" amount of lobbying.

proposed Schedule A, wherein they detail the research grants they have received, the results of that research, surgical or medical breakthroughs pioneered at the hospital, and any other relevant information demonstrating innovation on the part of the hospital and/or its medical staff, the ways in which that innovation has benefitted the national community, and the percentage of the hospital's budget dedicated to this purpose. Only hospitals with a significant contribution to research and innovation, as demonstrated by means of the articulated criteria, should qualify for the categorical exemption. All other nonprofit hospitals should continue to be governed by Revenue Ruling 69-545.

It is not likely that the possibility of a categorical exemption will cause hospitals to engage in duplicative or needless research. Research funds, far from appearing like manna from heaven, are obtained through a laborious grant seeking process,²¹⁴ and grant applications are far from rubber-stamped. Since research dollars are subject to the governmental axe,²¹⁵ it is counter-intuitive that a grant foundation will award funds to research that is ill advised or unnecessary. Furthermore, an unsound research proposal, even if funded, would have to be reviewed by an Institutional Review Board, where, ostensibly, it would be reformed or rejected.²¹⁶ Finally, medical publications present a barrier to unsound research in their refusal to publish submissions that will not advance the field.²¹⁷

214. See generally BIOMEDICAL RESEARCH: COLLABORATION AND CONFLICT OF INTEREST (Roger J. Porter & Thomas E. Malone eds., 1992).

215. See, e.g., Eliot Marshall, *The Price of Compromise*, 269 SCI. 1662, 1662 (1995) (detailing how the price of easing a deadlock in Congress over a funding bill for biomedical research resulted in a smaller budget for the National Institutes of Health).

216. Greater monitoring of Institutional Review Boards (IRBs) by the FDA and HHS will likely be required as some IRBs face increased pressure to approve questionable research proposals designed less to increase scientific knowledge than to provide indicia of research sufficient to qualify for the categorical exemption from federal income taxation.

217. Sadly, in at least one case, a refusal by the American Academy of Pediatrics to present what appeared to be a "batty" idea kept Dr. Arye Rubinstein's findings that AIDS was being passed from infected mothers to their fetuses from being disseminated in a timely manner. See SHILTS, *supra* note 183, at 104. The *New England Journal of Medicine* held Dr. Rubinstein's article for six months, but then returned it unpublished, having concluded that the children in the study did not have AIDS. See *id.* at 171-72.

VI. CONCLUSION

Although it is fanciful to believe that the approximately 3,363 exempt hospitals, having a total of approximately 674,197 beds, can solve the crisis in access to healthcare currently endured by forty million Americans, even if joined by the 2,042 public hospitals, having a total of 370,466 beds,²¹⁸ “[i]t is probably not accidental that the hospital tax-exemption issue developed and gained steam during a period of documented growth in the number of uninsured Americans. This source of pressure for tax-exemption reform will be present until universal health insurance legislation is passed.”²¹⁹ This pressure should not result in wresting tax exemption from hospitals or in adding further mechanical tests. When hospitals work to arrest disease, restore health, and advance medical knowledge, they have benefitted the community. Nonprofit hospitals whose work significantly advances medical knowledge should be encouraged, via the categorical tax exemption, to dedicate their assets to the continuation of these purposes.

218. See HILL & KIRSCHTEN, *supra* note 20, at § 3.01[2] 3-5 & 3-6 (comparing the number of beds in public hospitals to those in tax-exempt hospitals).

219. Gray, *supra* note 117, at 733.

