

Vanderbilt Law Review

Volume 49
Issue 1 *Issue 1 - January 1996*

Article 4

1-1996

Tax Exemption and the Health Care Industry: Are the Challenges to Tax-Exempt Status Justified?

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Kevin B. Fischer, Tax Exemption and the Health Care Industry: Are the Challenges to Tax-Exempt Status Justified?, 49 *Vanderbilt Law Review* 161 (1996)
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NOTES

Tax Exemption and the Health Care Industry: Are the Challenges to Tax-Exempt Status Justified?

| | | |
|------|--|-----|
| I. | INTRODUCTION | 162 |
| II. | TAX EXEMPTION AND THE HOSPITAL INDUSTRY..... | 164 |
| | A. <i>The Legal Framework</i> | 164 |
| | B. <i>Challenges to the Tax-Exempt Status of Hospitals</i> | 167 |
| III. | THE EVOLUTION OF THE HEALTH CARE ORGANIZATIONAL MODEL..... | 175 |
| | A. <i>Legal Framework for the Tax Exemption of Managed Care Entities</i> | 177 |
| | B. <i>The Geisinger Litigation: Redefining the Community Benefit Test</i> | 180 |
| | C. <i>Integrated Delivery Systems and What the IRS Wants From Them</i> | 185 |
| IV. | THE FUTURE OF TAX EXEMPTION IN THE HEALTH CARE INDUSTRY | 186 |
| | A. <i>Tax Exemption and Integrated Delivery Systems</i> . | 187 |
| | B. <i>The Search for a Rationale for Exempting Health Care Organizations From Taxation</i> | 191 |
| V. | CONCLUSION | 195 |

I. INTRODUCTION

The provision of health care has traditionally been deemed a charitable function.¹ Therefore, hospitals and other health care institutions have been afforded the benefits of tax exemption.² As a standard for determining which entities merit the tax exemption and which do not, the Internal Revenue Service ("IRS" or "Service") developed what has come to be known as the community benefit test.³ At the federal level, this test has been the basis for awarding tax-exempt status to hospitals and other health care entities.⁴ State legislatures have traditionally followed the federal government's standards for tax exemption and have thus allowed health care organizations to be exempt from state taxes as well.⁵

In recent years, the United States health care system has changed dramatically. These changes have altered the ways in which health care services are provided.⁶ In seeking to find new and innovative organizational models for health care delivery, the health care industry has been confronted with a major question—namely, whether these new models of health care delivery should be tax-exempt. Critics of the tax exemption afforded health care organizations argue that health care has become more of a business and that non-profit health care entities are no different than their for-profit counterparts.⁷

The debate over non-profit health care organizations has reached a critical point, as evidenced by the challenges to the tax-

1. John D. Colombo, *Health Care Reform and Federal Tax Exemption: Rethinking the Issues*, 29 Wake Forest L. Rev. 215, 215 (1994).

2. *Id.* These entities have sought exemption under I.R.C. § 501(c)(3) (1994).

3. Rev. Rul. 69-545, 1969-2 Cum. Bull. 117.

4. *Id.* See also *Geisinger Health Plan v. Commissioner*, 985 F.2d 1210 (3d Cir. 1993) (applying the community benefit standard to a health maintenance organization).

5. Often state statutes have merely provided that entities that are organized for charitable purposes are exempt from taxation. See, for example, Tenn. Code Ann. § 67-5-212 (1995), which exempts "charitable" institutions from property taxes. Statutes such as these leave the responsibility with the state courts to define what is charitable. Other statutes explicitly exempt property used for hospital purposes from taxation. See, for example, 72 Pa. Stat. § 5453.202(a)(3) (Purdon, 1995).

6. As this Note will discuss, a concept known as managed competition has led to the development of new health care affiliations such as integrated delivery systems. Mark A. Hall, *Managed Competition and Integrated Health Care Delivery Systems*, 29 Wake Forest L. Rev. 1, 4 (1994).

7. See Robert Charles Clark, *Does the Nonprofit Form Fit the Hospital Industry*, 93 Harv. L. Rev. 1416, 1417 (1980) (stating that the preference for the non-profit form has deprived the government of billions of dollars without corresponding efficiency advantages); John D. Colombo, *John Colombo Says Tax The Hospitals*, 9 Exempt Org. Tax Rev. 1294, 1295 (June 1994) (arguing for the revocation of the tax exemption for hospitals).

exempt status of hospitals in many states.⁸ It is further evidenced by the IRS's recent challenge to the tax-exempt status of a health maintenance organization ("HMO") in *Geisinger Health Plan v. Commissioner*.⁹

This Note will demonstrate that these challenges to tax exemption have essentially involved the issue of what the community benefit standard should require and what we should expect from our non-profit health care institutions. This Note will argue that the community benefit test is premised on two important aspects of non-profit health care entities, which the courts and the IRS have already implicitly recognized. First, non-profit health care entities must organize and govern themselves in a way that allows them to be responsive to the needs of their communities.¹⁰ Second, these organizations must produce socially desirable outcomes by providing benefits

8. See *Utah County v. Intermountain Health Care*, 709 P.2d 265, 278 (Utah 1985) (revoking the state property tax exemption for two non-profit hospitals); Texas Tax Code Ann. § 11.18(d)(i) (Vernon, 1992 & Supp. 1995) (setting forth specific charitable care standards that hospitals must meet in order to be exempt from state property taxes); *School District v. Hamot Medical Center*, 602 A.2d 407, 414 (Pa. 1992) (revoking a hospital's tax-exempt status); *Roger Williams General Hospital v. Littler*, 566 A.2d 948, 950 (R.I. 1989) (upholding an assessment of taxes on equipment leased by tax-exempt hospitals). Compare *Douglas County v. Anneewakee, Inc.*, 346 S.E.2d 368, 371-72 (Ga. App. 1986) (rejecting a county tax board's assessment of property taxes on a non-profit hospital); *Medical Center Hospital v. City of Burlington*, 566 A.2d 1352, 1357 (Vt. 1989) (rejecting a city officials' challenge to the tax-exempt status of a non-profit hospital); *Callaway Community Hospital v. Craighead*, 759 S.W.2d 253, 257 (Mo. App. 1988) (reversing the assessment of property taxes by county officials and upholding a hospital's tax-exempt status); *Downtown Hospital Association v. Board of Equalization*, 760 S.W.2d 954, 958 (Tenn. App. 1988) (reversing the State Board of Equalization's determination that a non-profit hospital was not exempt from property taxes).

9. 985 F.2d 1210 (3d Cir. 1993). Furthermore, many theorists have questioned whether a rationale exists for exempting non-profit health care entities from taxation. See, for example, Henry Hansmann, *The Rationale for Exempting Nonprofit Organizations from Corporate Income Taxation*, 91 Yale L. J. 54, 55 (1981); Mark A. Hall and John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 Wash. L. Rev. 307, 313 (1991).

10. In Revenue Ruling 69-545, the IRS stated that a non-profit hospital must be "organized and operated exclusively in furtherance of some purpose considered 'charitable.'" 1969-2 Cum. Bull. at 117-18 (cited in note 3). The IRS then promulgated the community benefit test to determine whether a hospital was carrying out these functions. *Id.* at 118. As this Note will argue, the IRS should make more explicit the dual rationale for the community benefit standard and should develop criteria that adequately measure both organization and operation. See also J. David Seay, *Tax-Exemption for Hospitals: Towards an Understanding of Community Benefit*, 7 Exempt Org. Tax Rev. 413, 414 (March 1993) (arguing that the community benefit standard is premised on expectations about how non-profit hospitals are organized and governed). Organizational requirements for non-profits are also set forth in the regulations for I.R.C. § 501(c)(3). See 26 C.F.R. § 1.501(c)(3) (1994). The regulations require that a charitable organization incorporate under state non-profit statutes, state an exempt purpose, and provide for the distribution of assets for an exempt purpose upon dissolution. *Id.*

to their communities that the government might otherwise have to provide.¹¹

Part II of this Note will analyze the legal framework for tax exemption that courts have applied to hospitals, discussing the major inroads on the tax-exempt status of hospitals, particularly at the state level. Part III will discuss the evolution of the health care industry into new organizational models and will analyze the tax-exempt treatment that these entities have received. Finally, Part IV will suggest that a refined version of the community benefit test provides the best means for preserving the beneficial characteristics of non-profit health care entities while not interfering with the taxing purposes of the IRS. This refined community benefit test should be premised explicitly on both the organizational advantages and the beneficial outcomes provided by non-profit health care entities.

II. TAX EXEMPTION AND THE HOSPITAL INDUSTRY

A. *The Legal Framework*

Since the advent of taxation, the law has traditionally accorded hospitals the benefits of tax exemption.¹² Non-profit hospitals have sought exemption from federal income taxes under Section 501(c)(3) of the Internal Revenue Code.¹³ This provision contains both

11. This notion is explicitly recognized in the requirement that non-profit health care entities be "operated" in furtherance of a charitable purpose. I.R.C. § 501(c)(3) (1994); 1969-2 Cum. Bull. at 117 (cited in note 3). The community benefit test has attempted to define which entities are operated for "charitable" purposes by requiring such services as an open emergency room. 1969-2 Cum. Bull. at 118 (cited in note 3). Several courts have also recognized this function of non-profits. See *Bob Jones Univ. v. United States*, 461 U.S. 574, 591 (1983) ("Charitable exemptions are justified on the basis that the exempt entity confers a public benefit—a benefit which the society or the community may not itself choose or be able to provide"); *Utah County*, 709 P.2d at 278 ("[A] charitable organization should be eligible for exemption because it performs a task which the government would otherwise have to perform"). See also Seay, 7 Exempt Org. Tax Rev. at 414 (cited in note 10) (stating that the community benefit standard is based on the fact that non-profit health care entities provide socially desirable benefits to their communities); J. David Seay and Robert M. Sigmond, *Community Benefit Standards for Hospitals: Perceptions and Performance*, 5 *Frontiers Health Services Mgmt.* 3, 11 (Spring 1989) (stating that one benefit provided by non-profit hospitals is the provision of services which are highly valued by patients but which are not provided as often by for-profit entities because of their low profitability).

12. Colombo, 29 *Wake Forest L. Rev.* at 215 (cited in note 1).

13. I.R.C. § 501(c)(3) exempts from taxation:

[c]orporations . . . organized and operated exclusively for religious, charitable, scientific . . . or educational purposes, . . . no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities

organizational and operational requirements to qualify for exempt status.¹⁴ To fulfill the organizational component, the entity must qualify as a charitable organization, and so must incorporate under state non-profit statutes, claim an exempt purpose, and provide for the distribution of corporate assets for an exempt purpose upon dissolution.¹⁵ To meet the operational test, the entity must pursue a charitable purpose and may not engage in private inurement.¹⁶ In addition to exemption from federal income taxes, non-profit hospitals benefit from the fact that donors to the organization receive a corresponding deduction from their income taxes.¹⁷ Non-profit organizations can also issue tax-exempt bonds¹⁸ and have traditionally been exempted from state and local income, sales, and property taxes.¹⁹

The standards the IRS developed for evaluating the tax-exempt status of hospitals have evolved throughout the years. The IRS originally required hospitals to provide charitable care to the extent of their financial ability in order to obtain tax-exempt status.²⁰ To maintain tax-exempt status, hospitals could not deny medical treatment to those unable to pay.²¹ After Medicare and Medicaid were implemented, the need for traditional charity care was reduced²² and the IRS set forth a new approach to the tax-exempt status of hospitals in Revenue Ruling 69-545.²³

This ruling held that even when a hospital's general admissions policy requires a patient to pay for services, the hospital benefits the community if it operates for charitable purposes and maintains an open emergency room.²⁴ The IRS further deemed the "promotion of health" to be a benefit to the community.²⁵ The fact that some members of the community, such as indigents, did not receive benefits did

of which is carrying on propaganda, or otherwise attempting, to influence legislation . . . and which does not participate in . . . any political campaign on behalf of (or in opposition to) any candidate for public office.

14. 26 C.F.R. § 1.501(c)(3)-1.

15. *Id.*

16. *Id.*

17. Seay and Sigmond, 5 *Frontiers Health Services Mgmt.* at 35 (cited in note 11).

18. *Id.*

19. *Id.* at 9.

20. Rev. Rul. 56-185, 1956-1 Cum. Bull. 202, 203.

21. *Id.*

22. Hall and Colombo, 66 *Wash. L. Rev.* at 320 (cited in note 9).

23. 1969-2 Cum. Bull. at 117 (cited in note 3).

24. *Id.* at 118.

25. *Id.*

not automatically disqualify a hospital from meeting the community benefit standard.²⁶ The IRS based its ruling partly on the notion that a hospital should be per se exempt, regardless of whether the patient pays for services, because the provision of health care is charitable in itself. The ruling also articulated a broader community benefit theory of hospital tax exemption, as evidenced by the IRS's focus on such factors as the hospital's open emergency room, its independent board of directors, and its open medical staff.²⁷

The IRS continued to expand the class of hospitals that could receive tax-exempt status with its issuance of Revenue Ruling 83-157.²⁸ In this ruling, the IRS stated that a hospital with limited services, no open emergency room, and a policy of treating only paying patients could qualify for tax exemption.²⁹ This ruling allowed specialty hospitals, such as cancer and eye hospitals, to qualify for tax-exempt status provided that other indicia of community benefits were present.³⁰

Although the IRS characterized its analysis of a hospital's tax-exempt status as a totality of the circumstances inquiry,³¹ its public pronouncements demonstrated that the Service was focusing on several distinct factors.³² These factors included whether a hospital possessed an independent board of directors drawn from the general community, an open medical staff, nondiscriminatory treatment of Medicare and Medicaid patients, and an emergency room open to nonpaying patients.³³ The delineation of these factors is the closest the IRS has come to explicitly defining the term "community benefit."

An analysis of the IRS's factors for granting tax-exempt status demonstrates that the community benefit test is in fact premised upon both organizational and outcome criteria.³⁴ The requirement

26. *Id.*

27. *Id.*

28. 1983-2 Cum. Bull. 94.

29. *Id.* at 94-95. This ruling held that an open emergency room was not required for tax-exempt status if it would be unnecessary or duplicative with respect to facilities already available. *Id.*

30. *Id.* at 95. The IRS stated that the hospital's open medical staff, board of directors drawn from the community, and treatment of Medicare and Medicaid patients demonstrated the hospital's benefit to the community. *Id.*

31. 1969-2 Cum. Bull. at 118 (cited in note 3).

32. Colombo, 29 Wake Forest L. Rev. at 219 n.28 (cited in note 1).

33. *Id.* In sum, a hospital seeking to qualify for federal tax exemption must be properly organized under I.R.C. § 501(c)(3) and must meet the community benefit standard. 1969-2 Cum. Bull. at 117-118 (cited in note 3). A hospital should also operate an open emergency room if it maintains one. *Id.*

34. In Revenue Ruling 69-545, the IRS explicitly stated that a non-profit hospital must be "organized and operated" exclusively for charitable purposes in addition to meeting the other

that a hospital maintain an independent board of directors drawn from the general community is an example of an organizational component of the community benefit test. Requiring that a hospital's board of directors be made up of members of the local community ensures that the hospital is organized in such a way that it can be responsive and accountable to the health care needs of its community.³⁵ The open medical staff requirement is also an organizational component of the community benefit test. This requirement gives physicians broad access to hospital facilities so that members of the public can have access to quality physician services at any hospital they choose to attend.³⁶

The IRS's community benefit test also contains outcome criteria. The requirement that hospitals provide non-discriminatory treatment to Medicare and Medicaid patients provides a measurable benefit to the community. It ensures that individuals who participate in government-sponsored health care programs receive the same care as those patients who are privately insured.³⁷ Finally, the requirement that non-profit hospitals maintain an open emergency room benefits the community by serving as a safety net for uninsured persons who would not otherwise have access to health care services.³⁸

B. Challenges to the Tax-Exempt Status of Hospitals

As the definition of "community benefit" for hospitals has become less dependent on charitable functions traditionally associated with medical care, people have begun to question the propriety of granting tax exemptions to entities that may no longer be "charitable."³⁹ Critics of tax-exempt status contend that hospitals now treat mainly paying patients and, as evidenced by Revenue Ruling 83-

requirements of I.R.C. § 501(c)(3). However, the IRS did not analyze the community benefit test by separately and explicitly delineating which aspects of the hospital furthered the organizational component and which furthered the operational component as this Note argues that it should. See 1969-2 Cum. Bull. at 117 (cited in note 3).

35. Colombo, 29 Wake Forest L. Rev. at 242 (cited in note 1).

36. Gerald R. Peters, *A Practical Examination of the IRS and OIG Rules for Integrated Delivery Systems*, 7 Exempt Org. Tax Rev. 765, 767 (May 1993).

37. Colombo, 29 Wake Forest L. Rev. at 218 (cited in note 1).

38. *Id.* at 243.

39. See, for example, N. Keith Emge, Jr., *Nonprofit Hospitals and the State Tax Exemption: An Analysis of the Issues Since Utah County v. Intermountain Health Care, Inc.*, 9 Va. Tax Rev. 599, 612 (1990) (noting that non-profit hospitals are being forced to behave more like for-profit facilities with regard to the patients they treat and the facilities they provide).

157, need not even maintain an open emergency room.⁴⁰ This shift in tax policy has led some states to challenge the tax-exempt status of their hospitals and to question the community benefit test as a standard for determining which entities deserve tax-exempt status.⁴¹

Historically, the states followed the federal government's standards for tax exemption and thus allowed similar exemptions from state taxes.⁴² Although state legislatures, not courts, have the power to grant tax exemptions, local officials have recently brought challenges to the tax-exempt status of hospitals before state courts.⁴³ The courts have therefore had to interpret state statutory and constitutional provisions granting health care entities tax-exempt status.⁴⁴ The Utah Supreme Court's decision in *Utah County v. Intermountain Health Care*⁴⁵ is representative of the trend toward state courts taking an activist role in determining the standards for tax exemption.

In *Intermountain Health Care*, the Utah Supreme Court denied state tax exemption to two non-profit hospitals because they were not operated for "charitable" purposes according to the court's interpretation of that term from the Utah Constitution.⁴⁶ The hospitals were operated by a non-profit corporation, Intermountain Health Care ("IHC").⁴⁷ They were supervised by an unpaid board of trustees.⁴⁸ The corporation had no stock, and no dividends were paid to its trustees.⁴⁹ The hospitals had policies of treating patients without regard for their ability to pay.⁵⁰ Furthermore, one of the hospitals was the sole provider of specialized tertiary care for a large geographic region.⁵¹

The court determined that non-profit status should not be based on whether a hospital provides a community benefit because even for-profit hospitals benefit their communities in some respect.⁵² Instead, the majority defined the word "charity" under the Utah

40. 1983-2 Cum. Bull. at 94 (cited in note 28).

41. See note 8.

42. But see Clark, 93 Harv. L. Rev. at 1475 (cited in note 7) (arguing that non-profit hospitals should not be exempted from state property taxes).

43. See note 8.

44. *Id.* See also note 100 and accompanying text.

45. 709 P.2d 265 (Utah 1985).

46. *Id.* at 278.

47. *Id.* at 267.

48. *Id.*

49. *Id.*

50. *Id.* at 274.

51. *Id.* at 274 n.14. Tertiary care is the term used for sophisticated and high cost medical services. See *id.*

52. *Id.* at 276.

Constitution as a gift to the community.⁵³ According to the court, a gift to the community could be identified either by a substantial disparity in the exchange between the charity and the beneficiary of the services or by a reduction of the government's burden through the charity's operation.⁵⁴

The court's definition of charity stemmed from its finding that non-profit hospitals are becoming increasingly indistinguishable from for-profit entities in terms of their charitable functions.⁵⁵ The court sought to ensure that a hospital would not be able to obtain the benefits of tax exemption merely because it was organized in the non-profit form.⁵⁶ The court thus established a multi-factor test for determining whether a hospital should be tax-exempt. This test considered whether a hospital was organized in a non-profit form and also examined whether the hospital provided specific outcomes to its community in the form of measurable community benefits.⁵⁷

More specifically, the test's organizational component considered whether the hospital had a stated purpose of providing services without compensation, whether private inurement was prevented, and whether the entity was organized so as to subordinate commercial activities to charitable ones.⁵⁸ The test's outcome component determined whether the hospital provided measurable benefits that reduced the government's burden.⁵⁹ The court focused on whether the hospital provided free care and whether the group

53. *Id.* at 269.

54. *Id.*

55. *Id.* at 271.

56. See *id.* at 275 (noting that the only distinction between the non-profit hospitals in this case and for-profit entities was their corporate form, not their operation).

57. *Id.* at 269. The court's test looked to:

(1) whether the stated purpose of the entity is to provide a significant service to others without immediate expectation of material reward; (2) whether the entity is supported, and to what extent, by donations and gifts; (3) whether the recipients of the "charity" are required to pay for the assistance received, in whole or in part; (4) whether the income received from all sources (gifts, donations, and payment from recipients) produces a "profit" to the entity in the sense that the income exceeds operating and long-term maintenance expenses; (5) whether the beneficiaries of the "charity" are restricted or unrestricted and, if restricted, whether the restriction bears a reasonable relationship to the entity's charitable objectives; and (6) whether dividends or some other form of financial benefit, or assets upon dissolution, are available to private interests, and whether the entity is organized and operated so that any commercial activities are subordinate or incidental to charitable ones.

Id. at 269-70.

58. *Id.*

59. *Id.*

eligible to receive such care was restricted.⁶⁰ The court's test also contained two components which were neither organizational nor outcome-oriented. These included whether the hospital had accumulated capital in excess of expenses and whether the hospital was supported by donations.⁶¹

The two non-profit hospitals in this case had policies in place requiring them to provide services regardless of ability to pay.⁶² They were also prohibited from using their earnings to benefit private individuals and from distributing assets to private individuals upon dissolution.⁶³ Therefore, the hospitals met these aspects of the court's organizational criteria.⁶⁴ The hospitals failed to show, however, that their commercial enterprises were subordinate to their charitable ones.⁶⁵

Moreover, the Utah Supreme Court found that the hospitals failed the test's outcome-based criteria.⁶⁶ The court focused on the fact that the vast majority of recipients of the hospital's services paid for such services.⁶⁷ This exchange of services for money did not satisfy the court's "gift" standard.⁶⁸ The court also noted several incidents where the hospitals had failed to treat indigent patients, indicating that the hospitals did not see themselves as being responsible for providing charitable care.⁶⁹ The court further found that the hospitals were not supported primarily by donations and gifts, but instead raised revenue by treating mostly paying patients.⁷⁰ Finally, the hospitals failed the court's test because they had revenues in excess of their expenses.⁷¹

The Utah Supreme Court's approach was novel in many respects. First, the court focused on the level of free care provided by the hospitals.⁷² The hospitals' acceptance of Medicare and Medicaid

60. Id.

61. Id.

62. Id. at 274.

63. Id. at 273.

64. Id. at 272-73.

65. Id. at 276.

66. Id. at 274-78.

67. Id. at 274.

68. Id. at 276-77.

69. Id. at 276.

70. Id. at 273.

71. Id. at 275-76.

72. See id. at 274 (rejecting the hospital's claim that opening their facilities to all persons regardless of ability to pay was sufficient, and looking to the actual amount of free care given). But see *Medical Center Hospital*, 566 A.2d at 1355 (rejecting a contention that a hospital's tax-exempt status should be determined by the level of free care provided).

patients did not meet the gift standard required by the court.⁷³ The court reasoned that the acceptance of Medicare and Medicaid patients merely constituted the provision of services for government money.⁷⁴ Collection of such "remuneration" did not constitute a gift under the court's definition.⁷⁵

The court also determined that non-profit hospitals should support themselves by donations rather than by payment for services, which primarily supports for-profit hospitals.⁷⁶ Although the court did not define the level of donative support it would require, many non-profit hospitals will probably encounter difficulty meeting this requirement given the prevalence of third-party payment systems, such as private insurance, Medicare, and Medicaid. This is because these forms of insurance now provide a majority of hospital revenue.⁷⁷

The Utah Supreme Court confronted yet another important issue by inquiring as to whether non-profit hospitals produce a "profit" in the sense that their revenues exceed their operating expenses.⁷⁸ Traditionally, profit-making hospitals have retained non-profit, tax-exempt status based upon the rationale that by plowing their revenues back into the entity, these hospitals use their profits to provide tangible community benefits, including improved facilities.⁷⁹ The court rejected this argument because it found that most for-profit hospitals also utilize excess revenues for expanding their facilities and for purchasing new technology.⁸⁰ The court stated that it would

73. *Intermountain Health Care*, 709 P.2d at 274.

74. *Id.* at 274.

75. *Id.*

76. *Id.* But see *Medical Center Hospital*, 566 A.2d at 1356 (rejecting such a requirement because of the difficulty that a modern non-profit hospital would have in meeting it due to the advent of third-party payment systems).

77. See Hall and Colombo, 66 Wash. L. Rev. at 405-08 (cited in note 9).

78. *Intermountain Health Care*, 709 P.2d at 269. The dissent argued that the charging of fees for services, as well as the receipt of revenues in excess of expenses, did not make the non-profit hospitals "noncharitable." All that is required is that the organization utilize all of its funds for its charitable purpose. The evidence showed that while the hospital did receive substantial revenues from patients and through third-party payments, all of these funds were used to provide hospital services to those in need. *Id.* at 282-83 (Stewart, J., dissenting).

79. *Id.* at 275-76. The court did in fact find that IHC's revenues were used for the construction and improvement of its facilities. *Id.* at 275. For a discussion of the argument that non-profits are distinguishable based on the fact that their revenues are used for the provision of improved services, see Hall and Colombo, 66 Wash. L. Rev. at 383-84 (cited in note 9).

80. *Intermountain Health Care*, 709 P.2d at 275. The dissent argued that the majority opinion ignored two fundamental differences between for-profit and non-profit hospitals. First, by definition for-profit hospitals exist to make a profit. *Id.* at 289 (Stewart, J., dissenting). Second, the for-profit hospitals' decisions are governed by economics rather than by the altruism that goverus non-profits. *Id.* at 289-90. Altruism may cause nonprofits to provide more complex

not require an entity seeking tax-exempt status to consume all of its assets before being eligible for a tax exemption.⁸¹ However, the court questioned the propriety of granting a tax exemption that would essentially function as a competitive advantage for non-profit hospitals when those hospitals could not be effectively distinguished from their for-profit counterparts.⁸²

The Utah Supreme Court's opinion raises several legitimate concerns regarding the exemption of hospitals from taxation. The court was concerned that non-profit hospitals may now function as mechanisms for maximizing physician incomes, rather than as mechanisms for providing charitable health care to the community.⁸³ Moreover, the court emphasized that both for-profit hospitals and non-profit hospitals can and do provide charity care.⁸⁴ Finally, the court considered whether the tax exemption functions as an unfair competitive advantage for non-profit hospitals.⁸⁵

The Utah Supreme Court's opinion implicitly reevaluated the community benefit standard. The court was skeptical that an entity's qualifications for tax exemption, or for that matter its provision of community benefits, could be measured solely by organizational criteria.⁸⁶ The court searched for outcome criteria that would measure the benefits that non-profit hospitals actually provide.⁸⁷

The test set forth by the Utah Supreme Court in *Intermountain Health Care*, however, does not adequately refine the community benefit test. Although the court's test contained an appropriate organizational component,⁸⁸ its outcome criteria are

services, such as trauma care or burn treatment, which would not be profitable for the for-profit entities to operate. *Id.* at 290.

81. *Id.* at 276.

82. *Id.*

83. *Id.* at 271-72.

84. *Id.* at 271 n.10, 275.

85. *Id.* at 276.

86. See *Howell v. County Bd. of Cache County*, 881 P.2d 880, 885 n.10 (Utah 1994) (stating the court's concerns about the *Intermountain Health Care* case, which had been decided nine years earlier).

87. *Id.* In *Howell*, the court determined that the state tax commission's standards for determining hospital tax exemption, which were promulgated in response to the test elaborated in *Intermountain Health Care*, were constitutional. *Id.* at 890. Referring to its previous decision in *Intermountain Health Care*, the *Howell* court stated: "by focusing only on an institution's organizational and financial framework, one risks missing the more central question of whether the institution has bestowed a gift on the community." *Id.* at 885 n.10. In evaluating the state tax commission's standards, the court also noted that several of the factors were "organizational," while the others attempted to define and quantify the concept of "gift to the community." *Id.* at 886 n.12.

88. The court's emphasis on the hospitals' prevention of private inurement, their subordination of commercial activities to charitable ones, and their stated mission of providing care regardless of ability to pay effectively determined whether the hospitals were organized in a

subject to criticism. The court's test examined the amount of charitable care the hospitals provided, but its conception of charitable care will not necessarily result in the greatest benefit to each hospital's community. The court should have focused instead on whether the hospitals were providing the services most needed in their communities. Under the court's standard, a hospital could satisfy a charitable care requirement by undertaking a small number of very costly, medically interesting charitable cases. The court's standard failed to recognize, however, that a hospital might be able to provide a greater benefit to its community by spending less money, yet providing preventive care such as immunizations, physicals, or prenatal care to a larger number of people.

Furthermore, the court's outcome criteria were not broad enough to encompass a major benefit provided by one of the non-profit hospitals in *Intermountain Health Care*. One of the hospitals was the sole provider of certain specialized hospital services for an entire geographic region.⁸⁹ An appropriate outcome measure should view the provision of such care as a community benefit.⁹⁰

Finally, the court's emphasis on donative support and on whether the hospitals' revenues exceeded expenses⁹¹ does not help determine whether a hospital is organized in such a way that it can respond to community needs, nor does it help to determine whether the hospitals are achieving beneficial outcomes through the provision of community benefits. The court's focus on donative support is incompatible with the operation of most modern hospitals that derive most of their funds from third party payments.⁹² Yet, this fact does not limit their ability to benefit their communities.

The Utah Supreme Court itself subsequently retreated from its strict donative support requirement. In *Howell v. County Bd. of Cache County*,⁹³ the court noted that the hospital in that case received donations but found that the level of donations received was small

manner that allowed them to respond to community needs. See also notes 58, 62-65 and accompanying text.

89. *Intermountain Health Care*, 709 P.2d at 274 n.14.

90. See Colombo, 29 Wake Forest L. Rev. at 247 (cited in note 1) (stating that one measure of community benefit should be the range of services provided by the non-profit health care entity).

91. *Intermountain Health Care*, 709 P.2d at 269.

92. The non-profit hospitals in *Intermountain Health Care* made a similar argument, which the court rejected. *Id.* at 274.

93. 881 P.2d 880 (Utah 1994).

compared to the hospital's overall revenue.⁹⁴ The court was not troubled by the fact that this hospital operated primarily from the funds of paying patients,⁹⁵ and found that the hospital nonetheless benefitted its community.⁹⁶ Apparently, the Utah Supreme Court has recognized that this factor should not be determinative of which entities provide community benefits.

The Utah court's focus on whether revenues exceeded expenses⁹⁷ is also not a valid outcome criteria. The real issue is whether the excess revenues are used to improve the services that the non-profit hospital provides to its community.⁹⁸ If excess revenues are used for this purpose, then the hospitals are still providing outcomes that benefit their communities. There is evidence that non-profit hospitals often use excess revenues to provide specialized services to purchase high technology equipment that would not otherwise be available to patients.⁹⁹

The Utah Supreme Court's decision in *Intermountain Health Care* remains a minority position.¹⁰⁰ This fact does not, however, reduce its significance. The decision embodies the continuing debate over what functions a health care organization should perform to be tax-exempt. Moreover, the same issues that troubled the Utah Supreme Court with regard to non-profit hospitals are coming to the

94. *Id.* at 889 n.19.

95. *Id.* at 889.

96. *Id.*

97. *Intermountain Health Care*, 709 P.2d at 269.

98. The IRS recognized this fact in Rev. Rul. 69-545, 1969-2 Cum. Bull. at 117 (cited in note 3), where it stated that the fact that a hospital had excess revenues over expenses did not preclude its exemption, so long as the revenues were used to improve the quality of facilities and services provided by the entity.

99. See Seay and Sigmond, 5 *Frontiers Health Services Mgmt.* at 11 (cited in note 11).

100. See Texas Tax Code Ann. § 11.18(d)(1) (setting forth the requirements for qualification as a charitable hospital). The Texas statute requires hospitals to meet one of six standards regarding charitable care in order to be exempt from property tax. To be tax-exempt a hospital must (1) provide a reasonable amount of charitable care, (2) provide 4% of net patient revenue as charity care, (3) provide charity care equivalent to the hospital's tax-exempt benefits, (4) be a disproportionate share hospital in one of the two previous years, (5) before 1996, provide 5% of net patient revenue as charity care and community benefits with at least 3% of net patient revenue being charity care, (6) after 1995, provide 5% of net patient revenue as charity care and community benefits with at least 4% of net patient revenue being charity care. *Id.* Compare *Medical Center Hospital*, 566 A.2d at 1355 (holding that a hospital should retain its tax-exempt status, so long as it made its services available to all who needed them regardless of financial standing); *Callaway Community Hospital Association*, 759 S.W.2d at 256 (holding that a hospital that is operated in a not-for-profit manner, and whose services are made available to both rich and poor persons, is charitable regardless of the number of indigent patients actually served); *Downtown Hospital Association*, 760 S.W.2d at 957-58 (rejecting the *Intermountain Health Care* test adopted by the Utah Supreme Court for determining the tax-exempt status of non-profit hospitals and ruling instead that an organization that devotes its efforts to improving the community is a charitable institution).

forefront of the debate over the non-profit status of other health care entities as the industry continues its trend toward managed care.

III. THE EVOLUTION OF THE HEALTH CARE ORGANIZATIONAL MODEL

New models of health care delivery have developed in response to rapid changes in the health care industry.¹⁰¹ Although these entities do not resemble traditional hospitals, they have been treated similarly for purposes of tax exemption because they perform essentially the same function of providing health care services.¹⁰² Furthermore, just as the tax-exempt status of hospitals has been challenged at the state level, these new health care entities have faced similar challenges at the federal level.

Many of the changes in the health care industry were brought about by a novel approach to health care reform called managed competition.¹⁰³ This approach seeks to build on our private insurance system by instituting several major changes. The basic goal of managed competition is to divide health care providers in each community into competing economic entities, thereby utilizing the market to encourage the efficient delivery of health care.¹⁰⁴

Various affiliations have developed between hospitals, doctors, and insurance companies in response to the managed competition

101. See generally Hall, 29 Wake Forest L. Rev. at 1 (cited in note 6).

102. Michael W. Peregrine and Bernadette M. Broccolo, *New IDS Determination Letters Offer Promise, Sparks Controversy*, 7 Exempt Org. Tax Rev. 757, 761 (May 1993).

103. This theory was first proposed by Stanford economist Alain C. Enthoven. For a history of the evolution of this concept, see Alain C. Enthoven, *The History and Principles of Managed Competition*, 1993 Health Affairs 25 (Supp. 1993) (tracing the development of the idea of managed competition, describing the theory, and discussing it as a means to U.S. health care reform). Enthoven envisioned a managed competition system in which individual subscribers would choose from a variety of enrollment options among private insurance plans that would be coordinated and monitored by a "sponsor." *Id.* at 30-35. In our traditional system, by contrast, employers or the government have usually paid for the insurance and have offered only one service option. *Id.* Requiring individuals to pay for the price of their insurance option in a managed competition system makes individuals more cost conscious in their health care decisions. *Id.* The managed competition system therefore relies on market forces rather than regulatory forces to create efficiencies in the health care industry. Hall, 29 Wake Forest L. Rev. at 4 (cited in note 6).

104. Enthoven, 1993 Health Affairs at 29 (cited in note 103). Consumers will also make individual judgments concerning the cost and quality of their medical care and will bear the economic consequences of these choices. *Id.* at 44. See also Hall, 29 Wake Forest L. Rev. at 2 (cited in note 6) (defining the goals of managed competition as universal health insurance coverage along with cost containment and describing managed competition as a middle ground between socialized medicine and our current market system of private insurance).

concept.¹⁰⁵ The reorganization of our health care system is currently focused on so-called "integrated delivery systems."¹⁰⁶ Integrated delivery systems are organizations that provide all levels and types of health care services through affiliated providers. They attempt to achieve efficiency advantages by coordinating case management and information flow among providers.¹⁰⁷

Integrated delivery systems are unique from the organizational models that have previously dominated the health care industry.¹⁰⁸ First, integrated delivery systems encompass a very broad range of services; at a minimum they provide the full spectrum of hospital and physician services, both inpatient and outpatient.¹⁰⁹ They also provide long-term care facilities and many specialized services.¹¹⁰

Another unique aspect of integrated delivery systems is the incorporation of insurance risk into the delivery aspect of health care.¹¹¹ This incorporation often occurs through a capitated payment system.¹¹² Integrated delivery systems thus contrast sharply with traditional health care models because the financial success of the integrated delivery system depends on increasing the number of enrollees while economizing the cost of care.¹¹³ With traditional models of health care delivery, financial success hinges on the volume of either the patients treated or the care provided.¹¹⁴ The growth of these new health care entities forces us to revisit many of the important issues faced by the hospital industry in determining how these entities should be treated for tax purposes.

105. Hall, 29 Wake Forest L. Rev. at 4 (cited in note 6). Doctors, hospitals, and insurers have quickly realized the necessity of forming "networks" in order to gain the benefits of the managed care world. *Id.* at 4-5. No single physician or hospital can provide all of the services that are required to participate in managed competition. *Id.*

106. *Id.* at 5.

107. Carl H. Hitchner, et al., *Integrated Delivery Systems: A Survey Of Organizational Models*, 29 Wake Forest L. Rev. 273, 274 (1994).

108. Hall, 29 Wake Forest L. Rev. at 5 (cited in note 6).

109. *Id.*

110. *Id.*

111. *Id.* Another change that is expected to be brought about by the increasing prevalence of integrated delivery systems is that physicians will eventually need to be affiliated with a particular health plan or network. *Id.* at 4-5. Physicians have formerly had staff privileges at many hospitals. *Id.* If managed competition is to be effective, both hospitals and physicians must be aligned as independent economic entities. *Id.* at 4.

112. *Id.* at 5-6. Capitation is a method of payment in which the provider promises a full spectrum of health care services for a fixed, per person fee. *Id.* at 6 n.10. This fee does not depend on the volume of services received. *Id.* Under this payment method, the provider takes on the function of an insurer. *Id.*

113. *Id.* at 6.

114. *Id.*

There are numerous varieties of integrated delivery systems.¹¹⁵ Because HMOs¹¹⁶ were one of the first attempts at health care integration and have received a great deal of attention from the IRS, this Note will examine the IRS's treatment of these organizations in order to set forth the framework within which new forms of integrated delivery systems are being evaluated.

A. Legal Framework for the Tax Exemption of Managed Care Entities

Case law, IRS General Counsel Memoranda, and IRS determination letters have established the basic framework for analyzing the tax-exempt status of new health care entities, including integrated delivery systems.¹¹⁷ The treatment of these new entities has generally paralleled the precedents of hospital exemption.

The earliest decision addressing the tax-exempt status of an HMO was the Tax Court's decision in *Sound Health Association v. Commissioner*.¹¹⁸ Sound Health, a staff model HMO,¹¹⁹ filed suit in tax court after it was denied tax-exempt status by the IRS.¹²⁰ The Association provided its own medical services through a staff of two physicians at its own clinic and contracted with outside physicians for other basic services.¹²¹

The Tax Court applied the exemption standards set forth by the IRS for hospitals in Revenue Ruling 69-545 and found that Sound Health provided sufficient community benefits to justify its tax-exempt status.¹²² The Tax Court held that while the HMO relied on a membership system, its membership class was practically unlimited.¹²³ This was because the HMO planned to subsidize the dues of

115. See Hitchner, et al., 29 Wake Forest L. Rev. at 273 (cited in note 107) (surveying various models of health care delivery systems).

116. HMOs issue contracts under which they agree to provide comprehensive health care services for subscribers in exchange for set payments. Mark Hall and Ira Mark Ellman, *Health Care Law and Ethics* 61 (West, 1990). The payments are capitated and thus not dependent on the extent or type of services provided. *Id.* at 61-62.

117. IRS General Counsel Memoranda and determination letters are not legally binding precedent. They do, however, articulate the IRS's position with respect to tax exemption issues.

118. 71 Tax Ct. 158 (1979).

119. Staff model HMOs employ their own physicians. They also typically own and operate their own clinics and hospitals. Hitchner, et al., 29 Wake Forest L. Rev. at 303 (cited in note 107).

120. *Sound Health*, 71 Tax Ct. at 159.

121. *Id.* at 168, 172.

122. *Id.* at 168-69, 181-84.

123. *Id.* at 185.

those persons unable to pay.¹²⁴ The presence of the subsidized membership program demonstrated to the court that the HMO did in fact benefit the community.¹²⁵

Furthermore, the HMO provided an emergency room open to all persons regardless of membership with the HMO or ability to pay.¹²⁶ The HMO also provided some free care to the poor, had an open medical staff, provided health education programs for the community, and maintained an independent board of directors drawn from the general community.¹²⁷ The IRS had not required hospitals to treat all nonemergency persons regardless of ability to pay, and the Tax Court held that an HMO should not be held to more stringent requirements for tax exemption.¹²⁸ The court noted that the HMO may have had an even stronger case for providing a public benefit than the hospital in Revenue Ruling 69-545.¹²⁹

Subsequent to the *Sound Health* decision, the IRS issued General Counsel Memorandum 39,057,¹³⁰ which denied tax-exempt status to an independent practice association ("IPA") model HMO.¹³¹ An IPA is made up of independent physicians who maintain separate practices but who contract with the IPA to provide services to an HMO or other managed-care purchaser.¹³² The IRS found that the standards from Revenue Ruling 69-545 were also appropriate for an IPA model HMO.¹³³ In contrast to *Sound Health*, however, the HMO in question did not enroll individual members, did not have a plan to enroll Medicare or Medicaid recipients, did not intend to implement a subsidized dues program for either members or non-members, and did not provide either emergency services or free care to the poor.¹³⁴ The HMO also did not have an independent board of directors drawn from the general community.¹³⁵ The IRS concluded that it operated primarily for the benefit of its member physicians.¹³⁶

124. Id.

125. Id.

126. Id. at 184.

127. Id. at 184-85, 187. The HMO also stated that approximately 34% of its patients served in year one were expected to be Medicaid patients while approximately 2% were expected to be charity patients. Id. at 171. The HMO anticipated that by the sixth year the figures would be 14% Medicaid and .7% charity care. Id.

128. Id. at 187-88.

129. Id. See notes 24-27 and accompanying text.

130. Gen. Couns. Mem. 39,057 (Nov. 9, 1983).

131. Id.

132. Hitchner, et al, 29 Wake Forest L. Rev. at 275 n.4 (cited in note 107).

133. Gen. Couns. Mem. 39,057 (cited in note 130).

134. Id.

135. Id.

136. Id.

The IRS continued to delineate its position on the tax-exempt status of HMOs with its issuance in 1990 of General Counsel Memoranda 39,828 and 39,829.¹³⁷ General Counsel Memorandum 39,828 set forth various factors that the IRS would assess in considering whether an HMO was tax-exempt under Section 501(c)(3) of the Internal Revenue Code.¹³⁸ These factors generally mirrored the requirements for hospitals with a few additional factors such as free care to the indigent, a subsidized membership program, and research and education programs.¹³⁹ The IRS further required that no meaningful restrictions be placed on the HMO's membership in order to assure that the HMO would benefit the whole community and not merely its members.¹⁴⁰ Through its initial analysis of HMOs, the IRS indicated that it would treat these entities as hospitals. The IRS's position in the *Geisinger* litigation indicated, however, that it did not view all HMOs as meriting this identical treatment. The *Geisinger* litigation attempted to define what the community benefit test should

137. Gen. Couns. Mem. 39,828 (Aug. 30, 1990); Gen. Couns. Mem. 39,829 (Aug. 30, 1990).

138. These factors included:

Actual provision of health care services and maintenance of facilities and staff; provision of services to nonmembers on a fee-for-service basis; care and reduced rates for the indigent; care for those covered by medicare, medicaid or other similar assistance programs; emergency room facilities available to the community without regard to their ability to pay (and communication of this fact to the community); a meaningful subsidized membership program; a board of directors broadly representative of the community; health education programs open to the community; health research programs; health care providers who are paid on a fixed fee basis; and the application of any surplus to improving facilities, equipment, patient care, or to any of the above programs.

Gen. Couns. Mem. 39,828 at 14 (cited in note 137). See also Gen. Couns. Mem. 39,829 (setting forth the factors required for an HMO to be tax-exempt under I.R.C. § 501(c)(4) as a social welfare organization). The Service relied on a community benefit test which included: whether membership was open to individuals and groups, whether the HMO serves the indigent, high risk persons, medically underserved areas, or the elderly, and whether the HMO utilized a community rating system for its premiums. *Id.* at 18-19.

139. Gen. Couns. Mem. 39,828 (cited in note 137).

140. *Id.* This requirement included provisions for individuals comprising a substantial portion of the HMO's membership, a program to attract individual members, uniform rates for prepaid care provided by a community rating system, similar rates charged to individuals and groups, and no substantive age or health barriers for determining eligibility. *Id.*

General Counsel Memorandum 39,828 further complicated the issue of tax exemption for HMOs by determining that an HMO was providing commercial insurance within the meaning of I.R.C. § 501(m). *Id.* The IRS set forth relevant factors for determining whether an HMO provides insurance within the meaning of I.R.C. § 501(m) in General Counsel Memorandum 39,829 (cited in note 137). These factors include: whether a transfer and distribution of an insurance risk is taking place, whether the HMO operates similarly to commercial insurers or Blue Cross/Blue Shield, whether the HMO markets a product similar to that of commercial insurers, whether and to what extent the HMO provides health care services directly, and whether the HMO has capitation or salary arrangements with providers that shift the risks of loss. *Id.* at 41.

require for HMOs in an attempt to distinguish clearly which organizations are deserving of tax-exempt status.

B. The Geisinger Litigation: Redefining the Community Benefit Test

The Third Circuit's decision denying tax-exempt status to an HMO in *Geisinger Health Plan v. Commissioner*¹⁴¹ was an extremely important decision for all types of health care providers. In *Geisinger*, the Third Circuit attempted to redefine the community benefit test for HMOs.¹⁴² Geisinger Health Plan ("GHP"), an HMO, was part of a system of eight other health care organizations in Pennsylvania, including two medical centers and one clinic.¹⁴³ All eight of the other health care entities in the Geisinger system were tax-exempt.¹⁴⁴ GHP encompassed a predominantly rural service area that included many medically underserved areas.¹⁴⁵ GHP was organized for charitable purposes, had an independent board of directors, and had a membership open to both individual and group members.¹⁴⁶ GHP also enrolled Medicare subscribers. The organization planned eventually to enroll Medicaid recipients and to offer a subsidized membership program.¹⁴⁷

The IRS refused to grant GHP tax-exempt status.¹⁴⁸ Affirming the IRS's position on appeal, the Third Circuit agreed with the *Sound Health* court that the standards for evaluating hospital tax exemption were appropriate for HMOs.¹⁴⁹ In analyzing the hospital precedents, however, the Third Circuit determined that Revenue Ruling 69-545 did not eliminate the requirement that hospitals provide free care to indigents.¹⁵⁰

The court next distinguished the *Sound Health* HMO from the *Geisinger* HMO because GHP did not directly provide health care services to its members through its own facilities, but instead contracted for their provision.¹⁵¹ The court also noted that the HMO in *Sound Health* operated an open emergency room, provided some free

141. 985 F.2d 1210 (3rd Cir. 1993).

142. See *id.* at 1220 (stating that an HMO must "primarily" benefit the community).

143. *Id.* at 1212.

144. *Id.*

145. *Id.* The court noted that 23% of GHP's enrollees resided in medically underserved areas while an additional 65% resided in counties with medically underserved areas. *Id.*

146. *Id.* at 1213.

147. *Id.* at 1214.

148. *Id.*

149. *Id.* at 1216.

150. *Id.* at 1217.

151. *Id.* at 1217-18.

care, and conducted research and educational programs.¹⁵² The HMO in *Geisinger*, however, did not operate an emergency room open to the general public, was not a research facility, and did not provide educational programs for its community.¹⁵³ Although GHP intended to subsidize membership for those unable to pay for its services, it had been unable to generate the necessary funds at the time of the Third Circuit's opinion.¹⁵⁴

In holding that GHP was not entitled to tax-exempt status, the Third Circuit found that GHP did not provide sufficient community benefits, because it solely benefitted its subscribers.¹⁵⁵ The court emphasized that in applying the community benefit standard, courts should inquire whether a tax-exempt entity "primarily" benefits the community, rather than simply whether it benefits the community at all.¹⁵⁶ The court found that GHP's plan to subsidize members who could not afford to join did not suffice to demonstrate that the HMO "primarily" benefitted its community.¹⁵⁷ The court stated that the community benefitted by GHP was limited to its own members, since membership was a precondition to service.¹⁵⁸ Furthermore, the court stated that GHP primarily benefitted itself by promoting membership in its service area.¹⁵⁹ The court concluded that self-promotion, and not a desire to benefit the community as a whole, was the reason that GHP required an individual to be a member before receiving health care services.¹⁶⁰

The Third Circuit also disagreed with the *Sound Health* court's emphasis on the subsidized membership program as an indicia of community benefit.¹⁶¹ The Third Circuit noted that the HMO in *Sound Health* benefitted its community in many other ways, such as by providing free care to non-subscribers and by offering educational programs to the public.¹⁶²

152. Id. at 1218.

153. Id. at 1219.

154. Id. at 1213-14.

155. Id. at 1219-20. GHP did not provide its own health care services, did not conduct educational or research programs, and did not maintain an open emergency room. Id.

156. Id.

157. Id. at 1219.

158. Id.

159. Id.

160. Id.

161. Id.

162. Id. at 1220.

After finding that the GHP did not qualify for tax exemption on its own, the Third Circuit remanded the case to the tax court to determine whether GHP qualified for the exemption as an integral part of the Geisinger system.¹⁶³ Under the integral part doctrine, one organization may obtain tax exemption vicariously through related organizations if the related organizations are involved in activities that would qualify for tax exemption and if the activities advance the exempt purposes of the related organizations.¹⁶⁴ The Tax Court nonetheless held that even under the integral part doctrine, GHP was not exempt.¹⁶⁵

On appeal, the Third Circuit affirmed on separate grounds.¹⁶⁶ The Third Circuit held that in order to obtain exemption under the integral part doctrine, an entity must carry on a trade or business that would be unrelated to the parent's primary trade or business if engaged in by the parent organization.¹⁶⁷ Furthermore, the entity's relationship to its parent must enhance its exempt character to the extent that when this "boost" provided by the parent is added to the contribution made by the subsidiary, the subsidiary would be entitled to tax-exempt status on its own.¹⁶⁸ The court found that GHP's relationship with the Geisinger system did not increase the number of people served by GHP.¹⁶⁹ Regardless of its association with its parent organization, GHP would serve its own subscribers and thus did not receive a sufficient "boost" to qualify for tax exemption under the integral part doctrine.¹⁷⁰

The Third Circuit's decision in *Geisinger* represents an effort by the courts and the IRS to determine what the community benefit standard should require from non-profit health care entities. The Third Circuit held that, as an initial matter, GHP must be organized as a tax-exempt entity.¹⁷¹ The court next attempted to refine the community benefit standard in order to measure the socially desirable

163. *Id.*

164. *Id.*

165. *Geisinger Health Plan v. Commissioner*, 100 Tax Ct. 394, 406 (1993). The Tax Court held that GHP would have produced unrelated business income if one of the Geisinger system's exempt entities had absorbed its activities. *Id.* at 404-06. Therefore, GHP was not entitled to tax exemption. *Id.* at 406.

166. *Geisinger Health Plan v. Commissioner*, 30 F.3d 494, 498 (3d Cir. 1994). The Third Circuit did not deem it necessary to address the issue of unrelated business income. *Id.*

167. *Id.* at 501.

168. *Id.*

169. *Id.* at 502.

170. *Id.*

171. *Geisinger*, 985 F.2d at 1214-15. GHP met this criteria because it was incorporated for charitable purposes and prohibited private inurement. *Id.* at 1213-15.

outcomes produced by HMOs.¹⁷² The court's new standard required an HMO to demonstrate that it "primarily" benefits its community.¹⁷³ The court also held that Revenue Ruling 69-545 did not eliminate the requirement that non-profit health care organizations provide free care.¹⁷⁴

The *Geisinger* court sought to ensure that HMOs receiving tax-exempt status were truly benefitting their communities and not simply themselves. The court's standard, however, failed to measure adequately the beneficial outcomes that HMOs can provide. First, the court placed undue emphasis on the distinction between providing health care services directly through a staff-model HMO and providing the same services through contractual relationships.¹⁷⁵ This is not a valid basis for distinguishing between those types of health care entities that provide socially desirable community benefits and those that do not.¹⁷⁶ The community benefits provided by a particular health care entity are the same regardless of whether its physicians are employees or independent contractors. There is simply no link between the socially desirable outcomes that an entity provides and its contractual relationships with its physicians.

Furthermore, the Third Circuit's test did not account for the fact that GHP enrolled Medicare patients and was in negotiation for a Medicaid contract.¹⁷⁷ The IRS had emphasized the non-discriminatory treatment of Medicare and Medicaid patients as an element of community benefit in its evaluations of hospitals.¹⁷⁸ Such a requirement furthers the socially desirable outcome of assuring that participants in governmental reimbursement programs receive the same level of care as privately insured patients.¹⁷⁹ The non-discriminatory treatment of Medicare and Medicaid patients should thus constitute a factor in meeting the outcome component of the community benefit test for HMOs.

172. See *id.* at 1219-20 (analyzing whether the HMO "primarily" benefitted its community such as by providing care to non-members).

173. *Id.* at 1220.

174. *Id.* at 1217.

175. Colombo, 29 Wake Forest L. Rev. at 245-46 (cited in note 1).

176. *Id.*

177. *Geisinger*, 985 F.2d at 1214.

178. 1969-2 Cum. Bull. at 117 (cited in note 3). See also notes 34-38 and accompanying text.

179. See note 38 and accompanying text.

The Third Circuit's test also focused on the amount of free care provided by GHP.¹⁸⁰ The court noted that GHP only planned to subsidize a small number of people in relation to its overall subscriber-ship.¹⁸¹ The Third Circuit's free care requirement resembles the one imposed by the Utah Supreme Court in *Intermountain Health Care*, and the same criticisms apply.¹⁸² If a determination of community benefit is based on the amount of benefits, rather than on whether the benefits provided actually meet community needs, then the health care entity may not be achieving the most socially desirable outcomes.¹⁸³

Even more problematic regarding appropriate outcome criteria was the court's holding that subsidized membership is not an indicia of community benefit.¹⁸⁴ The court stated that only in rare circumstances would a health care organization be able to demonstrate that a subsidized membership program was intended to benefit the community and not the entity itself.¹⁸⁵ This statement reflects the Third Circuit's concern that HMOs might be able to obtain tax-exempt status by maintaining only a superficial subsidized membership program that did not truly benefit the community. The court's standard, however, practically eliminates the ability of any health care entity relying on a membership program to demonstrate that its subsidized membership program provides community benefits. Even if individuals must become members before they can receive health care services, this should not negate the fact that they are receiving measurable benefits from the HMO in the form of care that they would not otherwise have received. This criticism was particularly relevant in *Geisinger* because the HMO provided services to medically underserved areas.¹⁸⁶ The court's standard should instead have focused on whether the entity's membership program was adequately serving the needs of its community.

180. *Geisinger*, 985 F.2d at 1220.

181. GHP had not yet generated the funds to operate its subsidized membership program. *Id.* at 1214. It argued, however, that this was because it had been unable to assure potential donees of the deductibility of their contributions because it had not been granted tax-exempt status. *Id.* The court assumed that GHP would eventually have operated its membership program yet still found the necessary element of community benefit to be lacking. *Id.* at 1220.

182. See note 88 and accompanying text.

183. *Id.* The Third Circuit did note that GHP might not have had to operate an open emergency room under Rev. Rul. 83-157 if this service was unnecessary or duplicative. *Geisinger*, 985 F.2d at 1219. However, the court stated that despite this argument, GHP did not primarily benefit its community. *Id.*

184. *Id.*

185. *Id.*

186. *Id.* at 1212.

The community benefit standard promulgated by the Third Circuit in *Geisinger* demonstrates that the courts and the IRS have taken a narrow view of community benefit with regard to HMOs. Neither the IRS nor the Third Circuit, however, has adequately refined the community benefit test by providing outcome criteria that measure the benefits that HMOs often provide to their communities. Against the backdrop of IRS precedents regarding hospitals and HMOs, integrated delivery systems developed. The IRS had to adopt a new framework to fit these innovative health care entities.

C. Integrated Delivery Systems and What the IRS Wants From Them

The IRS, through determination letters, has granted tax-exempt status to seven integrated delivery systems in the last two years.¹⁸⁷ While these rulings are not legally binding, they demonstrate the IRS's basic requirements for the tax exemption of integrated delivery systems.¹⁸⁸ In granting integrated delivery systems tax-exempt status, the IRS has focused on several factors that closely resemble the requirements for hospitals. The IRS has considered whether the integrated delivery system operates open emergency rooms, maintains open medical staffs, participates in Medicare and Medicaid, and conducts research and education programs.¹⁸⁹ In addition, the IRS has considered several other factors unique to integrated delivery systems. For example, the IRS has viewed favorably integrated delivery systems that have a twenty percent physician representation limitation for their boards of directors because this minimizes the potential for private inurement of the exempt organization's

187. Full-Text Exemption Ruling: Friendly Hills HealthCare Network (January 29, 1993) in 7 Exempt Org. Tax Rev. 490 (1993); Full-Text Exemption Ruling: Facey Medical Foundation (March 31, 1993) in 7 Exempt Org. Tax Rev. 828 (1993); Full-Text Exemption Ruling: DMC Centers, Inc. (December 8, 1993); Full-Text Exemption Ruling: Billings Clinic (December 21, 1993); Full-Text Exemption Ruling: Harriman Jones Medical Foundation (February 3, 1994) in 9 Exempt Org. Tax Rev. 719 (1994); Full-Text Exemption Ruling: Rockford Memorial Health Services Corporation (April 4, 1994); Full-Text Exemption Ruling: St. Luke's Medical Associates, Inc. (December 30, 1994) in 11 Exempt Org. Tax Rev. 490 (1995).

188. Determination letters are not official IRS precedent. Peregrine and Broccolo, 7 Exempt Org. Tax Rev. at 797 (cited in note 102). Yet, they are extremely helpful in delineating the IRS's position on what types of health care organizations can be tax-exempt. *Id.*

189. Friendly Hills, 7 Exempt Org. Tax Rev. at 491 (cited in note 187); Facey, 7 Exempt Org. Tax Rev. at 829-30 (cited in note 187); Harriman Jones, 9 Exempt Org. Tax Rev. at 720 (cited in note 187).

funds.¹⁹⁰ Likewise, the IRS has viewed favorably the extensive record-keeping advantages of integrated delivery systems, which are achieved through these organizations' ability to integrate patient records and avoid duplicate testing and procedures.¹⁹¹ Finally, the IRS has focused on whether an integrated delivery system has made a commitment to charitable care, either through a policy of admitting emergency indigent patients or through a specific dollar commitment to charitable care.¹⁹²

One determination letter demonstrates that the IRS may have changed its position regarding the necessity of providing health care services directly rather than through contractual relationships. In *Geisinger*, the IRS contended that one reason why the HMO was not providing a community benefit was that it did not provide health care services itself but merely contracted for them.¹⁹³ However, the IRS granted tax-exempt status to the Facey Medical Foundation even though it did not own or operate an acute care hospital.¹⁹⁴ Instead, the Foundation was responsible for organizing and facilitating health care services through other entities.¹⁹⁵ It also contracted with physicians to provide services rather than directly employing physicians.¹⁹⁶

IV. THE FUTURE OF TAX EXEMPTION IN THE HEALTH CARE INDUSTRY

The health care industry has encountered attacks on non-profit status from several fronts. State governments have increasingly

190. *Friendly Hills*, 7 Exempt Org. Tax Rev. at 491 (cited in note 187); *Facey*, 7 Exempt Org. Tax Rev. at 829-30 (cited in note 187); *Harriman Jones*, 9 Exempt Org. Tax Rev. at 720 (cited in note 187).

191. *Friendly Hills*, 7 Exempt Org. Tax Rev. at 491 (cited in note 187); *Facey*, 7 Exempt Org. Tax Rev. at 829-30 (cited in note 187); *Harriman Jones*, 9 Exempt Org. Tax Rev. at 720 (cited in note 187).

192. The *Friendly Hills* and *Facey* determination letters are representative of this fact. The *Friendly Hills* integrated delivery system was committed to admitting emergency indigent patients for free or discounted follow-up care. *Friendly Hills*, 7 Exempt Org. Tax Rev. at 491 (cited in note 187). The *Facey* integrated delivery system promised to provide \$400,000 of charitable care during its first two years of operation and corresponding amounts in future years. *Facey*, 7 Exempt Org. Tax Rev. at 830 (cited in note 187). The *Harriman Jones* integrated delivery system similarly promised to provide \$750,000 of charitable care in its first two years of operation. *Harriman Jones*, 9 Exempt Org. Tax Rev. at 795 (cited in note 187). The *Billings Clinic* promised to treat all patients regardless of ability to pay and further planned to implement charitable care programs to reach the elderly and children in its community. *Id.*

193. *Geisinger*, 985 F.2d at 1219.

194. *Facey*, 7 Exempt Org. Tax Rev. at 829 (cited in note 187).

195. *Id.*

196. *Id.*

looked toward the health care industry for new sources of revenue.¹⁹⁷ At the federal level, *Geisinger* reexamined tax-exemption standards for HMOs.¹⁹⁸ The IRS has also delineated new standards for the tax exemption of integrated delivery systems.¹⁹⁹ When viewed against the backdrop of the hospital tax-exemption cases and the *Geisinger* case, it is possible to analyze the IRS's requirements for integrated delivery systems to determine whether they adequately refine the community benefit test.

A. Tax Exemption and Integrated Delivery Systems

The IRS determination letters, along with the *Geisinger* case, have clarified the IRS's position on the tax exemption of integrated delivery systems. All of the integrated delivery systems that have been granted tax-exempt status by the IRS have provided community benefits beyond what was required of hospitals in Revenue Ruling 69-545.²⁰⁰ In addition to the benefits traditionally provided by hospitals,²⁰¹ integrated delivery systems have offered efficiency and record-keeping advantages, research and education programs, and specific goals for charitable care.²⁰²

Just as the IRS is struggling to redefine the tax-exempt status of hospitals and HMOs, the IRS is seeking to refine the community benefit test to fit integrated delivery systems. The IRS's criteria for integrated delivery systems have included both organizational and outcome based components. Nonetheless, the IRS has failed to refine adequately the community benefit test.

The requirement that an integrated delivery system limit physician representation on its board of directors to twenty percent is an organizational criteria. The new twenty percent restriction constitutes an effort on the part of the IRS to ensure that integrated delivery systems maintain their community focus and do not engage in

197. See Seay and Sigmond, 5 *Frontiers Health Services Mgmt.* at 3-4 (cited in note 11) (noting that non-profit hospitals are attractive revenue sources with their large property holdings and cash flows). See also notes 8, 100 and accompanying text.

198. See Part III.B.

199. See Part III.C.

200. See notes 190-92 and accompanying text.

201. In determining the tax-exempt status of an integrated delivery system, the IRS has considered whether the integrated delivery system operates an open emergency room, treats Medicare and Medicaid patients, maintains an open medical staff, and limits physician membership on its board of directors to 20%. See, for example, *Friendly Hills*, 7 *Exempt Org. Tax Rev.* at 491 (cited in note 187).

202. See notes 191-92 and accompanying text.

private inurement,²⁰³ goals consistent with the underlying rationale of the community benefit test. However, the IRS need not have established a rigid limitation on physician representation to achieve this goal. Under the original community benefit standard, the IRS required that the board of directors be composed of members of the community but did not specify a maximum percentage of physician representation.²⁰⁴ This requirement of an independent board of directors drawn from the general community served the same function as the IRS's twenty percent limitation on physician representation.²⁰⁵ Yet, it also had the benefit of greater flexibility, thus allowing health care systems an opportunity to involve physicians in their governance. By imposing a twenty percent physician limitation on its board of directors, the IRS may have discounted the contribution physicians can make in determining and responding to the needs of their communities.²⁰⁶

The open medical staff requirement is an organizational criterion that the IRS has carried over from its treatment of hospitals.²⁰⁷ This requirement ensures that physicians have broad access privileges to health care organizations so that patients can benefit from their services.²⁰⁸ The requirement is thus consistent with the rationale that non-profit health care entities should be organized in a manner that allows them to be responsive to the needs of their communities. If the trends toward managed care continue, however, this criterion may no longer be appropriate.²⁰⁹ The managed care concept is premised on competition.²¹⁰ It requires that distinct economic entities compete for patients.²¹¹ In order to compete effectively, these entities must align themselves with physicians so that they can offer their patients a select group of doctors.²¹² If competition in health care is a community benefit, then an open medical staff may not be necessary

203. Colombo, 29 Wake Forest L. Rev. at 241-42 (cited in note 1).

204. 1969-2 Cum. Bull. at 117 (cited in note 3).

205. See J. David Seay and Bruce C. Vladeck, *Mission Matters*, in J. David Seay and Bruce C. Vladeck, eds., *In Sickness and In Health, The Mission of Voluntary Health Care Institutions* 1, 13 (McGraw-Hill, 1988) (stating that the independent board of directors requirement ensures that non-profits maintain their community focus). The potential problem with the IRS's new requirement is that if the health care industry continues its trend toward managed care, physicians will need to be included and not alienated from leadership roles during this transition period. Colombo, 29 Wake Forest L. Rev. at 216 (cited in note 1).

206. Colombo, 29 Wake Forest L. Rev. at 216 (cited in note 1).

207. 1969-2 Cum. Bull. at 117 (cited in note 3).

208. Peregrine and Broccolo, 7 Exempt Org. Tax Rev. at 792 (cited in note 102).

209. Colombo, 29 Wake Forest L. Rev. at 216-17 (cited in note 1).

210. *Id.*

211. *Id.*

212. *Id.*

to ensure that health care entities are responsive to their communities.

In terms of outcome-based criteria, on the other hand, the IRS has focused first on the open emergency room requirement, which the IRS carried over from its treatment of hospitals.²¹³ This requirement ensures that integrated delivery systems serve as a safety net for those without health insurance,²¹⁴ a function consistent with the underlying rationales of the community benefit test.²¹⁵ The second outcome based criteria requires the nondiscriminatory treatment of Medicare and Medicaid patients, which was also required of hospitals.²¹⁶ This requirement is also consistent with the underlying rationale of the community benefit standard because it ensures that Medicare and Medicaid patients receive quality care.²¹⁷

The IRS has developed a new outcome criteria for integrated delivery systems based upon the efficiency advantages of health care integration.²¹⁸ If the integrated delivery systems create such efficiency advantages through the integration of medical and record-keeping functions or through the avoidance of duplicate tests and procedures, then encouraging such efficiency is certainly consistent with the underlying rationale for the community benefit standard. Efficiency advantages are a socially desirable benefit because they result in lower costs, making medical services available to a broader segment of the community. The IRS has also focused on medical research and public education as outcome criteria.²¹⁹ Since these considerations provide community benefits that the government might otherwise have to provide, they are also appropriate outcome criteria.²²⁰

Finally, charitable care has become an extremely important outcome criteria for determining which entities will be tax-exempt.²²¹ The requirement of charitable care certainly satisfies one of the traditional rationales of the community benefit standard in that it ensures that integrated delivery systems provide health care to members of

213. 1969-2 Cum. Bull. at 117 (cited in note 3).

214. Colombo, 29 Wake Forest L. Rev. at 217 (cited in note 1).

215. See note 38 and accompanying text.

216. 1969-2 Cum. Bull. at 117 (cited in note 3).

217. See note 37 and accompanying text.

218. See, for example, Friendly Hills, 7 Exempt Org. Tax Rev. at 491 (cited in note 187).

219. *Id.*

220. See note 11 and accompanying text.

221. See notes 72, 150, 180-83 and accompanying text.

the community who could not otherwise afford it.²²² The problem with this requirement is that the IRS and the Third Circuit in *Geisinger* have taken a narrow view of what charitable care is. The IRS and the Third Circuit agreed in *Geisinger* that subsidized membership programs do not provide community benefits.²²³ However, a managed care organization with a subsidized membership program is providing charitable care even when the persons benefitting from the services are required to become members. The fact that an indigent person becomes a member of such an organization neither reduces the health care benefits that such a person receives nor converts the community benefit into a private benefit enjoyed by the health care organization.

Furthermore, the IRS determination letters indicate that the Service looks favorably on institutions that specify a precise amount of charitable care that will be given away.²²⁴ This conception of the charitable care requirement far exceeds what has been required of hospitals since Revenue Ruling 69-545.²²⁵ While this requirement may further the extent to which a health care entity provides socially desirable benefits to its community, it will not necessarily do so.²²⁶ The IRS should instead provide incentives for hospitals and integrated delivery systems to offer the types of health care services that are most needed.²²⁷ Such services might include preventive care such as immunizations, physicals, prenatal care, high blood pressure testing, and diabetic monitoring.²²⁸ By providing incentives for integrated delivery systems to deliver the most needed services, the IRS would truly be furthering the community benefit standard's goal of providing outcomes that are socially desirable and that the government might otherwise have to provide.

The *Geisinger* case and the Facey Foundation determination letter leave one further issue unresolved. Namely, the extent to which an organization's integration affects its tax-exempt status. In denying tax-exempt status to an HMO, the *Geisinger* court focused on the fact that the Geisinger Health Plan did not provide any medical

222. See note 11 and accompanying text.

223. *Geisinger*, 985 F.2d at 1219. The court left open the possibility that in some circumstances an HMO might be able to demonstrate that a membership program was intended to benefit the community and not merely to promote subscribership. *Id.*

224. See, for example, Facey, 7 Exempt Org. Tax Rev. at 829 (cited in note 187) (promising to give away at least \$400,000 in charitable care every two years). See also note 192 and accompanying text.

225. See notes 24-27 and accompanying text.

226. See note 88 and accompanying text.

227. See notes 88, 183 and accompanying text.

228. See note 88 and accompanying text.

services itself but rather contracted for them.²²⁹ On the other hand, the IRS granted the Facey Foundation an exemption even though it only facilitated health care delivery without directly providing health care services.²³⁰ The reasoning in the Facey Foundation letter ruling should prevail because denying an entity tax-exempt status based on its integration cannot be justified on either organizational or outcome-based rationales. Entities that solely facilitate the provision of medical services can be organized and governed in a manner that is just as responsive to community needs as entities that directly provide the same services.²³¹ Furthermore, there is no tangible distinction between the community benefits produced by an organization that provides medical services itself and one that contracts for the provision of such services. Hopefully, the IRS has recognized the superficial nature of such a consideration in determining whether an entity meets the community benefit standard.

B. The Search for a Rationale for Exempting Health Care Organizations From Taxation

The debate over the tax exemption of hospitals and other health care entities illustrates the deep ideological underpinnings of current health care debates. The Utah Supreme Court, the Third Circuit, and the IRS have all attempted to refine the community benefit test to distinguish between the types of health care entities that deserve tax exemption and those that do not.

As this Note has demonstrated, the community benefit standard is supported by a dual rationale. Health care organizations should be exempt from taxation if they are organized in a manner that allows them to be responsive and accountable to community needs²³² and if they provide socially desirable community benefits to their communities that the government might otherwise have to pro-

229. *Geisinger*, 985 F.2d at 1219-20.

230. *Facey*, 7 Exempt Org. Tax Rev. at 828-29 (cited in note 187).

231. See notes 175-76 and accompanying text.

232. See *Seay*, 7 Exempt Org. Tax Rev. at 417 (cited in note 10) (stating that non-profit institutions are unique because of their governance and management processes). See also *Seay and Vladeck, Mission Matters*, in *Seay and Vladeck, eds., In Sickness and In Health* at 26-27 (cited in note 205) (stating that non-profit health care organizations should make continual efforts to reassess their commitment to the community and to address the community's health care needs).

vide.²³³ These qualities distinguish non-profit health care entities from their for-profit counterparts.²³⁴

The IRS and the courts must recognize the dual rationales supporting the community benefit standard and refine the test so that it is explicitly premised on both organizational and outcome criteria. As this Note has discussed, the IRS has already recognized the need to ensure that health care entities are organized in such a way as to be responsive to their communities.²³⁵ This is evidenced by the IRS's emphasis on an independent board of directors for hospitals, a twenty percent limitation on physician representation on an integrated delivery system's board of directors, open medical staffs, and prohibitions against private inurement.

However, the IRS has failed to state explicitly that the function of these requirements is to ensure that non-profits are organized in such a way as to be responsive to community needs. In implementing explicit organizational criteria, the IRS should not necessarily impose narrow, exclusive requirements on non-profit health care organizations. The organizational criteria should be broad enough to allow non-profit health care organizations to satisfy the standard in various ways. As this Note has previously discussed, strictly limiting physician representation on an integrated delivery system's board of directors may not further the underlying goal that non-profit health care entities be organized in a manner that allows them to be responsive to community needs.²³⁶ The IRS should not rule out the possibility that non-profit health care entities could create unique ways of meeting the organizational criteria.²³⁷

The community benefit standard must also measure outcomes, the socially desirable benefits produced by non-profit entities that relieve the government's burden of providing health care services. The IRS should also make this outcome criteria an explicit prong of the community benefit test. This Note has previously discussed the failure of both the IRS and the courts to develop outcome criteria that adequately measure the community benefits provided by non-profit

233. See notes 10-11 and accompanying text.

234. See Seay and Vladeck, *Mission Matters*, in Seay and Vladeck, eds., *In Sickness and In Health* at 9 (cited in note 205) (stating that these institutions have also symbolized an American tradition of limited governmental involvement in local affairs). See also note 10-11 and accompanying text.

235. See note 10.

236. See notes 204-206 and accompanying text.

237. For example, if an integrated delivery system has a committee composed of community members that attempts to develop plans for the provision of charitable care, the IRS's organizational criteria should take this into account.

health care entities.²³⁸ Consequently, the IRS and the courts have not developed outcome criteria that measure the benefits that non-profit health care entities provide through service to medically underserved areas or to a subsidized membership.²³⁹ Furthermore, the IRS and the courts have focused on the specific amount of charitable care provided by a health care organization in assessing whether the entity benefits its community, rather than on the type of care provided and its value to the community.²⁴⁰

The IRS and the courts have also ignored the benefits derived from the provision of medical services to medically underserved areas. For example, in *Geisinger*, twenty-three percent of the members of the Geisinger Health Plan lived in medically underserved areas while another sixty-five percent lived in counties with medically underserved areas.²⁴¹ The *Intermountain Health Care* case provides another example.²⁴² One of the non-profit hospitals in that case was the sole provider of specialized hospital services for its entire region.²⁴³ Because rural areas often do not receive modern health care benefits, service to such areas constitutes a socially desirable benefit that the government might otherwise have to provide.²⁴⁴ In failing to view service to underserved areas as a community benefit, the IRS has failed to utilize tax policy effectively to encourage the efficient delivery of health care services to a broad segment of the population.²⁴⁵ Granting a tax exemption based on service to medically underserved areas would encourage health care providers to move into these areas by providing a carrot of favorable tax treatment.²⁴⁶

Subsidized membership in a health care organization should also satisfy the outcome component of the community benefit standard. The IRS and the Third Circuit in *Geisinger*, however, failed to account for the socially desirable benefits that such membership programs can provide.²⁴⁷ As this Note has previously discussed, if an

238. See notes 88-92, 97-99, 175-86 and accompanying text.

239. See notes 89-90, 177-86 and accompanying text. See also Colombo, 29 Wake Forest L. Rev. at 219 (cited in note 1) (stating that outpatient service to medically underserved areas should be a component of community benefit).

240. See note 88 and accompanying text.

241. *Geisinger*, 985 F.2d at 1212.

242. *Intermountain Health Care*, 709 P.2d 265.

243. *Id.* at 274 n.14.

244. Colombo, 29 Wake Forest L. Rev. at 246 (cited in note 1).

245. *Id.* at 246-47.

246. *Id.* at 247.

247. *Geisinger*, 985 F.2d at 1219. See also notes 184-86 and accompanying text.

HMO or other form of integrated delivery system has a subsidized membership program that meaningfully attempts to meet the health care needs of the indigent members of its community, such an entity provides a measurable community benefit.²⁴⁸

Finally, the outcome component of the community benefit test should not focus solely on the amount of charitable care that an entity provides. As this Note has previously discussed, such a criterion bears no logical relationship to the needs of a particular community.²⁴⁹ Focusing on the dollar amount of charitable care provided allows health care organizations to seek out only medically interesting charity cases instead of providing services such as preventive care for which there is a greater need.²⁵⁰ The outcome component of the community benefit standard should look to whether a health care organization is responding to the needs of its particular community instead of whether the entity is meeting some arbitrary level of charitable care.²⁵¹ The outcome criteria should thus encourage health care organizations to provide services that are most needed in their particular communities. If preventive care such as physicals, immunizations, prenatal care, or blood pressure testing will provide the greatest benefits to a particular community, then the outcome criteria of the community benefit standard should encourage this result.²⁵²

The community benefit standard must be explicitly based on both organizational and outcome criteria. The organizational prong will ensure that non-profit health care organizations structure themselves so as to remain accountable and responsive to community needs. The outcome prong will ensure that these organizations actually provide socially desirable community benefits that the government might otherwise have to provide. As this Note has discussed, the organizational and outcome criteria must not be so narrow, however, that they fail to account for the benefits provided by non-profit entities.

248. See notes 183-86 and accompanying text.

249. See note 88 and accompanying text.

250. See Elizabeth M. Guggenheimer, *Making The Case For Voluntary Health Care Institutions: Policy Theories And Legal Approaches*, in Seay and Vladeck, eds., *In Sickness and In Health* 35, 62-63 (cited in note 205) (stating that tax-exempt health care entities should offer services important to their communities and should not focus on profitability).

251. *Id.*

252. See *id.* at 59 (stating that non-profit health care institutions should be encouraged to provide community benefits in a variety of ways).

V. CONCLUSION

At the present time, tax exemption has an uncertain future in the health care industry. Many states have attempted to revoke this benefit in order to tap into hospitals and other health care organizations as badly needed sources of revenue. Meanwhile, the *Geisinger* decision and the IRS's application of the community benefit standard have made it increasingly difficult for health care organizations to maintain tax-exempt status.

There *is* a valid basis for distinguishing between the types of entities that merit tax exemption and those that do not. That basis is a properly defined community benefit standard. A properly defined standard must focus on both the organizational structure and beneficial outcomes produced by non-profit health care organizations. The principal benefits of the non-profit structure will be eliminated if the courts and the IRS continue to narrow the definition of "community benefit" so as to preclude more efficient and innovative organizational structures within the health care industry. Implementation of a well defined community benefit standard, which explicitly focuses on both organization and outcomes, would help to align our tax policy with the overall goals of our health care system.

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* The Author wishes to thank Carl Wasserman and Hannah Vorwerk Cassidy for all of their help in editing this Note. The Author also wishes to thank Allis Dale Gillmor, research attorney for the Robert Wood Johnson Foundation Project, for her research assistance.

