

FEDERAL AND STATE TAX EXEMPTION POLICY, MEDICAL DEBT AND HEALTHCARE FOR THE POOR

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A substantial body of empirical evidence supports the proposition that medical debt plays a very significant role in consumer bankruptcies.¹ Another substantial body of empirical evidence indicates that tax-exempt nonprofit hospitals provide little more in the way of uncompensated care for the uninsured poor than for-profit hospitals do, except to call it by a different name (for-profits refer to it as bad debt; nonprofits refer to it as charity care),² and that many tax-exempt hospitals do not provide charity care in an amount equivalent to the value of their tax exemptions.³ It does not take long for

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1. *E.g.*, David U. Himmelstein et al., *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF., Feb. 2, 2005, at W5-63, available at <http://www.healthaffairs.org>; Melissa B. Jacoby, *The Debtor-Patient: In Search of Non-Debt-Based Alternatives*, 69 BROOK. L. REV. 453 (2004); Melissa B. Jacoby, Teresa A. Sullivan & Elizabeth Warren, *Rethinking the Debates Over Health Care Financing: Evidence from the Bankruptcy Courts*, 76 N.Y.U. L. REV. 375 (2001); Melissa B. Jacoby & Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical Related Financial Distress*, 100 NW. U. L. REV. 535 (2006).

2. *See* John D. Colombo, *The Role of Tax Exemption in a Competitive Health Care Market*, 31 J. HEALTH POL. POL'Y & L. 621, 628 (2006); Jill R. Horwitz, *Why We Need the Independent Sector: The Behavior, Law and Ethics of Not-for-Profit Hospitals*, 50 UCLA L. REV. 1345, 1354 (2003) (noting that "research on the gap between for-profit and not-for-profit provision of uncompensated care cannot support arguments in favor of the not-for-profit sector"). Schlesinger and Gray note:

Under this criterion, the performance of nonprofit health care appears far from adequate. For nursing homes and health plans, nonprofit ownership is not consistently associated with any propensity to treat low-income patients. Even in many hospitals, performance could not in itself justify tax exemptions. If one does not count bad debt, the amount of uncompensated care provided by as many as three-quarters of nonprofit hospitals is less than their tax benefits.

Mark Schlesinger & Bradford H. Gray, *How Nonprofits Matter in American Medicine and What to Do About It*, 25 HEALTH AFF., June 20, 2006, at W287, W293, available at <http://content.healthaffairs.org/cgi/reprint/25/4/W287.pdf>.

3. *See, e.g.*, David A. Hyman, *The Conundrum of Charitability: Reassessing Tax Exemption for Hospitals*, 16 AM. J. L. & MED. 327, 365 (1990) (reporting that the value of charity care provided by the Medical Center Hospital of Vermont was roughly half the value of its tax

people to connect these observations and decide that tax exemption policy can be used as a method to attack the problems of medical debt and healthcare for the uninsured poor by requiring nonprofit hospitals to meet minimum charity care requirements as a condition of tax exemption.⁴ As I write this, in fact, my own state (Illinois) is considering legislation that would do just this,⁵ and state officials in at least two other states (the Attorney General in Minnesota and the Tax Commissioner in Ohio) recently have used threats to revoke tax exemption to extract higher levels of charity care from nonprofit health providers.⁶

Early in my academic career, I was of the opinion that such strict charity care standards would be a good alternative to the federal “community benefit” test for hospital tax exemption.⁷ I still think that as a matter of tax policy, a strict charity care standard is an improvement over the diffuse community benefit standard, but over time I have become less convinced that this approach is good for health policy, bankruptcy policy, or any other policy, and as a result, I am now quite wary of using tax exemption in this way.

This article explains that wariness. As background, the article first summarizes federal law on tax exemption for hospitals and other health care providers (a story which has been often told, but I repeat here for completeness) and then contrasts the efforts in some states to use tax exemption policy to extract higher levels of free care for the poor from nonprofit health care providers. The article then turns to the policy benefits and weaknesses of pursuing this path. In the end, I suggest that there are dangers in using tax exemption policy in this manner and that other approaches to the problem of the medically uninsured (or under-insured) may offer better solutions. In particular, I suggest that those who favor enacting strict charity care requirements for tax exemption might instead want to consider a “provider

exemption); Nancy M. Kane & William H. Wubbenhorst, *Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption*, 78 MILBANK Q. 185, 199 (2000) (noting that depending on the methodology used for including bad debt as indigent care, as much as 86% of a surveyed sample of hospitals had tax benefits from exemption that exceeded the value of free care); Michael A. Morrisey et al., *Do Nonprofit Hospitals Pay Their Way?*, HEALTH AFF., Winter 1996, at 132, 137 (noting that only 20% of California hospitals provide a level of uncompensated care greater than the value of the tax subsidies they receive).

4. See *infra* notes 72–77 and accompanying text.

5. H.B. 5000, 94th Gen. Assemb. (ILL. 2006) (The Tax-Exempt Hospital Responsibility Act); see *infra* notes 73–81 and accompanying text.

6. E.g., Sarah Treffinger, *Ruling Presents New Challenge to Hospitals' Tax-Exempt Status*, CLEVELAND PLAIN DEALER, Nov. 27, 2005, at B6; *Statement of Minnesota Attorney General Michael Hatch Before the Senate Finance Committee*, 109th Cong. 220–28 (2005).

7. See, e.g., John D. Colombo & Mark A. Hall, *The Future of Tax-Exemption for Nonprofit Hospitals and Other Health Care Providers*, 2 HEALTH MATRIX 1, 30–31 (1992) (opining that without fundamental reform of health care financing, using charity care standards enforced via the tax laws is the next best method of attacking the problem of health care for the poor).

tax” that would generate funds to be used by local governments to provide a wider range of health care options for the poor.

I. BACKGROUND

A. *Understanding Tax Exemption Generally*

The first day of my course on tax-exempt organizations I spend dispelling certain common misconceptions about tax exemption. First, the term “nonprofit” is not a synonym for the term “tax-exempt.”⁸ “Nonprofit” is a concept connected to state organizational law.⁹ That is, one forms a nonprofit organization by incorporating under a state nonprofit corporations act or by forming a common-law charitable trust or a charitable unincorporated association.¹⁰ In either case, the chief requirement of state law for nonprofit status is what Professor Henry Hansmann has called “the nondistribution constraint”—a nonprofit cannot have equity owners who are entitled to receive distributions of the net revenues of a nonprofit.¹¹ Nonprofits can make “profits” in the sense of ending the year with revenues in excess of expenses, and many of them do;¹² they just are limited in what they can do with those profits.¹³

Nonprofit status is a requirement of tax exemption,¹⁴ but it is not a sufficient condition for exemption.¹⁵ Instead, tax exemptions are conferred not by state organizational law but by state and federal tax law.¹⁶ This is where tax exemption gets very complex, because in most cases “exemption” involves at least three, sometimes four, separate taxes imposed by at least two separate taxing jurisdictions: the federal income tax, the state income tax, the state property tax, and the state sales/use tax.¹⁷

At the federal level, exemption depends on meeting the standards of the relevant subsection of Section 501 of the Internal Revenue Code (“IRC” or

8. Henry Hansmann, *The Role of Nonprofit Enterprise*, 89 YALE L.J. 837, 874 (1980).

9. *Id.* at 838–39.

10. *Id.* at 838–40.

11. *Id.* at 839–40.

12. *See, e.g.*, GILBERT M. GAUL & NEILL A. BOROWSKI, *FREE RIDE: THE TAX EXEMPT ECONOMY* (Andrews and McMeel) (1993) (detailing profits made by many nonprofit institutions); Michele Evans, *Chicago’s Largest Hospitals*, CRAIN’S CHICAGO BUS., June 19, 2006, at 37 (listing, for example, Northwestern Memorial Hospital as having profits of \$117 million on revenues of \$947 million in 2005).

13. Hansmann, *supra* note 8, at 838.

14. *E.g.*, Treas. Reg. § 1.501(c)(3)-1(b)(4) (2005) (requiring that assets of an exempt charity be distributed to another exempt charity or to the government upon dissolution, and prohibiting distribution to “members or shareholders”).

15. Hansmann, *supra* note 8, at 838.

16. *See, e.g.*, *infra* notes 18 and 48 and accompanying text.

17. Hansmann, *supra* note 8, at 836–37.

“Code”).¹⁸ Specifically, health care providers usually try to qualify for federal income tax exemption under Section 501(c)(3) of the Code as “charitable” organizations.¹⁹ State income tax laws typically “key off” federal income tax exemption;²⁰ in Illinois, for example, 35 ILCS 5/205 bases state income tax exemption on federal exempt status under Section 501 of the Code.²¹

State property tax and sales tax exemption laws, however, generally have their own exemption standards—that is, an organization that qualifies for federal tax exemption under the Code usually will receive state income tax exemption as well, but does not automatically receive state property tax exemption or sales tax exemption.²² Of these latter two, the most important by far is the property tax exemption, since hospitals and other health care providers are often highly capital-intensive businesses with significant property holdings.²³ In many states, property tax exemptions are authorized by the state constitution and then implemented via enabling legislation passed by the state legislature.²⁴ Illinois is typical in this regard. Article IX, Section 6 of the 1970 Constitution states “The General Assembly by law may exempt from taxation only the property of the State, units of local government and school districts and property used exclusively for agricultural and horticultural societies, and for school, religious, cemetery and charitable purposes.”²⁵ ILCS Chapter 35, Section 200/15-65, is the statutory execution of the Illinois Constitution’s grant of exemption authority. This section provides a property tax exemption for property “actually and exclusively used for charitable or beneficent purposes” by “(a) Institutions of public charity.”²⁶

The disparate law, and therefore disparate standards, for exemption from federal income tax and state property tax is a major key to understanding the current forces shaping tax exemption policy in the health care sector. It means that states can and often do impose different and more rigorous exemption criteria than are currently imposed by federal law,²⁷ and much of the pressure on tax exemption for health care providers over the past several years has come

18. I.R.C. § 501 (2005).

19. *See, e.g.*, Rev. Rul. 69-545, 1969-2 C.B. 117.

20. *See, e.g.*, 35 Ill. Cond. Stat. § 5/205 (2005) (as described in next sentence, a good example of a state (Illinois) statute that is keyed from a federal statute).

21. *See id.*; I.R.C. § 501 (2005).

22. *See* JANNE GALLAGHER, PROPERTY TAX EXEMPTION FOR CHARITIES 10 (Evelyn Brody ed., Urb. Inst. Press 2002).

23. *See* Evans, *supra* note 12.

24. *See* GALLAGHER, *supra* note 22, at 4–6.

25. ILL. CONST. art. IX, § 6.

26. 35 Ill. Cond. Stat. § 200/15-65 (2005).

27. GALLAGHER, *supra* note 22.

at the state, not federal, level.²⁸ The next two subsections explore this conflict in further detail.

*B. Federal Exemption Standards for Hospitals and Health Care Providers*²⁹

Hospitals are not specifically enumerated as exempt entities anywhere in the Code.³⁰ Historically, however, nonprofit hospitals have been recognized as exempt as “charitable organizations” under Section 501(c)(3) of the Code.³¹

Prior to 1969, the official position of the Internal Revenue Service (I.R.S.) regarding the charitable purpose requirement as it applied to hospitals was set forth in Revenue Ruling 56-185, which required a hospital seeking exemption under Section 501(c)(3) to be “operated to the extent of its financial ability for those not able to pay for the services rendered.”³² While the I.R.S. never took an official position regarding how much charity care was “enough” or even how to define charity care for these purposes, if a hospital lacked a substantial charity care program, auditing agents almost always recommended denial or revocation of exempt status.³³ This charity care standard reflected the long-

28. This may be changing, however, given the interest in the past year from both the House Ways and Means Committee and the Senate Finance Committee (particularly its Chairman, Chuck Grassley) in hospital tax exemption. For example, the House Ways and Means Committee held a hearing on tax exemption for hospitals in May 2005; about that same time, Senator Grassley sent a letter to several major hospitals in the U.S. asking them to provide details on charity care policies and a number of other issues (particularly joint-venture relationships with staff doctors). See David L. Wolfe & Michael D. Rosenbaum, *GAO Survey of Nonprofit Hospitals Latest Step in Congressional Investigation of Tax-Exempt Organizations*, 52 EXEMPT ORG. TAX REV. 265 (2006). Perhaps prodded by this wave of congressional interest, the I.R.S. recently announced a “soft contact” (e.g., letter audit) audit program for hospitals aimed at gathering information on “community benefits” provided by exempt hospitals. See McDermott, Will & Emery, *IRS Announces Community Benefit Audits for Hospitals* (2006), available at http://www.mwe.com/index.cfm/fuseaction/publications.nldetail/object_id/1ca77617-679c-4acb-8c7f-ca5dc6af9b46.cfm.

29. Much of this subsection is adapted or taken from Colombo, *supra* note 2, and John D. Colombo, *The Failure of Community Benefit*, 15 HEALTH MATRIX 29 (2005) [hereinafter Colombo, *The Failure of Community Benefit*].

30. See I.R.C. § 501 (2005).

31. Administrative rulings on tax exemption for hospitals date back at least to 1928. *E.g.*, I.T. 2421, 7-2 C.B. 150–51 (1928).

32. Rev. Rul. 56-185, 1956-1 C.B. 202, 203. This ruling was consistent with the IRS view prior to 1959 that “charitable” organizations in Section 501(c)(3) had to be involved in “relief of the poor” in order to be exempt. See Daniel M. Fox & Daniel C. Schaffer, *Tax Administration as Health Policy: Hospitals, The Internal Revenue Service & the Courts*, 16 J. HEALTH POL. POL’Y & L. 251, 255–56 (1991).

33. While the ruling recognized that this test would be applied on all the facts and circumstances (and that a low charity care record would not necessarily bar exemption), I.R.S. auditing agents often denied or revoked exempt status if a hospital’s charity care was less than 5% of gross revenues. Robert S. Bromberg, *Charity and Change: Current Problems of Tax Exempt Health and Welfare Organizations in Perspective*, in TAX PROBLEMS OF NONPROFIT

held stance of the I.R.S. (and centuries of legal precedent in the charitable trust arena) that the “relief of the poor” constituted a charitable purpose.³⁴

Concurrent with congressional consideration of the Medicare and Medicaid legislation in the mid-1960s, however, exempt hospitals began pushing the I.R.S. for reconsideration of exemption standards on the grounds that between private medical insurance and the “new” Medicare and Medicaid programs, there simply would not be enough of a demand for charity care to satisfy the I.R.S., and hence, exemption standards should become more flexible in order to maintain exempt status for hospitals.³⁵ A young staff attorney with the I.R.S., Robert Bromberg, took the complaints of the hospital industry seriously and began work on a new exemption standard.³⁶

The new standard appeared in Revenue Ruling 69-545,³⁷ which quickly became known as the “community benefit” standard.³⁸ This ruling abandoned charity care as the touchstone of exemption at the federal level.³⁹ Instead, citing the law of charitable trusts, the I.R.S. held that the “promotion of health” for the general benefit of the community was itself a charitable purpose, even though some portion of the community, such as the uninsured, was excluded.⁴⁰ Factors that indicated that a hospital met the community benefit test included having a community board, having an open medical staff, treatment of Medicare and Medicaid patients, and operation of an emergency room that

ORGANIZATIONS 1970: EFFECT OF THE TAX REFORM ACT 249, 256 (George D. Webster & William J. Lehrfeld eds., 1970); see *Hospital Charity Care and Tax-Exempt Status 1990—Restoring the Commitment and Fairness: Hearings Before the U.S. House of Representatives, Select Committee on Aging*, 102d Cong. 58–59 (1990) (statement of James J. McGovern, I.R.S. Assistant Chief Counsel).

34. *E.g.*, Treas. Reg. § 1.501(c)(3)–1(d)(2) (2005) (listing “relief of the poor and distressed” as a charitable purpose). Historically, relief of the poor has been viewed as a charitable purpose at least since the Elizabethan Statute of Charitable Uses enacted by the English Parliament in 1601. The preamble to that statute, which is generally viewed as the “headwaters” of charitable trust law, listed “relief of aged, impotent and poor people” as an appropriate charitable purpose. See JOHN D. COLOMBO & MARK A. HALL, *THE CHARITABLE TAX EXEMPTION* 33–34 (1995). The official citation for the Elizabethan Statute of Charitable Uses is An Act to Redress the Mis-Employment of Lands, Goods and Stock of Money Heretofore Given to Certain Charitable Uses, 1601, 43 Eliz. 1, c. 4 (Eng.), reprinted in 7 STAT. AT LARGE 43 (Eng. 1763).

35. Fox & Schaffer, *supra* note 32, at 261–62, 269–70. In retrospect, of course, this complaint is almost hilarious for its inaccuracy.

36. *Id.*

37. Rev. Rul. 69-545, 1969-2 C.B. 117. For more general discussions on Rev. Rul. 69-545, see DOUGLAS M. MANCINO, *TAXATION OF HOSPITALS AND HEALTH CARE ORGANIZATIONS* § 4.03[1], 4.03[2][b] (Warren, Gorham & Lamont 2006) (1995); THOMAS K. HYATT & BRUCE R. HOPKINS, *THE LAW OF TAX-EXEMPT HEALTHCARE ORGANIZATIONS* 130–32 (2d ed. 2001).

38. Colombo, *The Failure of Community Benefit*, *supra* note 29, at 31.

39. *Id.*

40. Rev. Rul. 69-545, 1969-2 C.B. 117, 118.

provided emergency treatment to charity patients.⁴¹ Charity care other than emergency treatment, however, was not required, and in a 1983 ruling, the I.R.S. held that even hospitals without emergency facilities could qualify for exemption under the community benefit approach.⁴²

Despite the 1969 and 1983 rulings, recent cases dealing with tax exemption for hospital maintenance organizations (HMOs) have made clear that, despite the language in Revenue Ruling 69-545, the federal test for exemption is not a per se rule, and hence, exemption requires more than simply treating all patients who can pay for their care either directly or via private or government insurance.⁴³ In the most recent of these cases, dealing with subsidiary corporations of the Intermountain Health Care group, the Tenth Circuit stated plainly that “an organization cannot satisfy the community benefit requirement based solely on the fact that it offers health-care services to all in the community in exchange for a fee. . . . Rather, the organization must provide some additional ‘plus.’”⁴⁴ First on the list of these “plusses” was “free or below-cost services,” though the court acknowledged that “devoting surpluses to research, education and medical training” might also suffice, and that treatment of Medicare/Medicaid patients was a virtual requirement.⁴⁵ Under this “health care plus” standard, therefore, free care for the poor still is not a requirement for federal tax exemption under Section 501(c)(3).⁴⁶ Moreover, although Congress from time to time over the past two decades has discussed reinstating a charity care requirement for exemption, no such legislation has ever made it to a floor vote and no such legislation is currently pending.⁴⁷ Thus, the prospects for a federal charity care standard for exempting health care providers appear slim to none.

C. Exemption Standards in State Law

The exemption story at the state level is different and far more complex. Like federal law under Section 501(c)(3), most state property tax laws do not

41. *Id.* at 118–20.

42. Rev. Rul. 83-157, 1983-2 C.B. 94. This ruling held that if emergency services were deemed unnecessary by state regulatory agencies or by the nature of the hospital’s services (for example, cancer treatment hospitals), a hospital still could qualify for exemption under the community benefit approach even though it did not operate emergency facilities. *Id.*

43. For a complete discussion of the cases and rulings relating to federal income tax exemption for health care providers after Rev. Rul. 69-545, 1969-2 C.B. 117, see Colombo, *The Failure of Community Benefit*, *supra* note 29, at 32–37.

44. IHC Health Plans, Inc. v. Comm’r, 325 F.3d 1188, 1197 (10th Cir. 2003).

45. *Id.* at 1197–98 (“[T]he primary way in which health-care providers advance government-funded endeavors is the servicing of the Medicaid and Medicare populations.”).

46. Colombo, *supra* note 29, at 36–37.

47. See M. Gregg Bloche, *Health Policy Below the Waterline: Medical Care and the Charitable Exemption*, 80 MINN. L. REV. 299, 351–53 (1995); see generally Colombo, *supra* note 7 (discussing then-current proposals in Congress to tighten hospital exemption standards).

specifically enumerate hospitals as exempt organizations.⁴⁸ Instead, as with federal law, hospitals generally have obtained state property tax exemption by qualifying as “charitable” organizations.⁴⁹

Prior to the 1980s, state property tax law regarding the standards for exempting hospitals was fairly quiescent.⁵⁰ Most states had recognized that nonprofit community hospitals were exempt charities in very early interpretations of their tax laws, often without much analysis, and these things stood for the better part of the century.⁵¹ This state of affairs is likely attributable largely to the fact that until the 1980s, generous reimbursement rates from both private insurance and Medicare/Medicaid permitted hospitals to provide significant levels of free care for the poor by cross-subsidizing that care from charges paid by insured patients.⁵² As the generosity of these reimbursements declined, however, hospitals became increasingly focused on financial performance, and free care for the uninsured poor was an obvious first casualty.⁵³

48. See Janne Gallagher, *The Legal Structure of the Property Tax Exemption*, 28 ST. TAX NOTES 451, 452 (2003) (noting that even when there are no specific requirements, courts may decide that a hospital not operated as a “charity” will be denied exemption). Some states do specifically enumerate hospitals as eligible for property tax exemption, though often these have specific requirements attached. See, e.g., MISS. CODE ANN. § 27-31-1(f) (2006) (providing an exemption if hospital maintains at least one charity ward); TEX. TAX CODE ANN. § 11.1801 (Vernon 2004) (setting specific requirement for charity care).

49. Gallagher, *supra* note 48, at 452.

50. See *id.* at 455.

51. For example, case law recognizing the status of hospitals as charities under the Illinois property tax dates back to 1907 and 1908. See, e.g., Bd. of Review of Cook County v. Provident Hosp. & Training Sch. Ass’n, 84 N.E. 216 (Ill. 1908); German Hosp. v. Bd. of Review of Cook County, 84 N.E. 215 (Ill. 1908); Sisters of the Third Order of St. Francis v. Bd. of Review of Peoria, 83 N.E. 272 (Ill. 1907).

52. See Bloche, *supra* note 47, at 355–356 (providing statistics on cross-subsidization of charity care by privately insured patients); Randall R. Bovbjerg, Charles C. Griffin & Caitlin E. Carroll, *U.S. Health Care Coverage and Costs: Historical Development and Choices for the 1990s*, 21 J. L. MED. & ETHICS 141 (1993) (detailing the expansion of reimbursement for health services by both private insurers and the government during the 1960s and noting the significance of the federal government’s switch from cost-based reimbursement to the Prospective Payment System in the early 1980s); Alice A. Noble, Andrew L. Hyams & Nancy M. Kane, *Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives*, 25 J. L. MED. & ETHICS 116, 117 (1998) (“With the capital demands of competition and corporate transformations, hospitals claim less ability to subsidize free care or underfunded services internally”).

53. See Lawrence Singer, *Gloria Jean Ate Catfood Tonight: Justice and the Social Compact for Health Care in America*, 36 LOY. U. CHI. L.J. 613, 627 (2005) (“[A]s the numbers of uninsured have grown, and private and governmental insurance programs have slashed reimbursement, decreasing institutional funding is available for charity care, causing institutions to aggressively parcel out charity to only the most desperately needy.”).

These forces culminated in one of the most famous state property tax exemption decisions of the past three decades. In *Utah County v. Intermountain Health Care, Inc.*,⁵⁴ the Utah County Board of Equalization revoked state property tax exemption for several hospitals owned by Intermountain Health Care in Utah County on the grounds that the hospitals in question provided little free care for the poor (less than 1% of revenues).⁵⁵ On appeal, the Utah Supreme Court upheld the exemption revocation, noting that “the defendants in this case confuse the element of a gift to the community, which an entity must demonstrate in order to qualify as a charity under our Constitution, with the concept of community benefit, which any of countless private enterprises might provide.”⁵⁶ In other words, without a substantial charity care program, the hospitals in question did not meet the state law tests for property tax exemption.

At nearly the same time, the Supreme Court of Pennsylvania in *Hospital Utilization Project v. Commonwealth* held that a jointly-owned hospital support facility was not eligible for sales tax exemption as a “charity.”⁵⁷ In the course of its opinion, the court stated that Pennsylvania law required an organization to “donate or render gratuitously” a substantial portion of its services to those unable to pay in order for the organization to be considered charitable.⁵⁸ After this decision, aggressive local tax assessors challenged exemption for hundreds of organizations; by 1996, exemptions for 175 of the state’s 220 private nonprofit hospitals had been challenged.⁵⁹

Though the substance of the *Utah County* decision later was gutted by more lenient standards promulgated by the Utah State Tax Commission (after extensive lobbying by the nonprofit hospital industry),⁶⁰ and later actions by both the Pennsylvania legislature and courts similarly relaxed the strict interpretations of *Hospital Utilization Project*,⁶¹ the two cases were the

54. 709 P.2d 265 (Utah 1985). The decision is excerpted in virtually every comprehensive health law casebook. See, e.g., BARRY A. FURROW ET AL., HEALTH LAW 920–27 (5th ed. 2004); MARK A. HALL ET AL., HEALTH CARE LAW AND ETHICS 1100–04 (6th ed. 2003).

55. *Utah County*, 709 P.2d at 274.

56. *Id.* at 276.

57. 487 A.2d 1306, 1310 (Pa. 1985).

58. *Id.* at 1317.

59. Noble, Hyams & Kane, *supra* note 52, at 121.

60. After *Utah County*, the Utah State Tax Commission established standards for exempting health care providers that required hospitals to enumerate their “total gift to the community” in dollar terms, which had to exceed on an annual basis the annual property tax liability. *Id.* However, the state tax commission’s definition of “gift to the community” was so broad that it virtually eliminated a charity care requirement. See *id.* (noting that under the revised standards, even discounts negotiated with third party payers off the sticker price of health services would count in this calculation).

61. The Institutions of Purely Public Charity Act, passed by the Pennsylvania legislature in 1997, retained the requirement that a charity “donate or render gratuitously a substantial portion

beginning of a small “blip” in the late 1980s and early 1990s that saw a few states abandon the “community benefit” formulation of exemption for a more strict emphasis on charity care.⁶² Perhaps the most notable event in this “blip” occurred in Texas, where the attorney general was instrumental in getting the Texas Legislature to pass a law in 1993 that set specific financial guidelines for charity care by exempt hospitals (though as with Utah and Pennsylvania, the final legislation included “community benefit” concepts).⁶³ Meanwhile, a number of other states (including California, Indiana, Massachusetts, Missouri, and New York) enacted community benefit reporting statutes that provided either mandatory or “voluntary” reports by hospitals regarding how they served their community (and, by implication, how they “earned” their exempt status).⁶⁴

After this flurry of activity, another decade passed before states once again became active in hospital property tax exemption issues.⁶⁵ The current “blip” probably began with the highly publicized case of Yale-New Haven Hospital

of its services” but then laid out seven different methods for meeting this criterion. Janne Gallagher, *Pennsylvania’s Institutions of Purely Public Charity Act*, 19 EXEMPT ORG. TAX REV. 126, 129 (1998). One test required exempt nonprofits to provide uncompensated goods or services equal to the greater of 75% of net operating income or 3% of total operating expenses; the value of the goods/services rendered is based on “costs” including the value of volunteer labor. *Id.* Other methods of meeting this criterion include having a written schedule basing charges on family income with at least 20% of those served receiving services below cost, providing free services to at least 5% of those served, providing uncompensated goods/services to 20% of those served provided that at least half pay no more than 90% of cost, or providing uncompensated goods/services whose costs equal at least 5% of its total costs. *Id.*

62. See generally Noble, Hyams & Kane, *supra* note 52.

63. The Texas statute requires that

(1) charity care and government-sponsored indigent health care must be provided at a level that is reasonable in relation to the community needs, as determined through the community needs assessment, the available resources of the hospital or hospital system, and the tax-exempt benefits received by the hospital or hospital system;

(2) charity care and government-sponsored indigent health care must be provided in an amount equal to at least four percent of the hospital’s or hospital system’s net patient revenue;

(3) charity care and government-sponsored indigent health care must be provided in an amount equal to at least 100 percent of the hospital’s or hospital system’s tax-exempt benefits, excluding federal income tax; or

(4) charity care and community benefits must be provided in a combined amount equal to at least five percent of the hospital’s or hospital system’s net patient revenue, provided that charity care and government-sponsored indigent health care are provided in an amount equal to at least four percent of net patient revenue.

TEX. TAX CODE ANN. § 11.1801(a) (2006). See generally Noble, Hyams & Kane, *supra* note 52, at 129.

64. Noble, Hyams & Kane, *supra* note 52, at 123–28.

65. See Carol Pryor, *The Hospital Billing Flap: It’s Not Over Yet*, J. HEALTH CARE COMPLIANCE, May–June 2005, at 25, 26–27 (2005).

and Quinton White, whose wife died of cancer at the hospital twenty years earlier.⁶⁶ After her death, Mr. White made regular payments on the bill, eventually paying \$16,000 on the \$19,000 charge; because of compounding interest accumulations, however, the principal of the debt actually grew to some \$40,000.⁶⁷ Meanwhile, the hospital placed a lien on his house, and in 1996, it attached his bank account.⁶⁸ After a Wall Street Journal article in March 2003 recounting the Quentin White story,⁶⁹ and a lawsuit by the Connecticut Attorney General over the hospital's use of state "free bed" funds, Yale-New Haven voluntarily changed its billing policies.⁷⁰ The Connecticut General Assembly, however, also weighed in with a new statute regulating hospital bill collection procedures, requiring hospitals to notify patients of charity care programs, restricting the amount that can be collected to the hospital's "costs," and restricting the interest rate that could be charged on outstanding debt.⁷¹

At about the same time, Illinois and Minnesota also began pressuring hospitals regarding charity care and debt collection processes.⁷² In 2004, the Champaign County Board of Review (a citizens' board that reviews property tax exemptions and rates) recommended revocation of property tax exemption for Provena-Covenant hospital in Urbana, Illinois,⁷³ which recommendation was accepted by the State Department of Revenue. In April 2005, the Board of Review made a similar recommendation for Carle Hospital in Urbana.⁷⁴ In each case, the Board of Review found that the hospitals failed their charity-care obligations to the population by billing all patients, including the uninsured poor, for services and then pursuing aggressive debt collection techniques against them.⁷⁵

66. See CAROL PRYOR & ROBERT SEIFERT, *THE COMMONWEALTH FUND, UNINTENDED CONSEQUENCES: AN UPDATE ON CONSUMER MEDICAL DEBT* (June 2004), available at http://www.cmwf.org/usr_doc/pryor_medicaldebt_749.html.

67. *Id.*

68. *Id.*

69. Lucette Lagnado, *Twenty Years and Still Paying*, WALL ST. J., Mar. 13, 2003, at B1.

70. Mary E. O'Leary, *Yale-NH Hospital Alters Billing Procedures*, NEW HAVEN REGISTER, May 8, 2003, at A1.

71. Act of Oct. 21, 2003, Pub. L. No. 03-266, 2003 Conn. Acts 1402 (Reg. Sess.) (concerning hospital billing practices) (codified at CONN. GEN. STAT. ANN. §§ 19A-509b, -649, -673, 37-3b, -3c, 52-192a, -352b, -356a, -356d (West 2006)). For a summary of other provisions of the Act, see Jacoby & Warren, *supra* note 1, at 540-41.

72. Pryor, *supra* note 65, at 26-29.

73. CHAMPAIGN COUNTY BD. OF REVIEW, *PROVENA HOSPITAL DECISION 10* (2004), available at <http://www.co.champaign.il.us/BOR/PROVENA.pdf> [hereinafter *PROVENA DECISION*].

74. CHAMPAIGN COUNTY BD. OF REVIEW, *CARLE HOSPITAL DECISION 11* (2005), available at <http://www.co.champaign.il.us/BOR/CARLE2004.pdf>. At the time of the writing of this article, this recommendation was still pending before the Department of Revenue.

75. *Id.* at 9-10; *PROVENA DECISION*, *supra* note 73, at 7-8.

As with Texas and Pennsylvania in the 1990s and Connecticut in 2003, the publicity generated by the Provena and Carle cases culminated in legislation drafted by Illinois Attorney General Lisa Madigan and introduced in the Illinois legislature in January of 2006.⁷⁶ This encompassed two separate bills that went far beyond the Connecticut law, combining regulation of hospital billing with a tougher-than-Texas imposition of charity care requirements for tax exempt hospitals.⁷⁷ The debt collection regulation bill, which became law in June of 2006,⁷⁸ requires a hospital to publicize its free-care and financial aid programs⁷⁹ and to offer a reasonable payment plan to anyone (not just the poor) who cannot pay their bills,⁸⁰ and places serious procedural checks on when a hospital can go forward with bill collection proceedings.⁸¹

The proposed charity care legislation, which was later withdrawn pending discussions with the state's nonprofit hospitals,⁸² would have imposed two separate obligations on exempt hospitals.⁸³ One obligation is to provide free care to any uninsured Illinois resident with family income equal to or less than 150% of the federal poverty level and provide sliding-scale discounts to patients with family income between 150% and 250% of the federal poverty level.⁸⁴ The second obligation is that a hospital would be required to furnish an amount of charity care at least equal to 8% of the hospital's total operating costs as reported on its Medicaid cost reports.⁸⁵ The Act also makes clear that

76. H.R. 5000, 94th Gen. Assem., Reg. Sess. (Ill. 2006); H.R. 4999, 94th Gen. Assem., Reg. Sess. (Ill. 2006).

77. Ill. H.R. 5000; Ill. H.R. 4999.

78. Pub. Act 94-885, 2006-3A Ill. Comp. Stat. Ann. Adv. Legis. Serv. 252 (LexisNexis).

79. *Id.* § 15.

80. *Id.* § 30(a)(2).

81. *Id.* § 30.

82. See Shruti D. Singh, *Madigan to Negotiate Terms of Charity Care Bill—To a Point*, CHICAGO BUS., Apr. 26, 2006, http://www.chicagobusiness.com/cgi-bin/news.pl?post_date=2006-04-26&id=20365.

83. The title of the proposed legislation was the Tax-Exempt Hospital Responsibility Act. H.R. 5000, 94th Gen. Assem., Reg. Sess. (Ill. 2006). See, e.g., Lori Rackl, *Madigan: Hike Charity Health Care: Plan Puts Hospitals' Tax-Exempt Status On Line*, CHICAGO SUN-TIMES, Jan. 23, 2006, at 16.

84. H.R. 5000 § 15(a)(1)(A), (2)(A), 94th Gen. Assem., Reg. Sess. (Ill. 2006). Under this sliding scale, no bill can exceed between 20% and 35% of the actual cost of services. *Id.* § 15(a)(2)(B). In addition, to the extent that services exceed \$10,000 in any twelve-month period, the excess must be provided free of charge to this group of residents. *Id.* § 15(a)(2)(A). According to the *Chicago Sun-Times*, in 2005 the federal poverty level was \$9,570 for a single person and \$19,350 for a family of four. Rackl, *supra* note 83.

85. Ill. H.R. 5000 § 25(a). The proposed legislation appears to define charity care with reference to a hospital's marginal costs, although this also is somewhat unclear. In Section 10 of the Act, the definition of "charity care" is "medically necessary services provided without charge or at a reduced charge to patients who meet eligibility criteria no more restrictive than those set forth in Sections 15 and 20 of this Act." *Id.* § 10. That language seems to define charity care as any care provided at less than the hospital's standard charge. But in Section 25, the Act states

bad debt write-offs do not qualify as “charity care;” only free or discounted care for which the hospital expects no payment and is never recorded as revenue, an account receivable or bad debt qualifies.⁸⁶ However, Medicaid reimbursement shortfalls (that is, the amount by which reimbursements fail to cover “costs” as defined) are included in the charity care number,⁸⁷ and hospitals would also be able to count contributions to community health centers.⁸⁸

Minnesota’s charge was led by Minnesota Attorney General Mike Hatch and his aggressive review of nonprofit hospitals in that state.⁸⁹ Hatch’s tactics began with an audit of Allina Health System in 2001 that focused on executive salaries and perks, and ultimately led to a management shakeup and the separation of Allina and its affiliated HMO, Medica Health Plans.⁹⁰ Charity care and billing practices, however, came to the forefront in a report issued in January 2005 on Fairview Health Services that excoriated Fairview’s charity care and billing/debt collection practices.⁹¹ Eventually, the combination of pressure from Hatch’s office and the bad press generated by his investigations forced Fairview and other Minnesota exempt hospitals to enter into voluntary agreements that provided more charity care and discounts for services to the uninsured and that modified debt collection practices.⁹²

that a hospital can demonstrate that it meets its 8% obligation “by documenting the costs” of charity care provided under the Act. *Id.* § 25. That language seems to imply that the 8% obligation will be judged with reference to a hospital’s “costs” rather than charges, and the Act defines costs as “the actual expense a hospital incurs to provide each service or supply.” This definition of costs as “actual expense a hospital incurs” seems to adopt a marginal cost approach to valuing charity care, which is the most strict of the three approaches (charges, average costs, or marginal costs) discussed in the article.

86. *Id.* § 10.

87. *Id.* § 25(b)(5).

88. *Id.* § 25(b)(2).

89. See Tom Scheck, *Assessing the Impact of Allina’s Break-up*, MINN. PUB. RADIO, July 20, 2001, http://news.minnesota.publicradio.org/features/200107/20_catlinb_allina/scheck.shtml.

90. See, e.g., Bill Catlin, *A Breakup for Allina*, MINN. PUB. RADIO, July 20, 2001, http://news.minnesota.publicradio.org/features/200107/20_catlinb_allina/index.shtml.

91. MIKE HATCH, MINN. ATT’Y GEN., *FAIRVIEW COMPLIANCE REVIEW* (2005), <http://www.ag.state.mn.us/consumer/PDF/CharityCare.pdf>; see Tom Scheck, *Audit: Fairview Generous to Execs, But Aggressive in Collecting Payments*, MINN. PUB. RADIO, Jan. 31, 2005, http://news.minnesota.publicradio.org/features/2005/01/31_scheckt_fairview.

92. See *Charities and Charitable Giving—Proposals for Reform: Hearing Before the S. Comm. on Fin.*, 109th Cong. 224 (2005) (statement of Mike Hatch, Minn. Att’y Gen.); Lorna Benson, *Uninsured Will Get Hospital Discounts Under Hatch Agreement*, MINN. PUB. RADIO, May 5, 2005, http://news.minnesota.publicradio.org/features/2005/05/05_bensonl_hospitalcharges. A key provision of these agreements was that no person with a family income of less than \$125,000 would be charged more for services than the reimbursement rate provided by the hospital’s “most favored” insurers (for example, the insurance companies providing the largest dollar-volume payments to the hospitals in question). *Id.*

Even more recently, state authorities in Ohio have climbed aboard the tax exemption/debt collection reform train. In late 2005, the Ohio State Tax Commissioner revoked tax exemption for a satellite facility of the Cleveland Clinic on the grounds that the Clinic failed to dispense charity care at that facility.⁹³ Then in June 2006, Ohio Attorney General Jim Petro proposed extensive rules imposing new community benefit disclosures and bill collection procedures on nonprofit hospitals and other charities.⁹⁴ One of the major provisions of these rules appears to have been copied from Minnesota Attorney General Mike Hatch's agreements with hospitals on billing practices: the proposed Ohio rules would require hospitals to limit charges for persons with household income of \$125,000 or less to the amount reimbursed by the hospital's "most favored" insurance company.⁹⁵

In addition to these cases, Professor Nancy Kane notes in her contribution to this symposium that state officials in New Hampshire, North Carolina, and Kansas also have nonprofit hospitals on their policy agendas.⁹⁶ While it is too early to characterize the current "blip" as a general trend (and so far, legislative efforts to enact new charity care standards, such as in Illinois, have not succeeded), what is clear is that at least some states are once again aggressively using tax exemption policy as a means of extracting more charity care and amended debt collection policies from exempt hospitals. The next section of this paper examines whether these efforts are a wise use of exemption policy.

II. USING TAX EXEMPTION TO MANDATE CHARITY CARE: POLICY PROS AND CONS

A. *The Case in Favor*

As the recent state activities have demonstrated, tax exemption policy can be used effectively to change hospital behavior regarding charity care programs and debt collection policies. But little has been written about whether these efforts represent good policy choices or simply overzealous reactions to highly-publicized stories of abuse.

93. See Treffinger, *supra* note 6.

94. Press Release, Office of Ohio Attorney General, Petro Proposes More Transparency For Charitable Organizations, Including Most Hospitals (June 29, 2006), available at <http://www.ag.state.oh.us/press/06/06/pr060629.asp>. A summary of the proposed rules is available at <http://www.ag.state.oh.us/spotlight/cgrules.asp>.

95. Fair Billing and Collection Practices Policy, Ohio Proposed Rule 109:1-1-13 (A)(5)(b) (Off. of the Att'y Gen. 2006), available at http://www.ag.state.oh.us/business/pubs/char/rule/109_1-1-13.pdf.

96. Nancy M. Kane, *Tax-Exempt Hospitals: What is Their Charitable Responsibility and How Should it be Defined and Reported?*, 51 ST. LOUIS U. L.J. _ (2007).

The major legal advantage of a strict charity care standard for exemption such as that currently being considered by Illinois comes in the area of accountability. The current federal community benefit test provides essentially zero accountability in operational behavior.⁹⁷ The main behavioral guidelines for exemption are that a hospital must treat Medicare/Medicaid patients, must offer free emergency services if the hospital operates an emergency room, and according to the most recent interpretation of the Tenth Circuit, must offer some “plus” consisting of free care, health education programs, research, or the like.⁹⁸ But one finds all these behaviors in for-profit hospitals as well.⁹⁹ For-profit hospitals also treat Medicare and Medicaid patients,¹⁰⁰ under EMTALA, they too must provide free emergency care if they operate an emergency room.¹⁰¹ As for the “plus” behavior mandated by the Tenth Circuit’s recent interpretation of the community benefit test, empirical evidence finds little difference in uncompensated care rates between nonprofit and for-profit hospitals in similar markets,¹⁰² and many engage in health education or

97. See *supra* text accompanying notes 37–42.

98. See *supra* text accompanying notes 41–46. The other requirements of Rev. Rul. 69-545 are largely procedural or organizational, rather than behavioral: an exempt organization must be a nonprofit entity and must have a community board and an open staff policy. Rev. Rul. 69-545, 1969-2 C.B. 117.

99. See, e.g., U.S. GEN. ACCT. OFF. SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, SERVICES PROVIDED, AND FINANCIAL PERFORMANCE (Oct. 2003), <http://www.gao.gov/atext/d04167.txt> (reporting that for-profit specialty hospitals treated significant numbers of Medicaid patients, though at generally lower numbers than similar acute-care general hospitals—whether for-profit or nonprofit—in the same geographic areas); see also Schlesinger & Gray, *supra* note 2, at W291 (“[O]wnership seems unrelated to the propensity to treat Medicaid patients in hospitals”).

100. *Id.*

101. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395(dd) (2000). For an overview (and critique) of the obligations imposed by EMTALA, see David A. Hyman, *Patient Dumping and EMTALA: Past Imperfect/Future Shock*, 8 HEALTH MATRIX 29, 30 (1998); Karen H. Rothenberg, *Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care*, 26 HOUS. L. REV. 21, 60–64 (1989).

102. Empirical studies of gross data find little difference in the provision of “uncompensated care” by for-profit and nonprofit entities. See, e.g., Frank Sloan, *Not-for-Profit Ownership and Hospital Behavior*, in HANDBOOK OF HEALTH ECON. 1141, 1160 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000) (citing U.S. PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, MEDICARE AND THE AMERICAN HEALTH SYSTEM 84 (1996) (showing that uncompensated care constituted 4.5% of revenue for nonprofits and 4.0% for for-profits and little difference between pre- and post-conversion levels of charity care in nonprofit to for-profit conversion transactions)); Gary J. Young et al., *Does the Sale of Nonprofit Hospitals Threaten Health Care for the Poor?*, HEALTH AFF., Jan.-Feb. 1997, at 137 (finding essentially no difference in uncompensated care levels pre- and post-conversion in a study of seventeen California hospital conversions). Even supporters of the nonprofit form in health care agree that current charity care measures do not justify exemption. See Horwitz, *supra* note 2, at 1354; Schlesinger & Gray, *supra* note 2, at W293–94.

research (e.g., pre-natal care programs and drug trials) simply because it is good business to do so.¹⁰³ Enacting a strict charity care standard for exemption, therefore, makes nonprofit hospitals accountable for specific behavior that differs from for-profits, which are under no legal obligation to provide free care beyond the emergency room obligations imposed by EMTALA.

Second, we can expect that charity care by nonprofit hospitals in general will increase as a result of a specific charity care standard, at least if the bar is set high enough. In Illinois, for example, nonprofit hospitals as a group in 2005 spent a little over 1% of their revenues on charity care as defined in the draft Illinois legislation.¹⁰⁴ Mandating an 8% charity care target, therefore, should certainly cause a rise in the real amount of charity care provided, though because of certain “credits” toward charity care in the proposal, the increase may not be as great as the raw numbers might suggest.¹⁰⁵ Moreover, evidence exists that there is substantial additional capacity by nonprofits nationwide to engage in more charity care inasmuch as the value of tax exemption exceeds the amount of charity care provided by many nonprofit hospitals.¹⁰⁶

Finally, enacting a specific charity care standard might be politically feasible. Horror stories in the general press regarding medical billing, failure to treat the poor, and high CEO compensation may have created a climate that makes it possible for legislators to enact charity care legislation, although in Illinois, at least, the proposed charity care legislation was pulled by Attorney General Lisa Madigan for discussions with the state’s nonprofit hospital lobby after an outcry from nonprofit hospitals.¹⁰⁷ Nevertheless, recent congressional activity and statements from key legislators such as Senator Chuck Grassley,

103. See, e.g., Bloche, *supra* note 47, at 385–86.

104. Press Release, Office of Illinois Attorney General Lisa Madigan, Madigan Proposes Two Bills To Hold Hospitals Accountable for Charity Care, Stop Unfair Billing and Collection Practices (Jan. 23, 2006), available at http://www.ag.state.il.us/pressroom/2006_01/20060123.html.

105. The proposed Illinois legislation would permit a hospital to count unreimbursed Medicaid costs as part of its charity care target. In addition, the Attorney General’s office estimated that about half of all current bad debts could be reclassified as charity care if the hospitals simply put appropriate screening procedures in place. See Debra Pressey, *Charity Care: Caught in the Middle*, THE NEWS GAZETTE (Champaign, Ill.), Feb. 19, 2006, at A1 (“Madigan contends hospitals could convert half or more of their bad debt to charity care if they simply did a better job of identifying patients upfront who are too poor to pay their bills.”). Accordingly, the “real” rise in charity care would be far more modest than the 7% differential suggested by the proposed target.

106. See Kane & Wubbenhorst, *supra* note 3, at 199 (noting that depending on the methodology used for including bad debts as indigent care, as much as 86% of a surveyed sample of hospitals had tax benefits from the exemption that exceeded the value of free care).

107. See Singh, *supra* note 82.

chairman of the Senate Finance Committee, indicate that there is at least a plausible climate for changing hospital tax exemption standards.¹⁰⁸

B. *The Case Against*

Although a strict charity care standard has benefits in increasing accountability for nonprofit hospitals and possibly expanding care for the poor (both policy goals that I favor), the mandated charity care approach also has significant policy weaknesses. Perhaps the biggest policy weakness is that there simply is not enough money in the tax exemption system to make a significant dent in the problem of medical care for the uninsured.¹⁰⁹ Although they are several years out of date, estimates of the *total value* of tax exemptions for nonprofit hospitals, including federal and state income tax exemption and state property tax exemption, approximate \$10 billion (inflation adjusted to 2006) annually, at least some of which is already being used to fund charity care.¹¹⁰ Writing in 2000, Nancy Kane and William Wubbenhorst estimated that even if we required exempt hospitals to spend every dollar of the value of their exemptions on care for the poor, the total only would be enough to buy *one month* of health insurance for each uninsured individual.¹¹¹ Another recent article by David Himmelstein, Liz Warren and others on medical debt estimated that in 2001, there were over 700,000 bankruptcies for

108. For example, Senator Grassley recently identified “[n]onprofit hospitals that do not provide adequate charity care and community benefits” as a “key [area] of concern” (among others) for the nonprofit sector. Sen. Chuck Grassley, *Strengthening the Nonprofit Sector*, THE HILL, July 12, 2006, available at http://www.thehill.com/thehill/export/TheHill/News/Frontpage/071206/ss_grassley.html; see also Bloche, *supra* note 47, at 363–68 (discussing the “political allure” of mandatory charity care standards).

109. Kane & Wubbenhorst, *supra* note 3, at 208.

110. James Copland and Gabriel Rudney estimated aggregate tax subsidies to nonprofit hospitals at \$8.5 billion annually using 1986 data. James Copland & Gabriel Rudney, *Federal Tax Subsidies for Not-for-Profit Hospitals*, 46 TAX NOTES 1559, 1565 (1990). These estimates include not only federal income tax revenues, but also state income and property tax revenues and tax-exempt bond financing. *Id.* In the mid-1990s, William Gentry and John Penrod estimated the value of tax subsidies for nonprofit hospitals at close to \$8 billion. William M. Gentry & John R. Penrod, *The Tax Benefits of Not-for-Profit Hospitals*, in THE CHANGING HOSPITAL INDUSTRY: COMPARING NOT-FOR-PROFIT AND FOR-PROFIT INSTITUTIONS 285, 286 (David M. Cutler ed., 2000). If one takes the \$8 billion estimate and increases it for inflation based on the average CPI increase for the past ten years, the inflation-adjusted estimate for today would be approximately \$10.25 billion. See Robert Sahr, *Inflation Conversion Factors for Dollars 1665 to Estimated 2016*, available at http://oregonstate.edu/Dept/pol_sci/fac/sahr/sahr.htm (last visited Jan. 22, 2007).

111. Kane & Wubbenhorst, *supra* note 3, at 208. Given that health care costs have significantly outpaced inflation over the past several years, this estimate is likely to be overly generous for today’s market.

which medical debt was a major factor.¹¹² The average amount of out-of-pocket costs for health care for these filers was almost \$12,000.¹¹³ That means that these bankruptcy filers alone would have absorbed over \$8 billion in health services, and these numbers do not include what is likely a much larger number of families that avoided bankruptcy despite similar financial problems.¹¹⁴ Put bluntly, we have an enormous problem in financing medical care for the uninsured and under-insured, and tax exemptions simply cannot pay for it.

Second, mandating charity care for hospitals does not deal with the issue of care (and associated debt) from non-hospital sources, such as doctors, pharmacies, medical equipment suppliers, and so forth. In the article cited above, Himmelstein and his co-authors recited the case of a teacher whose \$20,000 hospital debt was written off by the hospital, but who nevertheless ended up filing bankruptcy because of the doctor and prescription drug bills.¹¹⁵ Jacoby and Warren noted that among the group of bankruptcy filers who indicated medical debt as a cause of bankruptcy, 21% identified prescription drugs as the single largest medical bill and another 20% identified doctors' bills as the single largest medical bill.¹¹⁶ Since neither pharmacies nor doctors are tax-exempt entities, using tax exemption to compel additional charity care will not affect bills (or produce more care) from these non-hospital providers.¹¹⁷

112. Himmelstein et al., *supra* note 1, at W5-63. The authors reported that in 2001, 1.458 million Americans filed for bankruptcy; they estimated that about half of these filings had a medical debt cause, meaning that about 729,000 bankruptcy filings were caused by medical debt. *Id.*

113. The average medical debt in these cases was \$11,854. *Id.*

114. Jacoby & Warren, *supra* note 1, at 551.

115. Himmelstein et al., *supra* note 1, at W5-70.

116. Jacoby & Warren, *supra* note 1, at 555.

117. Of course, this statement is not necessarily true in the case of tax-exempt integrated providers, such as HMOs. Imposing a charity care requirement on an HMO as a condition for exemption presumably would encompass all the services provided by the HMO, including doctors' bills and pharmacy fees. Ironically, however, IRS litigation strategy has made it virtually impossible for a modern HMO that does not also run its own hospital to qualify for charitable tax exemption under Section 501(c)(3). *See, e.g., IHC Health Plans, Inc. v. Comm'r*, 325 F.3d 1188, 1200 (10th Cir. 2003) (rejecting exemption for HMOs formed by Intermountain Health system); *Geisinger Health Plan v. Comm'r*, 985 F.2d 1210, 1221 (3d Cir. 1993) (rejecting exemption for an HMO formed by the Geisinger Health System). *But see Sound Health Ass'n v. Comm'r*, 71 T.C. 158, 191 (1978) (permitting exemption for a "staff model" HMO that provided its own emergency services via employee-doctors). For an in-depth discussion of the *Geisinger* and lower-court opinions in the IHC cases, see John D. Colombo, *The IHC Cases: A Catch-22 for Integral Part Doctrine, A Requiem for Rev. Rul. 69-545*, 34 EXEMPT ORG. TAX REV. 401 (2001). For a general overview of *Sound Health*, *Geisinger*, and the *IHC* opinions and tax exemption for HMOs generally, see THOMAS K. HYATT & BRUCE R. HOPKINS, *THE LAW OF TAX-EXEMPT*

Third, a strict charity care test will do nothing to address loss of income as a result of illness, a major contributor to the medical debt problem.¹¹⁸ Jacoby and Warren reported that in their survey of bankruptcy filers, over 70% reported that income lost as a result of health problems contributed “very much” to their bankruptcy,¹¹⁹ and more than half the filers who lost income prior to their bankruptcy did so because they took time off to care for someone else, often a sick child.¹²⁰ These statistics indicate that our society needs more AFLAC ducks¹²¹ as much as more charity care.

Fourth, a strict charity care standard is probably poor health care policy on a number of grounds that have been catalogued by health policy experts.¹²² Because it is aimed primarily at hospitals, which generally treat the sick rather than the healthy, a charity care standard will fund mostly in-hospital care for the sick at the expense of preventive care.¹²³ One can expect that the uninsured will wait until they are sick and seek free care in a hospital setting, therefore, rather than pay for routine preventive care,¹²⁴ a situation that is the exact opposite of the advice of most health care experts, who stress the importance of preventive care in health policy.¹²⁵ Checkups and routine dental and eye care will all be shortchanged by a policy focus on charity care alone. In addition, the focus on charity care elevates it to a preferred status in health policy that may make little sense for given communities, and may result in hospitals shifting resources from other needed, but unprofitable services. San Francisco might need more AIDS clinics than free care for the poor; people in

HEALTHCARE ORGANIZATIONS 177, 177–201 (2d ed. 2001); DOUGLAS M. MANCINO, TAXATION OF HOSPITALS AND HEALTH CARE ORGANIZATIONS § 6.02 (2005).

118. Jacoby & Warren, *supra* note 1, at 560–63.

119. *Id.* at 561.

120. *Id.* at 562.

121. For those who have been off the planet for the past few years and have not experienced one of the many humorous AFLAC television commercials featuring their famous duck, AFLAC offers supplemental insurance to cover lost wages and expenses of sickness not traditionally covered by either health insurance or traditional disability policies. See <http://www.aflac.com/>.

122. See, e.g., Bloche, *supra* note 47, at 368–71.

123. *Id.* at 369.

124. See Peter H. Schuck, *Designing Hospital Care Subsidies for the Poor*, in UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 72, 77 (Frank A. Sloan et al. eds., 1986).

125. See, e.g., AMERICAN HEART ASSOCIATION, PREVENTIVE HEALTH CARE (2006), <http://www.americanheart.org/presenter.jhtml?identifier=4734> (finding that an emphasis on prevention is necessary because “[i]f all heart attack-prone people were treated surgically, the cost would be prohibitive”); SHARON A. FALKENHEIMER, CTR. FOR BIOETHICS & HUMAN DIGNITY, THE ADEQUACY OF PREVENTIVE HEALTH CARE: DOES THE HEALTH CARE PROVIDER MATTER? (Sept. 24, 2004), http://www.cbhd.org/resources/healthcare/falkenheimer_2004-09-24.htm (“Preventing chronic and/or often-incurable diseases such as breast cancer and emphysema certainly is preferable to long-term clinical treatment, with its associated suffering, limitations, and costs.”).

Montana might need more access generally (e.g., more facilities spread throughout the state). Certain empirical research supports the conclusion that nonprofit hospitals offer more unprofitable services (e.g., emergency psychiatric care and AIDS clinics) than their for-profit counterparts.¹²⁶ If hospitals are forced to reallocate funds to charity care, the result may be a reduction in these unprofitable services, which may harm a particular community more than increased charity care helps it.¹²⁷

Fifth, using hospitals to administer a charity care program from excess revenues is an exceedingly odd way to provide government relief to the poor. As other commentators have noted, such a system in effect is a “private tax” on paying patients who produce the revenues to cover the costs of treating the uninsured, without any of the procedural or political protections that a “public tax” involves.¹²⁸ In addition, this approach permits private parties (hospitals) not only to set the tax rate and distribution, but also to determine *who is eligible* for the benefits funded by the tax *and* to determine *how much relief* each person gets with no guarantee that the money will actually be spent on those who need it the most.¹²⁹ I cannot think of another government poor-relief program that operates in this fashion. When people are too poor to afford food, we don’t attack the problem by giving the local supermarket tax exemption and letting it decide who gets free food and how much free food they get. Yet this is exactly what at least some of the charity care models provide. In Texas, for example, a hospital can meet its community benefit obligations by providing

charity care and community benefits . . . in a combined amount equal to at least five percent of the hospital’s or hospital system’s net patient revenue, provided that charity care and government-sponsored indigent health care are provided in an amount equal to at least four percent of net patient revenue.¹³⁰

The law then defines “charity care” as “providing, funding, or otherwise financially supporting health care services on an inpatient or outpatient basis to a person *classified by the hospital* as ‘financially indigent’ or ‘medically indigent.’”¹³¹ In other words, a charity patient is whomever the hospital’s internal policies define as a charity patient. Moreover, there is no legal

126. Horwitz, *supra* note 2, at 1354; *see also* Schlesinger & Gray, *supra* note 2, at W290, Exhibit 2.

127. *See* Charles E. Phelps, *Cross-Subsidies and Charge-Shifting in American Hospitals*, in UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 108, 115 (Frank A. Sloan et al. eds., 1986) (“Each decision to subsidize uncompensated care represents a choice to give up alternative uses of those funds within the hospital.”).

128. *See* Bloche, *supra* note 47, at 355–58. Bloche notes that this “tax” in fact may be highly regressive. *Id.* at 375–79.

129. *See id.* at 371; Schuck, *supra* note 124, at 77–78.

130. TEX. HEALTH & SAFETY CODE ANN. § 311.045(b)(1)(C) (2006).

131. § 311.031(2)(A) (emphasis added).

requirement that charity patients receive all their services for free; it is legally possible under this system for a hospital to “cut off” free services once it has met its 4% threshold. To use my food-stamp hypothetical, imagine a system under which grocery stores each set their own standards for food stamp eligibility and then could legally decide not to honor food stamps once they had given away food equal in value to 4% of their revenues. Far from being a solution, this system seems to have significant built-in elements of chaos.¹³²

Finally, the armchair political scientist in me speculates that doing something like this will result in legislators patting themselves on the back for having addressed the problem of medical care for the uninsured, when in fact they have not. As noted above, the problems of providing health care for the uninsured simply cannot be solved through tax exemption policy.¹³³ Yet enacting a charity care standard gives the illusion that government has acted to address this problem and thus potentially provides a convenient path to avoid tackling the truly difficult issues at the core.¹³⁴ If the trade-off for marginal additional charity care is continued gridlock on facing the core issues, we ought to carefully consider whether that trade-off is worth it.

C. A Word About Hospital Billing Regulation

While the above discussion is limited to the pros and cons of a mandatory charity care policy in exchange for tax exemption, Part I.C. above notes that recent state activity in Connecticut, Illinois, Minnesota, and Ohio also has focused on billing policies by hospitals.¹³⁵ In a recent article, Melissa Jacoby and Elizabeth Warren addressed many of the legal and policy issues raised by what they refer to as the “hospital misbehavior” model that appears to be the basis for recent state legislation regarding hospital billing procedures, offering many cautions regarding this trend.¹³⁶ One issue that they do not address, however, and which has been a part of the Minnesota agreements and the proposed rules in Ohio, is the requirement that hospitals give “most favored nation” billing treatment to uninsured individuals with family income below

132. To be fair, there is no evidence that Texas hospitals actually do “cut off” charity patients once they have reached their 4% threshold. Nevertheless, the fact that it is legally possible should give policy-makers some pause. The Illinois charity care proposal attempts to address these problems by providing specific standards of eligibility for free care. The proposed Illinois law would mandate free care for any uninsured Illinois resident with family income equal to or less than 150% of the federal poverty level and would provide sliding-scale discounts to patients with family income between 150% and 250% of the federal poverty level. *See supra* notes 82–88 and accompanying text. Thus hospitals could not legally “cut off” free or discounted care for persons within these guidelines.

133. *See supra* Part II.B.

134. *See Bloche, supra* note 47, at 363–68 (discussing the “political allure” of mandatory charity care standards).

135. *See supra* Part I.C.

136. Jacoby & Warren, *supra* note 1, at 538.

\$125,000—that is, the hospital can charge this class of patients no more than what it charges its “most favored” insurer.¹³⁷

While one can certainly sympathize with the desire to make hospital billing more fair,¹³⁸ these provisions do one thing that no one has yet discussed: they alter the fundamental “bargain” under which nonprofit, tax-exempt hospitals charge more to those who can pay in order to cross-subsidize free care for the poor.¹³⁹ Neither the proposed Ohio billing regulations nor the agreements reached by Attorney General Hatch in Minnesota use any kind of means testing for this requirement.¹⁴⁰ The “most favored nation” billing does not require the patient to demonstrate an inability to pay the bill; rather, the provision is applicable to all, presumably even to a single individual with an income up to \$125,000.¹⁴¹ These provisions, therefore, in effect regulate the extent to which hospitals can engage in cross-subsidization of the poor by charging more than average cost to a segment of the population that may well be able to pay this amount. According to the most recently-available I.R.S. statistics, an annual adjusted gross income of \$125,000 falls into the top 10% of incomes in the United States and very nearly falls into the top 5% of

137. *See supra* notes 92–95 and accompanying text.

138. A recent report by the Health Research Institute at PriceWaterhouseCoopers noted this transparency problem:

Decades ago, charges were used to set prices; today, charges are essentially meaningless to the patient. . . . A comparable analogy to this pricing system occurs in the hotel industry. It's sometimes shocking to see the amount per night that is posted on the back of the closet door—the hotel “rack rate.” In reality the “rack rate” is rarely paid due to pricing policies connected to company or association discounts or special rates. Hospital charges are similar to the hotel “rack rate”—a charge that government and insurer discounts are based. . . . Pricing transparency would allow anyone, including the average consumer, to understand the price of healthcare services and make comparisons across institutions. Currently, this is difficult because price varies widely between hospitals and geographic areas for the same procedure. For example, the charge for a level three emergency room visit differs dramatically among . . . fifteen different cities.

PRICEWATERHOUSECOOPERS HEALTH RES. INST., MY BROTHER'S KEEPER 3 (2006), *available at* <http://pwchealth.com/cgi-local/hregister.cgi?link=reg/community.pdf>.

139. *See Bloche, supra* note 47, at 354–68; Phelps, *supra* note 127, at 119 (“In the broadest sense, one could argue that a social contract has been formed between hospitals and society. Certainly part of the contract specifies that hospitals will treat patients whose health would be impaired by turning them away”).

140. *See Fair Billing and Collection Practices Policy, supra* note 95; Press Release, Office of the Minnesota Attorney General Mike Hatch, Agreement Between Attorney General and Minnesota Hospitals Will Provide Fair Pricing to Uninsured Patients, Establish Code of Conduct for Debt Collection Practices (May 5, 2005), *available at* http://www.mnhospitals.org/inc/data/pdfs/AG_agreement_press.pdf.

141. *See Fair Billing and Collection Practices Policy, supra* note 95; Press Release, *supra* note 140.

incomes.¹⁴² There is also some evidence that relatively high-income young professionals deliberately forego the cost of adequate health insurance in order to maximize their disposable income.¹⁴³ Thus, these “most favored nation” provisions would seem to encompass a number of individuals who are primary targets of cost-shifting policies. A recent report by the Department of Justice and Federal Trade Commission on competition in health care noted that competitive forces are already limiting the ability of hospitals to engage in cost-shifting, and those forces are likely to intensify.¹⁴⁴ Accordingly, before we enact blanket billing regulations that fundamentally alter the ability of hospitals to engage in this cost-shifting (or that provide benefits to individuals who could afford insurance but choose to buy a big-screen plasma HDTV instead), we should ask whether we really want to go down a policy path that almost certainly will have some negative impact on the ability of hospitals to fund charity care.

III. IF NOT CHARITY CARE, THEN WHAT?

The above analysis indicates that using tax exemption policy to mandate charity care by hospitals has many policy weaknesses. Of course, there remains the perennial problem of whether our political system can do any better than this. Rather than rehash here the arguments in favor of and against some kind of public-financed universal health care, I will confine myself to two observations.

The first is that if policy makers are hell-bent on a mandatory charity care standard for exemption, they might want to consider instead some kind of provider tax on exempt hospitals that would be distributed to the local communities served by the exempt hospital to use for health care purposes.¹⁴⁵ If, for example, the Illinois legislature ultimately concludes that exempt

142. In 2003, the top 10% of incomes began at an adjusted gross income of \$94,891; an adjusted gross income of \$130,080 was the cut-off for the top 5%. Internal Revenue Service, *Individual Income Tax Returns with Positive Adjusted Gross Income (AGI)*, tbl. 5, available at <http://www.irs.gov/pub/irs-soi/03in05tr.xls> (last visited Jan. 29, 2007).

143. See, e.g., Christian Czerwinski, *The Uninsured Life*, LANSING ST. J., May 10, 2006, at 20, available at <http://hub.lsj.com/apps/pbcs.dll/article?AID=/20060510/NOISE08/605100312/1112&temp> (“But health insurance isn’t a pressing concern for some twentysomethings. They would rather spend their money on things like entertainment, cars or clothes than on policies they feel they may never need. The insurance industry terms them ‘young invincibles.’”).

144. FEDERAL TRADE COMMISSION AND THE DEPARTMENT OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION 40 (2004), available at <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf> (“Competition will also undermine the ability of hospitals to engage in cross-subsidization, however.”).

145. See, e.g., Gail R. Wilensky, *Underwriting the Uninsured: Targeting Providers or Individuals*, in UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 148, 160 (Frank A. Sloan et al. eds., 1986) (discussing advantages of grants to local governments as a funding mechanism).

hospitals can afford to spend 8% of their costs on charity care, why not instead enact a provider tax equal to that amount that would then be distributed to and spent by the local communities? The rationale for preferring this approach is two-fold. First, it injects a level of government control over who qualifies for health care benefits and in what amounts, instead of leaving these decisions to the whim of individual hospital administrators.¹⁴⁶ Second, it provides the option for local communities to spend the money on preventive care, rather than care for the sick, which may be a better choice from a public health perspective.¹⁴⁷ Of course, this approach still will not solve the overall problem of health care for the uninsured (at least as long as the tax does not exceed the value of tax exemption), and a provider tax, though no longer “hidden,” would likely still suffer some of the same policy problems (such as regressivity) as a charity care approach since the tax likely still would be funded by the same sources (e.g., cross-subsidization from paying patients).¹⁴⁸ As a “second best” approach, however, a provider tax would appear to offer at least some advantages over a charity care standard for exemption.

My second observation is that in formulating a test for tax exemption for health care providers, I believe that a somewhat more flexible system that still provides significant accountability for nonprofit hospitals is a better policy option than a mandatory charity care standard. I previously have suggested that one could take the middle ground between our current no-accountability-at-all community benefit test and a strict-accountability charity care standard by enacting an exemption standard based upon “increasing access.”¹⁴⁹ Under my suggested approach, “increasing access” would encompass not only charity care for the poor, but also any service that either would bring “typical” care to underserved populations (e.g., an HMO designed specifically to enroll members in medically underserved areas) or that is otherwise not provided (or under-provided) by for-profit competitors (e.g., traditionally unprofitable services such as AIDS clinics or emergency psychiatric care).¹⁵⁰ In order to be exempt, a health care provider would have to specifically identify the service or services that increase access in its market (that is, the specific services that are directed toward underserved markets or that are not otherwise adequately provided by for-profit providers) and would have to actually commit a

146. *Id.*

147. *See supra* text accompanying notes 102–03.

148. *See Wilensky, supra* note 145, at 162 (noting that “a tax on insurance premiums would be . . . a formalization of cost-shifting” policy and that “the same general groups of people ultimately would pay the bill”).

149. *See John D. Colombo, The Role of Access in Charitable Tax Exemption*, 82 WASH. U. L.Q. 343, 371–74 (2004) [hereinafter *Colombo, The Role of Access*]; *Colombo, supra* note 2, at 637–38.

150. *Colombo, supra* note 2, at 638. AIDS clinics and emergency psychiatric care are two services often identified as unprofitable for a provider. *See Horwitz, supra* note 2, at 1365.

substantial amount of its operating budget to such services each year.¹⁵¹ This approach would be far more flexible than a strict charity care standard, but still would provide a much greater degree of accountability than the current community benefit approach, which (as noted above) does not require a nonprofit hospital to do *anything* differently from a for-profit competitor.

IV. SUMMARY

A favorite saying of grandmothers everywhere is “be careful what you wish for.” I think this admonition is especially apt in the area of tax exemption policy for nonprofit health care providers. A strict charity care standard for exemption would greatly improve the accountability of nonprofit hospitals, but may carry a number of negative consequences discussed above that have not been thoroughly vetted by policymakers. Given the central role health care plays in all sorts of public policy debates, one hopes that a bit more care will be exercised before the wishes are made and granted.

151. Colombo, *The Role of Access*, *supra* note 149, at 371–73. There are, of course, other policy approaches, such as entity-neutral incentives (either direct grants or tax incentives) targeted at specific health care needs. For a summary of these other approaches and their advantages and disadvantages, see Colombo, *supra* note 2, at 638–39.