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THE FAILURE OF COMMUNITY BENEFIT

John D. Colombo†

I. INTRODUCTION

It has been thirty-five years since the Internal Revenue Service issued Revenue Ruling 69-545, adopting the “community benefit” standard for tax exemption of hospitals and by implication, other health care providers. While hindsight is always 20/20, what we now know is that the community benefit test as articulated in that ruling has proven to be a complete failure. As Part II of this article indicates, it has failed as a legal test for tax exemption, having been virtually abandoned in practice by the courts and the IRS, who have pretty much morphed it back into a charity-care standard for exemption. A similar trend is occurring at the state level. Revenue Ruling 69-545 has also been a behavioral failure. Part III of this article provides a summary of the empirical evidence available today which indicates that very few differences exist between nonprofit and for-profit hospitals in their daily operations (and what differences do exist are not necessarily the result of the community benefit standard of exemption).

Accordingly, to paraphrase Marc Antony’s famous speech in Julius Caesar, I come to bury the community benefit test, not to praise it. Let us fervently hope that the evil it has done will not live after it, and that we can give it a decent memorial service and move on with our lives. Part IV of this article, therefore, examines various alternatives and concludes that, depending on one’s policy bent, viable alternatives include simply repealing the community benefit test or “rede-

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2 WILLIAM SHAKESPEARE, THE TRAGEDY OF JULIUS CAESAR, act 3, sc 2.
fining" it to condition exemption on certain explicit behavior by those seeking exempt status.

II. LEGAL FAILURE: THE SHORT AND BRUTAL HISTORY OF THE COMMUNITY BENEFIT TEST

A. Federal Exemption

Prior to 1969, federal income tax exemption for hospitals (and presumably other health care providers) was tied to charity care. The official ruling position of the IRS was set forth in Revenue Ruling 56-185, which required a hospital seeking exemption under Code § 501(c)(3) to be "operated to the extent of its financial ability for those not able to pay for the services rendered." While the IRS 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. This charity care standard reflected the long-held stance of the IRS (and centuries of legal precedent in the charitable trust arena) that the "relief of the poor" constituted a charitable purpose.

Concurrent with Congressional consideration of the Medicare and Medicaid legislation in the mid-1960s, however, exempt hospitals

4 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), IRS auditing agents often denied or revoked exempt status if a hospital's charity care was less than five percent of gross revenues. Robert S. Bromberg, Charity and Change: Current Problems of Tax Exempt Health and Welfare Organizations in Perspective, in TAX PROBLEMS OF NON-PROFIT ORGANIZATIONS 249, 256 (George D. Webster & William J. Lehrfeld eds., 1970); see Hospital Charity Care and Tax-Exempt Status: Restoring the Commitment and Fairness: Hearings Before House Select Comm. on Aging, 101st Cong. 58-63 (1990) (Statement of James J. McGovern, IRS Assistant Chief Counsel).
5 e.g., Treas. Reg. § 1.501(c)(3)-1(d)(2) (as amended in 1990) (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 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., c. 4, reprinted in 7 STAT. AT LARGE 43 (1763) (Eng.). The statute, however, also refers to "maintenance of sick or maimed soldiers or mariners," which indicates that treatment of the sick was itself considered a charitable purpose in some circumstances even in 1601.
began pushing the IRS for reconsideration of exemption standards. The common complaint (almost hilarious, in retrospect, for its inaccuracy) was 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 IRS, and hence exemption standards should become more flexible in order to maintain exempt status for hospitals. One wonders, of course, why the most appropriate response to these arguments was not “well, if there isn’t any need for charity care, then there isn’t any need for exemption,” but a young staff attorney with the IRS, Robert Bromberg, apparently took the complaints of the hospital industry seriously and began work on a new exemption standard.

This new standard appeared in Revenue Ruling 69-545, which quickly became known as the “community benefit” standard. This ruling abandoned charity care as the touchstone of exemption. Instead, citing the law of charitable trusts, the IRS 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 indigent patients, were excluded. Factors that indicated that a hospital met the community benefit test included a community board, an open medical staff, treatment of Medicare and Medicaid patients, and operation of an emergency room that provided emergency treatment to charity patients. Charity care other than emergency treatment, however, was not required, and in a 1983 ruling the IRS held

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7 *Id.* at 261-62.
8 *Id.*. Bromberg was not the only lawyer taken with the circular reasoning advocated by the hospitals (the circularity being that if hospitals could no longer meet charity care standards of exemption, those standards needed to change in order to keep hospitals from losing exemption). The D.C. Circuit Court of Appeals was equally duped. In Eastern Kentucky Welfare Rights Organization v. Simon, 506 F.2d 1278 (D.C. Cir. 1974), the Court opined that exemption standards needed to be more flexible because “the rationale upon which the limited definition of ‘charitable’ was predicated has largely disappeared.” It apparently never occurred to the court that exemption ought to disappear as well, “Gone with the Wind” of charity care.
11 *Id.*
that even hospitals without emergency facilities could qualify for exemption under the community benefit approach.\textsuperscript{12}

This lead-in to the adoption of the community benefit standard is well-known. What is less well known, or perhaps more accurately, less well-appreciated, is that almost immediately after adopting the community benefit test, the IRS began to undermine it. The undermining began with IRS challenges to charitable exemption for HMOs. In \textit{Sound Health Association},\textsuperscript{13} decided by the Tax Court in 1978, the IRS challenged 501(c)(3) exemption for a "staff model" HMO\textsuperscript{14} that accepted all paying patients, operated an open emergency room and had a board of directors drawn from the general community. Though the IRS argued that Sound Health should be denied exemption because it primarily served the private interests of its members, rather than the general community, the Tax Court held that in practice, Sound Health's membership was unlimited, and therefore it "promoted health" for the general benefit of the community much as the exempt hospital in Revenue Ruling 69-545 did. \textit{Sound Health}, however, marked the beginning of IRS assertions that, notwithstanding the language in Revenue Ruling 69-545, simply providing health care to all paying patients was insufficient to warrant exemption. Such an assertion, of course, was directly contrary to the broad language in Revenue Ruling 69-545, and at this stage the courts (or at least the Tax Court) appeared still committed to applying the broad standard of Revenue Ruling 69-545.

In the late 1980s into the early 1990s the IRS's pullback from the broad language in Revenue Ruling 69-545 became more pronounced and appellate courts started adopting a similar skeptical view of the ruling. The first major crack in the foundation of the community benefit standard came in the context of another HMO case, as the IRS denied 501(c)(3) exemption to Geisinger Health Plan, a separate corporate subsidiary of a large integrated health care network formed to expand medical services to underserved areas in rural northeastern

\textsuperscript{12} Rev. Rul. 83-157, 1983-2 C.B. 94. This ruling noted that specialty hospitals, such as cancer treatment hospitals, generally could qualify for exemption under the community benefit approach even though they did not operate emergency facilities.

\textsuperscript{13} Sound Health Ass'n v. Commissioner, 71 T.C. 158 (1978).

\textsuperscript{14} While there are many different permutations of the relationship between an HMO and the doctors that provide services to the HMO subscribers, one can break HMOs into two general categories: "staff model" HMOs where doctors are employees of the HMO, and "contract model" HMOs where the HMO contracts for services with individual doctors or groups of doctors. The contract model has several different variations, depending on how the contract between the HMO and doctors is executed. See generally, Barry R. Furrow et al., \textit{HEALTH LAW} 54 (2d ed. 2000).
and north-central Pennsylvania.\textsuperscript{15} As with the HMO in \textit{Sound Health},
the Geisinger HMO offered membership to virtually anyone in the
Geisinger service area.\textsuperscript{16} Unlike Sound Health, however, Geisinger
was a “contract model” HMO, offering services via contracts with
area doctors and other entities in the Geisinger health system, rather
than employing doctors and operating health facilities directly (the
“staff” model employed by Sound Health).\textsuperscript{17} In addition, Geisinger
had virtually no charity care program: though it had formally adopted
a subsidized dues program for indigents, at the time of its exemption
application it had not implemented that plan due to financial con-
straints, and the plan itself was quite modest, projecting a maximum
of thirty-five indigent enrollees during the first three years of opera-
tion.\textsuperscript{18} The IRS used these two main differences, along with the fact
that Geisinger did not yet have an approved Medicaid provider plan in
place (though it did enroll Medicare patients) to support its denial of
exemption.

The Tax Court rejected the IRS arguments that Geisinger failed to
meet the standards of Revenue Ruling 69-545, noting that as with
Sound Health, Geisinger’s membership of some 70,000 persons in its
service area was “practically unlimited” and that accordingly the
HMO provided the same community benefit required by Revenue
Ruling 69-545 as Sound Health by promoting health care for a broad
cross-section of the community.\textsuperscript{19} In short, the Tax Court continued
to apply the broad “promotion of health” standard articulated in Reve-
nue Ruling 69-545 despite IRS arguments focusing on the lack of
charity care and the method of delivery of services (contract model vs.
staff model).

On appeal, however, the Third Circuit reversed. The court found
that the Tax Court had too liberally applied the community benefit
standard, and bought the IRS arguments that Geisinger’s lack of char-
ity care, as-yet unrealized treatment of Medicaid patients and use of
the contract model meant that Geisinger was “primarily benefiting

\textsuperscript{15} The Geisinger Health System at the time of the litigation was a conglom-
erate of related organizations that included the Geisinger Foundation, Inc. (the parent
corporation), two large regional acute care hospitals recognized as exempt under IRC
§ 501(c)(3); a medical group practice clinic; an alcohol detox center; two professional
liability trusts and a management services entity. Geisinger Health Plan v. Commis-
\textsuperscript{16} The only membership requirements were that an individual be at least
eighteen years old, reside in the Geisinger service area, and fill out a medical history
questionnaire. \textit{Id.} at 1659.
\textsuperscript{17} \textit{Id.} at 1658.
\textsuperscript{18} \textit{Id.} at 1658-60, 1663.
\textsuperscript{19} \textit{Id.} at 1663.
itself” rather than the general community.\textsuperscript{20} This reversal by the Third Circuit was especially significant in that the court refused to accept the Tax Court’s view that “promotion of health” for the general community essentially meant delivery of medical services to a broad cross-section of the population. Instead, the Third Circuit appeared to want evidence of something more than simply the providing of medical services to paying patients. But, providing health care services to a broad cross-section of paying patients was what Revenue Ruling 69-545 was all about; in requiring “something more,” the Third Circuit essentially signaled that the community benefit test, as articulated in Revenue Ruling 69-545, was inadequate to distinguish “charitable” health care from “non-charitable” health care, and the overall fate of the community benefit standard as set forth in Revenue Ruling 69-545 became a major question mark.

More evidence of the IRS’s discomfort with the broad standard articulated in Revenue Ruling 69-545 came as a result of the accelerating trend for vertical integration in health care delivery in the late 1980s and early 1990s. In a series of rulings dealing with integrated delivery systems (IDSs), the IRS considered how to apply the community benefit standard to the parent corporation of these integrated providers.\textsuperscript{21} In each case, it was clear that the organization in question met the general requirements of Revenue Ruling 69-545 by having a community board, operating acute-care facilities with an open emergency room, and participating in Medicare/Medicaid reimbursement programs.\textsuperscript{22} Yet in each ruling, the IRS stressed the organization’s commitment to charity care as a significant factor in granting exemp-

\textsuperscript{20} Geisinger Health Plan v. Commissioner, 985 F.2d 1210, 1219-20 (3d Cir. 1993).

\textsuperscript{21} In general, an IDS consisted of a parent corporation and several corporate subsidiaries. In general, these integrated systems directly operated acute-care hospitals, outpatient clinics, and specialty health services such as psychiatric clinics, and either employed staff physicians on salary or contracted with a physician group practice to provide services and paid them on a capitated basis. The first highly-publicized ruling on an IDS involved the Friendly Hills Healthcare Network, and was released by the Internal Revenue Service on January 29, 1993. Letter from Marvin Friedlander, Chief, Exempt Organizations Rulings Branch 1, to Peter N. Grant, Friendly Hills Network (Jan. 29, 1993), reprinted in 7 EXEMPT ORG. TAX REV. 490 (1993). The Friendly Hills ruling was followed by a ruling on exemption for Facey Medical Foundation, Letter from Jeanne S. Gessay, chief, Exempt Organizations Rulings Branch 2, to Don Abramsky, Facey Medical Foundation (Mar. 31, 1993), reprinted in 7 EXEMPT ORG. TAX REV. 828 (1993). The third major ruling, involving Harriman Jones Medical Foundation, followed a few months later. Full Text of Harriman Jones Medical Foundation Exemption Ruling, reprinted in 9 EXEMPT ORG. TAX REV. 719 (1994). For more extensive discussions of the facts of these rulings, see MANCINO, supra note 9, at § 8.03.

\textsuperscript{22} See MANCINO, supra note 9, at § 8.03.
tion\textsuperscript{23} – and even IRS officials and administrative audit guidelines issued during this period admitted that charity care had become a major part of exemption analysis for integrated providers.\textsuperscript{24} The IRS sounded this same theme a few years later in its famous public ruling on joint ventures between hospitals and for-profit health care organizations, Revenue Ruling 98-15, where the IRS noted that denying services to indigents would tend to negate charitable status.\textsuperscript{25} Thus in all of these rulings, the IRS followed a consistent analysis: the mere fact that these entities clearly were providing health care services to a broad cross-section of paying patients (including participation in Medicaid programs) was insufficient to support exempt status; more (and the most-cited "more" was some significant charity care commitment) was required. Indeed, in its 2002 textbook advising field agents on issues relating to tax exemption, the two examples the IRS gave of health care organizations that qualified for exemption were an organization that provided free medical screening to uninsured inner-city residents, and an organization that provided free dental care to children from low-income families.\textsuperscript{26}

The not-so-slow transition of the community benefit standard from "health care for the general benefit of the community" to "health care for the general benefit of the community plus something else like charity care" became complete at the turn of the century with a series of cases dealing once again with the exempt status of HMOs. The cases involved three subsidiary corporations in the Intermountain Health Care system, each of which had been formed to conduct an HMO business in IHC's service area.\textsuperscript{27} While each of these cases also

\textsuperscript{23} The Friendly Hills ruling noted that Friendly Hills had agreed to provide free or discounted follow-up care to any charity patient admitted for emergency treatment; in the Facey and Harriman Jones rulings, the IDS committed to a specific level of charity care per year for a set time period ($400,000 in Facey; $750,000 in Harriman Jones). See Mancino, supra note 9, § 8.03[2]. Each ruling also discussed other "plus" factors such as health education and medical research programs. Id.


\textsuperscript{25} Rev. Rul. 98-15, 1998-1 C.B. 718, 719 (quoting language from Sonora Community Hospital v. Commissioner, 46 T.C. 519, 525-26 (1966) that "something more is required" for exemption than diagnosis and cure of disease).

\textsuperscript{26} Lawrence M. Brauer et al., Update on Health Care, in EXEMPT ORGANIZATIONS CONTINUING PROFESSIONAL EDUCATION (CPE) TECHNICAL INSTRUCTION PROGRAM FOR FISCAL YEAR 2002, 173-74 (IRS 2001).

\textsuperscript{27} IHC Care v. Commissioner, 82 T.C.M. (CCH) 617 (2001); IHC Group, Inc. v. Commissioner, 82 T.C.M. (CCH) 606 (2001); and IHC Health Plans, Inc. v. Commissioner, 82 T.C.M. (CCH) 593 (2001).
dealt with whether the HMO subsidiaries could claim derivative exemption based on being an "integral part" of the larger IHC health care enterprise, the Tax Court addressed arguments that the HMOs were exempt in their own right. In dismissing these arguments (and holding against a grant of exemption), the Tax Court in the *IHC Health Plans* case specifically highlighted the lack of a significant charity care component of the HMOs' operations:

> [d]espite petitioner's open enrollment policy and the wide acceptance of its plans by individuals and groups alike, petitioner's operations differed materially from the operations of Sound Health Association HMO and Geisinger HMO. Significantly, petitioner did not own or operate its own medical facilities, did not employ (to any significant extent) its own physicians, and did not offer free medical care to the needy. Additionally, petitioner did not institute any program whereby individuals were permitted to become members while paying reduced premiums, and, aside from the few free health screenings that petitioner conducted in 1999, petitioner did not provide or arrange to provide any free or low cost health care services. The record does not reflect whether petitioner applied surplus funds to improve facilities, equipment, patient care, or to enhance medical training, education, and research. See Revenue Ruling 83-157, 1983-2 C.B. 94.28

In the companion *IHC Care* decision, the language was similar:

> [a]gainst this backdrop, we further note that, unlike the HMO in *Sound Health Association v. Commissioner*, supra, petitioner did not own or operate its own medical facilities, nor did petitioner employ its own physicians. Consequently, petitioner could not provide free medical care to those otherwise unable to pay for medical services. Additionally, petitioner did not establish a subsidized premiums program, conduct research, or offer free education programs to the public. Petitioner's Core Wellness Program was offered exclusively to its enrollees.29

These cases were a watershed of sorts, because they represented the first time that the Tax Court agreed with the IRS position that

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simply providing health services for pay to the general community was insufficient to support exemption; rather some "plus," such as charity care, education or research programs, was required. Moreover, this "promotion of health plus" standard was embraced on appeal by the 10th Circuit.\textsuperscript{30} In its discussion of the community benefit test, the court 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.'"\textsuperscript{31} 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.\textsuperscript{32}

B. The Role of the States

The transition of the community benefit standard from a test based on the promotion of health for the general community back to a focus on charity care is not only a federal phenomenon. Prior to the mid-1980s, most states seemed to use a broad community benefit approach similar to Revenue Ruling 69-545 in defining exempt status for health care providers.\textsuperscript{33} During the 1980s and early 1990s (at the same time the IRS was pulling back from the broad exemption standards in Revenue Ruling 69-545), however, several states began to question property tax exemption for nonprofit hospitals.\textsuperscript{34} The result in many of these cases mirrored the federal shift to a charity care emphasis in defining exempt status.

The renewed interest in charity care in state property tax exemption cases began with a legal challenge to the exempt status of the

\textsuperscript{30} IHC Health Plans, Inc. v. Commissioner, 325 F.3d 1188 (10th Cir. 2003) (ruling that HMO did not operate for the benefit of the community and therefore did not qualify for a charitable exemption).

\textsuperscript{31} \textit{Id.} at 1197.

\textsuperscript{32} \textit{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.").


Intermountain Health Care organization in Utah. In an opinion that is excerpted in many health care legal texts and casebooks, the Utah Supreme Court denied tax exemptions to two nonprofit hospitals based on the finding that they failed to render sufficient charity care.\(^{35}\) In particular, the Utah Supreme Court chastised Intermountain for its practice of billing all patients and aggressively seeking collection, to the point of offering only assistance in getting bank loans for those unable to pay.\(^{36}\) Subsequently, the Utah State Tax Commission established standards for exempting health care providers that required “open access to medical service regardless of race, religion, gender or ability to pay” and required hospitals to enumerate their “total gift to the community” in dollar terms, which had to exceed on an annual basis the value of the tax exemption.\(^{37}\) However, the state tax commission’s definition of “gift to the community” was so broad that it virtually eliminated a charity care requirement.\(^{38}\)

Pennsylvania courts soon followed suit, with the state supreme court holding in *Hospital Utilization Project v. Commonwealth* that a charitable organization had to “donate[ ] or render[ ] gratuitously a substantial portion of its services” in order to qualify for state property tax exemption.\(^{39}\) By 1996, county tax assessors in Pennsylvania had used this standard to challenge the tax exemptions of 175 of the state’s 220 private nonprofit hospitals.\(^{40}\) In response, the Pennsylvania legislature passed the Institutions of Purely Private Charities Act which spells out in detail an exempt hospital’s charity care responsibilities.\(^{41}\) Similar legislation exists in Texas,\(^{42}\) the result of the Texas Attorney


\(^{36}\) Intermountain, 709 P.2d at 274.

\(^{37}\) See Noble, supra note 33, at 121-22; Howell v. County Board of Cache County ex rel. IHC Hosps. Inc., 881 P.2d 880, 886-89 (Utah 1994) (upholding these standards).

\(^{38}\) Noble, supra note 33, at 121 (noting that even discounts negotiated with third-party payers off the “sticker price” of health services would count in this calculation).

\(^{39}\) 487 A.2d 1306, 1317 (Pa. 1985).

\(^{40}\) Noble, supra note 33, at 121.

\(^{41}\) H.B. 55, 181st Gen. Assem. Reg. Sess. (Pa. 1997). See also, Noble, supra note 33, at 121. One test contained in the Pennsylvania legislation requires an institution to provide “uncompensated goods or services at least equal to 75% of the institution’s net operating income but not less than 3% of the institution’s total operating expenses.” H.B. 55 at § 5(D).

\(^{42}\) TEX. TAX CODE ANN. § 11.1801(a) (Vernon 2001). The Texas statute
General's suit against Methodist Hospital in 1990 seeking revocation of exempt status on the grounds of insufficient charity care. Though the suit was dismissed, the Attorney General pursued the issue with the Texas legislature, and in 1993 Texas became the first state to enact legislation specifying a percentage of revenues that exempt hospitals had to dedicate to charity care.

Perhaps the most recent example of state courts returning to a charity care focus in exemption for hospitals occurred in Illinois. Recent Illinois decisions have made clear that exemption in Illinois requires some substantial charity care program, and that the common practice of billing all patients and then writing off uncollectible debts as "charity care" will not fulfill this obligation.

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.

See Noble, supra note 33, at 123.

Id. at 129.


Other states that appear to use charity care as an important measure of exemption include Alabama (ALA. CODE § 40-9-1 (1975), exempting hospitals if "the treatment of charity patients constitutes at least 15 percent of the business of such hospitals"); Arkansas (See Burgess v. Four States Memorial Hospital, 465 S.W.2d 693 (Ark. 1971) where the court stated that "a benevolent and charitable organization's property used as a hospital may be constitutionally exempt from taxation if it is open to the general public, if no one may be refused services on account of inability to pay and if all profits from paying patients go toward maintaining the hospital and extending and enlarging its charity."); Florida (See Orange County v. Orlando Os-
Even in those states that have not "officially" returned to a charity care focus for exemption, the current trend is having an effect. For example, a number of states have enacted reporting requirements that force exempt healthcare entities to disclose their charity care efforts, and healthcare associations in several states, including Missouri, New Jersey and Massachusetts, have begun issuing charity care guidelines for members in attempts to stave off more drastic governmental intervention.

C. Summary

As the foregoing illustrates, the community benefit standard as articulated in Revenue Ruling 69-545 did not last long as a legal test of exemption. By the late 1980s, the IRS had essentially abandoned the broad standard of the ruling in the IDS and HMO cases, substituting a sort of "health care plus" standard in its place. Although the Tax Court continued to adhere to the "promotion of health" standard into the early 1990s, the IHC cases found the Tax Court and 10th Circuit also abandoning the notion that the promotion of health for the general benefit of the community is itself a charitable purpose that supports exemption, adopting instead the "health care plus" standard. These various rulings and court decisions also make clear that the chief "plus" is a substantial charity care program, although certain outreach programs such as wellness education and medical research may also be significant. Similarly, a number of states re-examined charity care practices by charitable hospitals in the context of state

tepathic Hospital, 66 So. 2d 285 (Fla. 1953) noting in support of exemption that "[p]atients who are unable to pay are received for treatment and receive the same care and attention as those who are able to pay."); Ohio (See Cleveland Osteopathic Hospital v. Zangerle, 91 N.E.2d 261 (Ohio 1950) where court denied exemption to hospital operating "very largely" to those who can pay and that free care was only given incidentally); and West Virginia (See City of Morgantown v. West Virginia University Medical Corp., 457 S.E.2d 637 (1995) where court appeared to adopt the standard from IRC § 501(c)(3), but stated "the determinative issue is whether the hospital refuses admittance to patients who cannot pay.").

On the other hand, at least two states, Vermont and Tennessee, have specifically rejected the notion that hospitals must provide some charity care in order to qualify for exemption. Med. Ctr. Hosp. v. City of Burlington, 566 A.2d 1352, 1355-57 (Vt. 1989) (exemption requires only an "open door" policy showing that hospital admits all patients including charity patients, but not specific levels of charity care); Downtown Hosp. Ass'n v. Bd. of Equalization, 760 S.W.2d 954, 955 (Tenn. Ct. App. 1988) (charitable tax exemption not conditioned on providing uncompensated care). Many other states simply have not examined the issue recently. 46 See Noble, supra note 33, at 123-128 (detailing the reporting requirements of Indiana, Massachusetts, New York and California).

47 Id.
property tax exemption laws. This trend, which began with Utah County in the 1980s, has continued today with the recent revocation of Provena-Covenant's exemption by the Illinois Department of Revenue and the class-action lawsuit filed by Richard Scruggs in late June 2004 against exempt hospitals for their failure to provide adequate charity care. These lawsuits are likely to push this issue to the forefront of the exemption debate.\textsuperscript{48}

Why this transition has occurred is fairly easy to discern. If providing health care services for a fee is itself charitable, then the test for exemption requires no more than what for-profit organizations do in the course of their business. As the 10th Circuit observed, "numerous for-profit enterprises offer products or services that promote health."\textsuperscript{49} Instead, the original community benefit standard articulated in Revenue Ruling 69-545 focused largely on organizational structure (e.g., organizing as a nonprofit corporation, as opposed to a for-profit one, and having a community board, instead of a private one) as the key to exempt status. While at least one commentator has opined that the mere act of forming a nonprofit corporation (with its resultant inability to distribute profits to individual shareholders) should be sufficient to warrant exemption,\textsuperscript{50} most observers of the tax-exemption world justify exemption on the basis of differential behavior between nonprofit and for-profit entities. The two parts of Revenue Ruling 69-545 that did focus on behavior — operation of an open emergency room and treatment of Medicare/Medicaid patients — proved largely insufficient in mandating behavioral difference, particularly with regard to non-hospital health care providers. The IRS admitted in Revenue Ruling 83-157\textsuperscript{51} that an open emergency room could not be an absolute requirement of exemption inasmuch as some health care providers simply do not have emergency services, and even for-profit providers participate in Medicaid programs.\textsuperscript{52}

This lack of quantifiable behavioral differences to guide the grant of exemption has dogged community benefit proponents almost from

\textsuperscript{48} See Lawsuits Challenge Charity Hospitals on Care for Uninsured, WALL ST. J., June 17, 2004, at B-1.

\textsuperscript{49} IHC Health Plans, Inc. v. Commissioner, 325 F.3d 1188, 1197 (10th Cir. 2003).


\textsuperscript{51} 1983-2 C.B. 94.

\textsuperscript{52} See, e.g., GEN ACCOUNTING OFFICE, SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, SERVICES PROVIDED AND FINANCIAL PERFORMANCE, Report No. 04-167 (2003) available at http://www.gao.gov/atext/d04167.txt (last viewed June 14, 2004). This study reported that for-profit specialty hospitals treated significant numbers of Medicaid patients, though at generally lower numbers than similar acute-care general hospitals in the same geographic areas.
the beginning. In fact, the problem of identifying specific, quantifiable “community benefits” became so severe that supporters of the nonprofit exempt hospital industry published a number of articles in the early 1990s warning of the need to quantify these other community benefits to preserve exemption. And, trade associations such as the Voluntary Hospitals of America and the Catholic Health Association developed detailed community benefit assessment and reporting programs.\(^{53}\) Even today operational definitions of community benefit remain “inconsistent, narrow, fragmented and only loosely related to the ways in which communities actually affect the health of their residents.”\(^{54}\) Moreover, many services that nonprofit hospitals pointed to as “community benefits” had commercial potential: outreach programs, for example, such as community education and health screening “may serve marketing and other promotional purposes for hospitals, just as sponsorship of sporting events or the arts does for many for-profit corporations.”\(^{55}\) The community benefit test, therefore, failed to isolate any significant quantifiable behavioral differences between for-profit and nonprofit health care providers, and hence it probably was doomed as a doctrinal legal test of exemption literally from its inception.

The new “promotion of health plus” standard that seemingly guides the IRS and courts today attempts to address that critical shortcoming by requiring some specific behavioral component for exemption (the “plus”) beyond what one might expect from a for-profit provider. But the 10th Circuit’s opinion in \(IHC\) illustrates some critical difficulties with this new formulation. First, health care organizations still do not know precisely what this “plus” is. For example, is it enough to conduct outreach programs to the community without any substantial charity care? While proponents of the community benefit standard might wish it so, and the 10th Circuit opinion in \(IHC\) seems to endorse such a possibility,\(^ {56}\) all the administrative and court deci-

\(^{53}\) See M. Gregg Bloche, *Health Policy Below the Waterline: Medical Care and the Charitable Exemption*, 80 MINN. L. REV. 299, 384 nn.320-22 (1995) and sources cited therein. See, e.g., J. DAVID SEAY & BRUCE C. VLADECK, *MISSION MATTERS* 8 (United Hospital Fund of New York 1987) (“To some extent... the malaise exhibited towards nonprofit health care institutions has appeared in the institutions themselves.... This paper identifies a rationale – indeed, a series of rationales – for the special role of voluntary, not-for-profit health care institutions.... That every single voluntary institution is not living up to these ideals, however, is obvious.”).


\(^{55}\) Bloche, supra note 53, at 385.

\(^{56}\) See supra text accompanying notes 30-31.
sions on health care exemption in the last decade and a half have fo-
cused squarely on charity care as a major exemption component. Al-
though the "health care plus" standard seems to permit significant
outreach and medical research programs as a substitute "plus," the
simple fact is that no IRS ruling or court case in the past decade and a
half has approved exemption for a health care provider that lacked a
substantial charity care program.\textsuperscript{57}

And then there is the lingering question of how to quantify the
"plus." Even the 10th Circuit had no good answer for this problem,
saying only that the "plus" involved "must be sufficient to give rise to
a strong inference that the public benefit is the primary purpose for
which the organization operates."\textsuperscript{58} Thus the 10th Circuit appeared to
signal that the "plus" factor must be more than a de-minimis "side-
show" and part of the overall purpose of the organization, but it is
inevitable in the world of litigation that these phrases will become
attached to dollars spent, number of employees involved, and other
quantitative measures of the importance of these plus factors, for
which the 10th Circuit offered no guideline. Accordingly, outside of
the case in which a health care organization has a specific and sub-
stantial charity care program, the new "health care plus" standard does
not seem to provide much doctrinal legal improvement over the origi-
nal promotion of health test.

The situation with state property tax exemption is similar. Like
the federal exemption standards, states appear to be drifting back to
charity care as the essential behavioral guideline for granting exemp-
tion out of a desire for identifiable and quantifiable behavioral differ-
ences to justify exempt status. As a result, "community benefit" in the
broad sense articulated in Revenue Ruling 69-545 no longer governs
exemption in the majority of cases dealing with health care providers.

\textsuperscript{57} I should clarify that I have no doubt that an institution dedicated primarily
to medical research would be exempt, but such an institution would not need to rely
on the community benefit test for exemption. Instead, it would be a species of scien-
tific research organization exempt under § 501(c)(3) and automatically classified as a
public charity under § 509(a)(1) via § 170(b)(1)(A)(iii). Similarly, an organization
dedicated primarily to health education would be exempt as an educational organiza-
The question posed in the text is whether an HMO would be exempt if it had no char-
ity care program but conducted, say, a few clinical trials of new drugs each year or
had weekly prenatal care seminars open to the public. So far, we have had no case to
test this proposition, and I remain dubious that, in cases other than a stand-alone acute
care hospital, a health care provider with no significant charity care program would be
exempt.

\textsuperscript{58} IHC Health Plans, Inc., v. Commissioner, 325 F.3d 1188, 1198 (10th Cir.
2003).
III. BEHAVIORAL EVIDENCE: EMPIRICAL STUDIES ON NONPROFIT BEHAVIOR

Despite these failures of the community benefit test as doctrinal legal standard of exemption, it is possible that the standard serves to recognize *ex post* some differential behavior between nonprofit and for-profit health care providers that should be rewarded by exemption. That is, whatever the failures of community benefit as a method of identifying specific socially worthy behavior, if in fact nonprofit providers differ in significant socially beneficial ways from for-profit counterparts, we might simply live with the community benefit formulation as a way to recognize exemption for (and thus financially encourage) this general differential behavior. In this formulation, we might say that the community benefit standard, however imprecisely it does so, simply grants exemption for a range of socially-beneficial behaviors that are in fact connected with the nonprofit form. Or put another way, if the community benefit test consistently identified for exemption entities that provided better care for patients, or that provided cheaper but still-quality care, or that treated significantly higher numbers of charity patients than for-profit entities, then perhaps we should be inclined to leave well-enough alone. Before we jettison the community benefit test, therefore, it would be helpful to know whether the test performs such a function.

Over the past twenty years, a number of health policy experts in the social sciences have undertaken empirical studies of the behavior of nonprofit and for-profit hospitals and other providers on a variety of outputs-related behavior. In general, these studies have focused on three main metrics of differential behavior: quality of care; costs of care; and treatment of charity patients. Before proceeding to a summary of these studies, however, several cautions are in order. First, the nonprofit sector in health care encompasses three distinct subgroups, at least where hospitals are concerned: the private nonprofit, the government-owned nonprofit, and the university-affiliated teaching/research nonprofit. Since government-owned nonprofits would be exempt from federal income taxes (and presumably their own state property taxes) without regard to the exemption standard under § 501(c)(3), the behavioral data with respect to such entities sheds no light on whether the community benefit test should be retained in some form. Similarly, university-affiliated or free-standing teaching hospitals or medical research organizations presumably would be ex-

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empt as "educational institutions" or as "scientific" organizations under § 501(c)(3) without regard to the community benefit standard of exemption because of their educational or research mission. Ergo, data relating to teaching hospitals also says nothing about the efficacy of the community benefit standard in distinguishing charitable from non-charitable behavior. Or put another way, because both government-owned hospitals and university-affiliated teaching hospitals would be exempt without the community benefit standard, if these two subgroups account for all or nearly all the differential behavior between nonprofit and for-profit health care providers, then there is no reason to keep a separate community benefit standard. That leaves the private nonprofit group as the one on which we should focus our attention, yet several early studies failed to differentiate these three nonprofit groups.

Second, because these studies focus on gross behavioral differences, they may shed little light on the causes of these differences. In particular, as Part II B notes, state property-tax exemption standards often differ from federal exemption standards under § 501(c)(3). In Illinois, for example, recent cases dealing with property tax exemption for health care providers suggest that a substantial charity care program is a requirement for state property tax exemption, and that certain billing practices of nonprofit hospitals are inconsistent with exempt status. As a result of these cases and local exemption challenges, some hospitals in Illinois have drastically altered their charity care programs and billing practices. This anecdotal evidence suggests that what differences in behavior there are between the nonprofit and for-profit sector might be more attributable to state property tax exemption standards than the federal community benefit test.

In general, independent reviews of the existing literature on the behavioral differences of nonprofit and for-profit hospitals find the studies at best inconclusive regarding whether nonprofit hospitals

60 Educational organizations encompass a broad variety of activities other than "real schools" (e.g., schools with a permanent campus, faculty and regularly-enrolled students) – for example, museums, zoos, symphony orchestras and jazz festivals all qualify for educational status, as do a variety of magazines (such as National Geographic) and organizations providing counseling services. See generally, FRANCES R. HILL & DOUGLAS M. MANCINO, TAXATION OF EXEMPT ORGANIZATIONS §§ 3-21-3-31 (2002); John D. Colombo, Why is Harvard Tax Exempt? (And Other Mysteries of Tax Exemption for Private Educational Institutions), 35 ARIZ. L. REV. 841, 847 (1993). Scientific organizations include those engaged in research for the benefit of the public. See Treas. Reg. § 1.501(c)(3)-1(d)(5)(i) (as amended in 1990); HILL & MANCINO, supra, at 3-37-3-38.

61 See supra text accompanying note 45.

provide more socially-beneficial behavior in the form of better care, cheaper-but-equally-as-good care, or more charity care. Writing in 1995, Professor Gregg Bloche noted that a review of the literature indicated that nonprofit and for-profit hospitals "display remarkable heterogeneity in their production of biomedical research, education, indigent care and community service."\(^{63}\) On the research front, Bloche found that "a small number of elite teaching hospitals staffed by medical school faculty conduct the vast majority of this research" and that the private community nonprofit "performs little or no biomedical research."\(^{64}\) On the whole, nonprofit hospitals appeared to provide somewhat more "uncompensated care" than for-profits, but again "[u]ncompensated care performed by the private sector is concentrated in major urban teaching hospitals, . . . Studies of comparable nonprofit and for-profit hospitals, matched on the basis of community demographics and patient characteristics, have not shown a significant difference in rates of uncompensated care."\(^{65}\)

Frank Sloan reached similar conclusions in his review of the literature in 1998.\(^{66}\) Sloan noted that "[h]ospitals of nonprofit and for-profit ownership are similar in provision of uncompensated care, in quality of care, and in adoption of technology. . . . Conversions of nonprofits to for-profit hospitals do not appear to reduce provision of uncompensated care."\(^{67}\) With regard to medical research, Sloan agreed that "[r]elatively few hospitals have made major commitments to medical education and biomedical research," and hence excluded such hospitals from his overall review.\(^{68}\)

Similarly, a report issued in July 2004 by the FTC and Department of Justice on competition in health care stated, "several panelists maintained that the best available empirical evidence indicated no significant differences between the pricing behavior of for-profit and nonprofit hospitals."\(^{69}\) The report also noted:

\(^{63}\) Bloche, *supra* note 53, at 315.

\(^{64}\) *Id.* at 316.

\(^{65}\) *Id.* at 317-18.

\(^{66}\) Frank A. Sloan, *Commercialism in Nonprofit Hospitals, in To Profit or Not to Profit: The Commercial Transformation of the Nonprofit Sector* 151 (Burton Weisbrod ed., 1998).

\(^{67}\) *Id.* at 166. Sloan also noted that "[t]hese generalizations reflect averages" and that individual cases may vary.

\(^{68}\) *Id.*

Recent empirical studies of pricing behavior paint a fairly consistent picture. One study found that there was no significant difference in how for-profit and nonprofit hospitals exerted market power; for-profit hospitals generally had higher prices in 1986, but nonprofits increased their prices faster from 1986 to 1994. A case study of a nonprofit hospital merger in Santa Cruz, California, found significant evidence of post-merger price increases. Another study noted that “the most interesting result for antitrust policy is the finding that nonprofit hospital mergers lead to higher prices, not lower ones, and that the price increases resulting from a nonprofit merger are getting larger over time.”

Merger simulation studies have produced a similar picture. One study found nonprofit status did not lead to lower prices in urban markets, but did result in modestly lower prices in rural markets. Other studies found no differences in pricing behavior resulting from institutional status.70

With respect to charity care, the report concluded that “[g]overnment statistics indicate that on average, uncompensated care accounts for a similar percentage of total costs at for-profit and nonprofit hospitals.”71

More recent studies tend to support the conclusions reached by Bloche, Sloan and the FTC/DOJ report. Professors Thomas Greaney and Kathleen Boozang noted that “[o]ne cannot confidently conclude that the nonprofit form does or does not ‘make a difference’ in terms of its net ‘payback’ for tax exemption and other benefits it enjoys.”72 Reviewing the economic literature on hospitals, the two authors found that “[e]vidence further suggests that characteristics of the local market, such as the presence of other hospitals, managed care penetration, and socio-economic status of the community are far more powerful predictors of performance than the nonprofit form.”73

70 Id. at 32 (citations omitted).
71 Id. at 33.
73 Id. (manuscript at 33-34, on file with author).
On the quality front, Mark McClellan and Douglas Staiger reported in 2000 that while gross statistics showed that for-profit hospitals had higher mortality among elderly patients with heart disease, "[w]hen we compare hospital quality within specific markets, for-profit ownership appears, if anything, to be associated with better quality care." In a study published in 2002, Gabriel Picone, Shin-Yi Chou and Frank Sloan used data from hospital conversions to study the effects of conversion from nonprofit to for-profit form on quality. Using data from the 1982, 1984, 1989, and 1994 National Long-Term Care Surveys and the American Hospitals Association's Annual Survey of Hospitals from the same years, the trio studied health outcomes (death at thirty days, six months, and one year) of Medicare patients at hospitals both pre-conversion and post-conversion. Picone, Chou and Sloan found that converting from not-for-profit to for-profit causes a reduction in quality immediately after conversion, but found that these effects generally reversed themselves in the third year after conversion.

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Note that many researchers have commented on the difficulty of measuring quality in the health care arena. Data on patient outcomes, particularly on how the patient fares after discharge, is often simply not collected. Moreover, "noise" in the available data is rampant: as McClellan and Staiger noted, "important health outcomes are determined by an enormous number of patient and environmental factors; differences in the quality of medical care delivered by hospitals are only one component." Mark McClellan & Douglas Staiger, Comparing Hospital Quality at For-Profit and Not-for-Profit Hospitals, in The Changing Hospital Industry 93, 95 (David M. Cutler ed., 2000). There is also the issue of bias in patient selection. Hospitals with the reputation for highest quality, for example, might attract a disproportionate number of very difficult cases which turn out badly, skewing data on patient outcomes. Id. Finally, even the results of the studies that are done are often open to multiple interpretation. For example, I characterize McClellan and Staiger's results as generally supporting the conclusion that there is not any noticeable difference in quality of care between for-profit and nonprofit hospitals because they report that within specific markets, for-profit providers score higher on their quality measures than nonprofits, even though the gross data shows nonprofits slightly ahead on their quality measures. Professor Jill Horwitz, however, cites the gross data in the same article for the proposition that quality differences indeed may exist. Jill R. Horwitz, Why We Need the Independent Sector: The Behavior, Law, and Ethics of Not-for-Profit Hospitals, 50 UCLA L. REV. 1345, 1362 n.89 (2003). Compare Greaney & Boozang, supra note 72, (manuscript at 10 n.31, on file with author) (citing the McClellan-Staiger study as "a more positive outcome for the for-profit entity" on quality measures.).

McClellan & Staiger, supra note 74, at 94.

Gabriel Picone, Shin-Yi Chou, & Frank Sloan, Are For-Profit Hospital Conversions Harmful to Patients and to Medicare?, 33 RAND J. ECON. 507 (2002).

Id. at 510.

Id. at 521. The authors speculate that pressure to increase profits immediately after a conversion results in a reduction in the number of employees and salaries, leading to a quality decline, which then reverses once managers become aware of
THE FAILURE OF COMMUNITY BENEFIT

With respect to charity care, the story is similar. On the charity care front, studies of gross data find little difference in the provision of "uncompensated care" by for-profit and nonprofit entities and little difference between pre- and post-conversion levels of charity care in nonprofit to for-profit conversion transactions. Researchers note that the bulk of uncompensated care in the nonprofit sector is provided by government or teaching hospitals rather than private nonprofits, that some nonprofits provide no charity care at all, and that what charity care is provided often does not measure up to the value of taxes foregone by exemption. As a result, even supporters of the nonprofit form and associated tax-exemption conclude 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." Results from recent research on the costs of care are more

... the adverse effects of these steps on quality of care.

Researchers generally use the phrase "uncompensated care" to encompass both bad debts (which is obviously the bulk of such care provided by for-profit institutions) and "charity care" by nonprofit institutions. See, e.g., David A. Hyman, The Conundrum of Charitability: Reassessing Tax Exemption for Hospitals, 16 AM. J.L. & MED. 327, 360 (1990); Horwitz, supra note 74, at 1354.

E.g., Frank Sloan, Not-for-Profit Ownership and Hospital Behavior, in 1B HANDBOOK OF HEALTH ECONOMICS at 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).

E.g., Gary J. Young et al., Does the Sale of Nonprofit Hospitals Threaten Health Care for the Poor?, HEALTH AFF., Jan.-Feb. 1997, at 137 (essentially no difference in uncompensated care levels pre- and post-conversion in a study of seventeen California hospital conversions); Kenneth E. Thorpe et al., Hospital Conversion, Margins, and the Provision of Uncompensated Care, HEALTH AFF., Nov.-Dec. 2000, at 187, 191 (finding a decline in uncompensated care from 5.3% of revenues to 4.7% of revenues in private nonprofit-to-for-profit conversions).


E.g., Nancy M. Kane & William H. Wubbenhorst, Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption, 78 MILBANK Q., 185, 199 (noting that depending on the methodology used for including bad debt as indigent care, as much as eighty-six percent of a surveyed sample of hospitals had tax benefits from exemption that exceeded the value of free care); Charles B. Gilbert, Health-Care Reform and the Nonprofit Hospital: Is Tax-Exempt Status Still Warranted?, 26 URB. LAW. 143, 173-174 (1994). See also, Hyman, supra note 79, at 365 (noting that the value of charity care provided by the Medical Center Hospital of Vermont was roughly half the value of its tax exemption annually).

Horwitz, supra note 74, at 1354.
variable, with some finding no differences and others large differences, particularly in administrative costs, although once again these studies often fail to differentiate between government, educational and private nonprofits.

On the other hand, one recent study does provide some evidence of systematic differences with regard to nonprofit and for-profit hospitals in an area relating to access to services. In a study published in 2003, Professor Jill Horwitz compared for-profit, nonprofit and governmental hospitals with regard to the range of services offered by each type and whether the hospitals in question differed in supplying profitable and unprofitable services. Controlling for a number of variables relating to hospital characteristics (including size, teaching status, geographic region, demographics), Professor Horwitz found that for-profit hospitals were more likely than nonprofit or government hospitals to offer profitable services and less likely to offer unprofitable services. Government-owned hospitals offered the most unprofitable services and least profitable services among the three types, with private nonprofit hospitals in the middle. This study, which carefully controlled for various hospital characteristics in order to compare services provided by similar hospitals serving similar demographic areas, probably constitutes the best evidence to date that private nonprofit hospitals have some behavioral differences in comparison to their for-profit counterparts. Professor Horwitz acknowl-

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86 E.g., Timothy S. Snail & James C. Robinson, Organizational Diversification in the American Hospital, 19 ANN REV. PUB. HEALTH 417, 436-37 (1998) (describing five studies measuring the effects of hospital mergers and consolidations on the hospital costs). The DOJ/FTC REPORT, supra note 69, cites a number of studies on pricing behavior. Id. at 31-33.

87 E.g., Elaine M. Silverman, Jonathan S. Skinner, & Elliott S. Fisher, The Association between For-Profit Hospital Ownership and Increased Medicare Spending, 341 NEW ENG. J. MED. 420, 424 (1999) (expenditures by hospitals are highest in areas in which all hospitals are for-profit, lowest where all are non-profit); Steffie Woolhandler & David U. Himmelstein, Costs of Care and Administration at For-Profit and Other Hospitals in the United States, 336 NEW ENG. J. MED. 769, 772 (1997) (finding administrative costs at for-profit hospitals to be twenty-three percent higher than at nonprofits).

88 E.g., Silverman, Skinner & Fisher, supra note 87, at 421 (classifying government hospitals as nonprofit along with private nonprofits).

89 Horwitz, supra note 74, at 1365. Professor Horwitz classified various hospital services as high profitability, low profitability or variable profitability based upon interviews with doctors, hospital administrators, a review of trade publications and Medicare reimbursement guidelines, and an analysis of the insurance status of patients likely to need the service (e.g., insured vs. uninsured).

90 Id. at 1364 n.100.

91 Id. at 1367-68.

92 Id.
edged, however, that one cannot use her study to draw a causal connection between tax exemption and the observed behavioral differences, and also notes that hospital behaviors vary widely depending on their specific characteristics such as size and demographics of location.

In sum, the available behavioral evidence presents a very weak case for retention of the community benefit test for tax exemption. The best evidence of a consistent behavioral difference between non-profit and for-profit hospitals to date is that presented by Professor Horwitz's study, yet even she admits that one cannot draw a causal connections between exemption standards and the observed behavior differences. Because behaviors vary widely depending on other specific hospital characteristics, including size and location, there may be a number of other policy "levers" that could be used to affect behavior more directly than exempt status. Other studies show a remarkable lack of consistently identifiable behavioral differences. At the very least, therefore, one can conclude that the community benefit test does not perform the function of consistently identifying nonprofits that produce socially worthy outputs meriting reward via exemption.

IV. ALTERNATIVES TO COMMUNITY BENEFIT

Parts II and III of this article warrant the title of this piece. As both a legal test and behavioral guide, the community benefit test of exemption (at least as originally articulated in Revenue Ruling 69-545) has been a complete failure. The result at both the federal and state levels has been an almost inexorable return to charity care as the significant behavioral differentiation between exempt and non-exempt health providers. The next obvious question, therefore, is what (if anything) we should do about it. This section of the paper explores two basic alternatives, with some variations. Those two basic alternatives are either to simply ditch the community benefit test altogether or to transform the test into one that requires more specific behavior to justify exemption.

93 Id. at 1409 ("We cannot know whether not-for-profit hospitals provide these goods because of the tax exemption without performing the social experiment of removing it.").

94 Id. at 1367. Horwitz notes:

[These findings do not mean that all for-profit hospitals are more likely than others to offer profitable services, or that all government hospitals are more likely than others to offer unprofitable services. Large hospitals are more likely to have more of everything, and not-for-profit hospitals are larger than for-profit and government hospitals. So, not-for-profit hospitals offer more profitable and unprofitable services than both other types.

See also Greaney & Boozang, supra note 72.
A. Repealing the Community Benefit Test

One option for dealing with the overall situation that has been endorsed by a number of commentators is for the IRS to abandon the community benefit test.\(^9\) While this may seem draconian at first, one should note that many nonprofit hospitals could remain tax-exempt under other tests.\(^9\) Government-owned hospitals, for example, would continue to be tax-exempt under § 115. University-affiliated teaching hospitals undoubtedly would qualify for exemption as educational organizations under § 501(c)(3). Medical research centers likely would be exempt scientific research organizations under that same section. In addition, repealing the community benefit test would not affect the general tests of charitability already set forth in Treasury Regulations § 1.501(c)(3)-1(d)(2). Thus the charity care standard for

\(^9\) E.g., Thomas R. Barker, *Reexamining the 501(c)(3) Exemption of Hospitals as Charitable Organizations*, 48 Tax Notes 339, 350-51 (1990) (recommending charity care standard for exemption instead of community benefit); Bloche, *supra* note 53, at 390-91 (recommending ultimate complete repeal of exemption); Nina J. Crimm, *Evolutionary Forces: Changes in For-Profit and Not-For-Profit Health Care Delivery Structures: A Regeneration of Tax Exemption Standards*, 37 B.C.L. REV. 1 (1995) (recommending replacing community benefit test with specific behavioral incentives as discussed below); Gilbert, *supra* note 84, at 173-74 (urging exemption for only those hospitals that provide charity care at a level equal to the value of exemption); Hall & Colombo, *supra* note 35 (recommending a test of exemption based upon percentage of operating budget that comes from donations); Hyman, *supra* note 79, at 379 (“There is little in the way of theoretical, intellectual or financial reasoning to maintain the current structure of tax exemption.”).

Though I have in the past been a proponent of repealing the community benefit test for exemption, as discussed in Part IV C, below, I recently have recommended adopting an “enhancing access” test for exemption, which one could interpret as a considerably-narrowed community benefit approach (the focus being on a single, relatively quantifiable benefit of enhancing access to services that are otherwise unavailable to the target population).

\(^9\) The fact that repeal of the community benefit test would leave exemption intact for many hospitals has often been overlooked in the legal literature dealing with tax exemption. In a recent article, for example, Professor Jack Karns criticized the proposal made by Mark Hall and myself several years ago to limit tax exemption to donative entities on the grounds that “these commentators implicitly support a per se rule disallowing the tax exemption” for nonprofit hospitals. Jack E. Karns, *Justifying the Nonprofit Hospital Tax Exemption in a Competitive Market Environment*, 13 WIDENER L.J. 383, 528 (2004). He later notes that the opinions of exemption critics “would mean that all non-governmental hospitals would fall into the for-profit category.” *Id.* at 554. There are many similar comments throughout this article, which seems to misapprehend the fact that repeal of the community benefit test would not equate with repeal of tax exemption for all nonprofit hospitals. Indeed, in our first work on tax exemption for nonprofit hospitals, Professor Hall and I noted that charity care would be a perfectly acceptable grounds for granting exemption, and that even under our donative proposal, specialty hospitals such as the Shriners’ hospitals for children likely would remain exempt. Hall & Colombo, *supra* note 35, at 409-10.
exemption articulated in Revenue Ruling 56-185 would remain intact, and any health care provider whose "primary purpose" was relief of the poor and distressed (e.g., an inner city clinic providing free or below-cost care for the poor) would continue to be exempt under traditional notions of charity.

Nevertheless, there is little doubt that many private nonprofit hospitals and nonprofit HMOs would lose exemption under this approach unless they adopted far more rigorous charity care programs. This probability, in turn, sparks two main criticisms. The first is that loss of the exemption would essentially equate to the loss of the nonprofit form in health care and its beneficial community orientation. This argument has been made and responded to in many different venues and many different ways over the years as the debate over differences between for-profit and nonprofit providers has raged. I have little to add to this argument at this stage beyond what is covered in Parts II and III of this article, which recount that modern empirical evidence shows little difference in the quantifiable behavior of for-profit and nonprofit hospitals with respect to cost, quality of care and charity care. Further legal tests of exemption have abandoned a broad community benefit test in favor of specific behavioral measures, primarily charity care, because of the behavioral imprecision of a broad community benefit standard.

But I do offer the following observations. First, it seems particularly odd to me that proponents of the community benefit standard of exemption for private nonprofit hospitals grow almost fanatic over the prospect of losing exempt status for hospitals when virtually every other component of the health care system operates on a for-profit basis. It may well be true, as several commentators have suggested, that health care differs significantly from other consumer choices in the consumer's ability to judge quality, and therefore the issue of trust in health care is far more critical than in most other consumer choices. But doctors, nurses, pharmaceutical companies, local

97 Mark Schlesinger, Bradford Gray and J. David Seay have eloquently set forth the case for community benefit test in their extensive writing. See, e.g., Mark Schlesinger, Bradford Gray & Elizabeth Bradley, Charity and Community: The Role of Nonprofit Ownership in a Managed Health Care System, 21 J. HEALTH POL. POL'Y & L. 697 (1996); J. David Seay, Tax-Exemption for Hospitals: Towards an Understanding of Community Benefit, 2 HEALTH MATRIX 35, 36 n.3 (1992). Two of the more detailed refutations of the community benefit test are contained in Bloche, supra note 53, at 382-90, and Hyman, supra note 79.

98 See, e.g., Mark A. Hall, Law, Medicine, and Trusts, 55 STAN. L. REV. 463 (2002); Frank A. Sloan & Mark A. Hall, Market Failures and the Evolution of State Regulation of Managed Care, 65 LAW & CONTEMP. PROBS. 169, 172-74 (2002); Greaney & Boozang, supra note 72, manuscript at 6 nn.18-22, on file with author).
pharmacies, medical equipment providers, insurance companies, etc. all operate as for-profit entities. As a nation, we do not seem to distrust our doctors because they practice their profession for a profit. We do not begrudge the local pharmacy their for-profit orientation. We do not ask whether the wheelchair manufacturer is nonprofit or for-profit. Why is it, therefore, that a suggestion that hospitals might be able to operate in a similar for-profit environment without destroying the health care system is met by exemption proponents with such disdain?

I suppose that one answer to this question might be that the hospital is the "central mixing valve" for health care services. That is, it is the primary place where all the for-profit providers come together with the consumer. Ergo, if one truly believed that nonprofits operated under different behavioral norms, it might make some sense for this central valve to be nonprofit in order to mediate (or perhaps a better word would be "moderate") the "bad" for-profit influences on patient care. But there is little evidence that the nonprofit form itself provides this mediated behavior. As noted above, the bulk of empirical evidence indicates that the behavior of nonprofit healthcare providers tends to converge with that of for-profits in competitive markets. Unless one is prepared to completely outlaw the for-profit form in health care delivery, this convergence indicates that the nonprofit form does not automatically result in more trustworthy behavior; rather, market forces (particularly competition between nonprofit and for-profit providers) largely dictate the behavioral response. In

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99 As Mark Hall has noted, a variety of studies have failed to find that managed care financial incentives undermine patients' trust. Although patients in managed care plans that use financial incentives have somewhat lower trust in their physicians, the magnitude of difference is not large and the overall level of trust is still high. In a randomized controlled study, disclosing physician incentives to HMO members did not measurably reduce trust in physicians or insurers, and actually increased trust slightly in physicians, possibly by demonstrating candor. Hall, supra note 98, at 505-06.

100 Professor Horwitz alludes to this function of the hospital, noting that "[a]ll physicians practice within the constraints set by hospital-level investment and policy decisions." Horwitz, supra note 74, at 1405.

101 See supra notes 66-71 and accompanying text. This convergence has been noted by a number of commentators. See, e.g., Frank A. Sloan, Commercialism in Nonprofit Hospitals, in To Profit or Not to Profit: The Commercial Transformation of the Nonprofit Sector 151 (Burton Weisbrod ed., 1998); Richard G. Frank & David S. Salkever, Market Forces, Diversification of Activity, and the Mission of Not-for-Profit Hospitals, in The Changing Hospital Industry 195 (David M. Cutler ed., 2000); Jack Needleman, The Role of Nonprofits in Health Care, 26 J. Health Pol'y, Pol'y & L. 1113, 1125 (2001).
addition, scandals involving the salaries of nonprofit executives, or the example of the Red Cross deciding to divert donations made for 9/11 victims to other uses, certainly should give one pause before concluding that nonprofits are inherently more trustworthy than for-profits. Moreover, even the ardent proponents of hospital exemption admit that the hospital is rapidly losing its place (or perhaps has already lost it) as the “central valve” in the health care system, as independent outpatient centers (such as for imaging or outpatient surgeries) and managed care plans take on more responsibility. Thus the notion that the nonprofit hospital serves as a moderating influence on the evils of for-profit medicine appears daily less relevant.

Another possible distinction is that with all the for-profit health care providers mentioned above, the profit incentive is aligned to provide more health care to the consumer. If the doctor is paid on a per-service basis, for example, the doctor’s profit motive is to provide more services, which the consumer may interpret as better care. On the other hand, a for-profit hospital might have an incentive to cut corners on patient services to enhance profits. But I do not understand why the corner-cutting arguments are not equally applicable to other segments of the health care chain. For example, why don’t we believe that doctors might be tempted to cut time spent reviewing patient files in order to cram in more patient visits and enhance the doctor’s bottom line? Perhaps the intervention of the FDA makes us comfort-

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102 The most visible of these scandals was the disclosure in 1992 of United Way President William Aramony’s $463,000 salary and generous fringe benefits, which led to Congressional hearings on the matter. See JAMES J. FISHMAN & STEPHEN SCHWARZ, NONPROFIT ORGANIZATIONS: CASES AND MATERIALS, 246 (2d ed. 2000). Nonprofit executive salaries, particularly for hospitals, are once again a major news item, however, and there are Congressional murmurings on the issue. See, e.g., Julie Appleby, Non-profit Hospitals’ Top Salaries May Be Due for a Check-up, USA TODAY, Sept. 30, 2004, at 1B.


104 In fact, supporters of the community benefit approach, recognizing this fact, have recently begun a push to apply community benefit standards to managed care plans. See, e.g., Schlesinger, supra note 103. If one believes in the benefits of the community benefit formulation, this change in focus makes perfect sense as the nonprofit hospital becomes less relevant to the gatekeeping function in health care and managed care plans become more relevant.

105 One explanation might be our faith in professional ethics, but other academics have questioned the ability of professional ethics to protect the consumer. The role of professional ethics in providing optimal health services was highlighted by Kenneth Arrow in his seminal 1963 work on health care. Kenneth J. Arrow, Uncertainty and the Welfare Economics of Medical Care, 53 AM. ECON. REV. 941, 949-51 (1963). For a summary of the critiques of professional ethics as either a necessary or appropriate consumer safeguard, see, e.g., M. Gregg Bloche, The Market for
able that drug companies are not systematically cutting corners with respect to prescription drugs, but what makes us believe that the local pharmacy won't short us on a pill now and then to save a few bucks? The stories about insurance companies and HMOs denying coverage for various health care procedures are legion; yet we permit them to operate on a for-profit basis (although admittedly subject to government regulation). If one truly believes that nonprofit form provides superior trust, it would seem to lead inexorably to the conclusion that the best policy decision would be to require doctors, HMOs and insurance companies to adopt nonprofit form!106

A second argument against repealing the community benefit test recently has been articulated by Professors Jill Horwitz and Jack Karns.107 In essence, both assert that the nonprofit hospital is a necessary part of the proper “mix” of health care entities, and that the system as a whole would suffer if nonprofit hospitals ceased to exist.108 This argument differs from the traditional community benefit argument in that its focus is not on the loss of specific benefits of individual nonprofit entities to their communities, but rather on the damage that the loss of nonprofit form would bring to the overall mix of services provided in the industry. Professor Horwitz asserts that nonprofits are necessary because they bring a mix of health services that for-profits do not provide, and offer protection against “a class-based, two-tiered medical system” in which the poor are treated by government-owned hospitals while the well-insured have access to private hospitals.109 Professor Karns similarly warns against removing tax exemption because there is no empirical data on how a transformation to for-profit hospitals would affect the health care market.110 Karns paints something of a doomsday scenario in which hospitals close in droves, leaving patients with no viable care alternatives and no governmental policies to fill the gap.111

While Karns is undoubtedly correct that a repeal of the community benefit standard for tax exemption would result in market disrup-
tions, his "sky is falling" view is also undoubtedly overblown. When Congress withdrew tax exemption from the Blue Cross-Blue Shield health insurance plans several years ago, the health system did not collapse despite the central role the "Blues" played in the health care system. Most, in fact, remained nonprofit entities, and recent conversions of Blue Cross plans to for-profit status generally have not resulted in significant negative consumer consequences. Karns asserts that without exemption, health education and research would likely come to an end, but he offers no rationale for this outcome and ignores the fact that many for-profit organizations, ranging from drug companies to computer chip makers, engage in significant research activities because their continued market position demands it.

Professor Horwitz's points in favor of continued exemption are more muted, but ultimately more powerful. As noted in Part III, her empirical research demonstrates that private nonprofit hospitals provide more unprofitable services than similar for-profit ones (though far less than government-owned institutions). As a result, she documents a behavioral difference attributable to nonprofit form and argues that because of this behavioral difference, our health care system is best served by a mix of providers, including for-profits, nonprofits and government-owned. While she notes that she cannot draw a

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112 Congress withdrew federal tax exemption from the Blues in 1986, adding § 501(m) to the Code to eliminate exemption for organizations providing "commercial-type insurance." See generally Mancino, supra note 9, at § 6.03.

113 See Mark A. Hall & Christopher J. Conover, The Impact of Blue Cross Conversions on Accessibility, Affordability, and the Public Interest, 81 MILBANK Q 509, 537 (2003) ("We did not detect any major negative health policy effects so far from the freestanding conversions of Blue Cross plans in states where they have occurred."); Joy M. Grossman & Bradley C. Strunk, For-Profit Conversions and Merger Trends Among Blue Cross Blue Shield Health Plans, Issue Brief No. 76 (Center for Health System Change Jan. 2004) available at http://www.hschange.org/CONTENT/644/ (last viewed Sept. 17, 2004). Hall and Conover observe, however, that in many cases, the business practices of Blue Cross plans had changed long before the actual conversion to for-profit status, usually as a result of competition with other health insurers. Hall & Conover, supra, at 519-20. They also note that many of their interviews with executives confirmed that nonprofit insurers did, in fact, operate differently at the margins than for-profit plans. Id.

114 Karns, supra note 96, at 554 ("Further, collateral charitable activities, such as education and research ... would not likely be performed at comparable levels by the for-profit hospitals. Not only would there be no economic basis for them to do it, shareholders would legitimately contend that these activities were a diversion of assets ... "). As the text notes, however, this statement simply is not true. All manner of for-profit corporations engage in significant research efforts. See, e.g., Mark Hachman, Intel Research: MEMS, "Motes", and Wetware, Oh My! at http://www.extremetech.com/article2/0,1558,120522,00.asp (last visited July 27, 2004) (detailing the research efforts of Intel Corporation and how many of these research initiatives have no specific profit payoff in mind).
causal connection between exemption and this differential behavior, she opines that exemption may (likely does) play a role in the adoption of nonprofit form for hospitals, and that given the relatively small amount of money at stake, we should not withdraw exemption because of the role it may play in fostering this positive mix of ownership in the hospital sector.115

Because I agree with Professor Horwitz that the differences in behavior she observed are important ones, I suggest in IV.C. below that one might adopt a more targeted doctrinal test of exemption that would mesh with Professor Horwitz’s empirical observations. Nevertheless, as is true of Professor Karns, Professor Horwitz’s plea that we not abandon exemption because it might have some indirect effect on measurable differences in hospital behavior is a fairly weak defense of the status quo. As I suggest below, if we want to take the route of using exemption to affect the behavior of health care providers, we can (and should) adopt more targeted methods of doing so.

Second, if the major problem identified by Professor Horwitz is that needed health care services are unprofitable or unavailable because governmental and insurance reimbursement policies make it so, one way to fix this is to change health reimbursement policies. That is, one might conceive of addressing the mix of services provided by hospitals directly in health policy, as opposed to using exemption as an incentive to adopt nonprofit form, which in turn provides an indirect means of achieving these goals.116 One of the benefits of jettison-

115 Horwitz, supra note 74, at 1409.
116 This argument is hardly new; Professor Robert Clark made this exact point some twenty-four years ago. Robert Charles Clark, Does the Nonprofit Form Fit the Hospital Industry?, 93 HARV. L. REV. 1416, 1418. See also, Hyman, supra note 79, at 380 (“[a] shift to focused goals and away from an undifferentiated subsidy would better serve the public interest by encouraging obviously desirable conduct.”); David A. Hyman, Hospital Conversions: Fact, Fantasy, and Regulatory Follies, 23 J. CORP. L. 741, 775-776 (1998) (“In short, organizational status leaves a great deal to be desired as a proxy for conduct – and optimal subsidy policy would require that any and all subsidies be closely tied to conduct.”). The FTC/DOJ Report also makes this point in Recommendation 3. FTC/DOJ REPORT, supra note 69, at 23. Evelyn Brody has made a similar point on a more general plane, noting that “society might prefer to subsidize charitable and other social outputs produced by all organizations rather than subsidize nonprofits based on their organizational form.” Evelyn Brody, Agents Without Principals: The Economic Convergence of the Nonprofit and For-Profit Organizational Forms, 40 N.Y.L. SCH. L. REV. 457, 461 (1996). See also, Frances R. Hill, Targeting Exemption for Charitable Efficiency: Designing a Nondiversion Constraint, 56 SMU L. REV. 675 (2003) (proposing a plan to target exemption at “exempt activities” to avoid the possibility that exemption would help subsidize commercial activities). Professor Horwitz considers and rejects this approach, arguing that in the case of medical care, directly attacking these issues “may be neither possible nor desirable,” given the difficulty of measuring health care quality. Horwitz, supra note
ing the community benefit test, in fact, would be to get the IRS, state and local taxing authorities largely out of the business of regulating health policy through tax policy. The one thing that virtually everyone who writes or thinks about tax exemption for health care providers agrees on is that current tax exemption policies make taxing authorities unwitting (and often uninformed) major players in health care policy. Yet exemption proponents seem to cling to the status quo as a way of regulating the health care system through the IRS and state revenue departments without really regulating it, seemingly out of fear that the processes of democratic government cannot come to grips with sound health policy. Perhaps a better approach would be to get the taxing authorities out of this game and force government to own up to our serious, systematic health care problems. Right now, for example, federal and state government can largely dodge the issue of health care for the uninsured by shoving that burden off to private nonprofit organizations as part of the exemption rules. How much worse would our system be if we simply ended exemption and forced government to undertake a serious review of providing health care for

74, at 1410. But the focus of her research is not on the quality factor; rather, it is on the mix of services, and the service mix would certainly respond to reimbursement rates. In fact, her research results show a strong correlation between the profitability of a particular service and the likelihood of it being offered across all ownership types. "Controlling for hospital, market, and demographic characteristics, the probability of offering home health services increased for all three types of hospitals when the service was profitable." Id. at 1371. Ergo, it is logical to conclude from her work that making services more profitable (raising reimbursement rates) will make them more available.

Daniel Fox and Daniel Schaffer made this point eloquently in their superb article recounting the history of Revenue Ruling 69-545. Fox & Schaffer, supra note 6, at 278:

[t]ax officials often make health policy, even when they are secure in their professional judgment that they are only performing legal analysis. They are not held accountable for the making of health policy, however, because their professional judgment is persuasive to others as well as to themselves. We all pay a price when substantive policy is made by people who agree that they are not equipped to do so and insist, in spite of the evidence, that since they are not making policy there is no reason to hold them accountable for it.

This, in fact, is largely the theme sounded by Professor Karns, who notes that "the government's reliance on the status quo to regulate healthcare . . . precludes the wholesale abolition of the exemption policy. Current critics of the hospital tax exemption . . . overlook the reality of the political process . . . ." Karns, supra note 96, at 555. See also, Horwitz, supra note 74, at 1410 (suggesting use of nonprofit form as a regulatory tool for health policy).

119 C.f., Hyman, supra note 79, at 371 (suggesting that nonprofit hospitals are forced to recover unreimbursed costs from insurance companies as well as the citizens within the local tax district).
the uninsured and other community health issues, instead of letting them dodge the issues through exemption?

B. Reformulating Community Benefit into a Behavior-specific Test

A different approach suggested by some commentators from abandoning the community benefit test completely is to "reformulate" it to encourage specific behavior. In fact, as Part II above recounts, this is essentially what has happened in the federal legal arena, where recent IRS pronouncements and court cases have more or less returned to a charity care standard of exemption embodied in the "health care plus" test. It is also true at the state level, where specific legislation and court decisions have emphasized charity care as a necessary part of property tax exemption. In effect, this approach would embrace exemption or other tax benefits as a means of government regulation of health care policy: exemption (or the other benefits) becomes the carrot to force health providers to adopt certain behaviors that we deem beneficial. Or to respond to the argument made by Karns and Horwitz, this approach would require some direct causal connection between exemption and socially desirable behavior, rather than keeping exemption because of a generalized fear that its elimination would have a negative impact on some diffuse socially desirable behaviors that might currently exist.

Of course, one such behavior-inducing test would be to simply tie exemption to certain levels of charity care, as some states have done. But as other commentators have noted, using exemption to squeeze hospitals to provide care for the poor is an exceptionally poor way to implement health care policy. Second, at least some empirical work (particularly the recent work of Professor Horwitz described in Part III, above) suggests that nonprofits engage in socially-desirable behavior other than simply charity care (e.g., providing a wider range of health services) that, unlike some "community benefit" criteria, is not replicated by for-profits pursuing a sound business plan. Thus the question raised in this section is whether there are specific behavioral tests that might guide exemption other than simply a charity care-based test. In particular, this section discusses two possibilities raised by legal academics: Nina Crimm's approach of rewarding specific

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120 See, e.g., sources cited supra note 114.
behavior by health care providers (whether for-profit or nonprofit) that promotes health policy goals, and my recent suggestion that "enhancing access" become the dominant legal doctrine for testing exemption for "commercially similar" services.

1. Crimm's Specific Behavior Reward Approach

In an article published in 1995, Nina Crimm suggested using an entirely different tax regime than exemption as the basis of encouraging both nonprofit and for-profit hospitals to provide socially desirable health care services. The essence of Crimm's proposal is to designate certain services as "charitable activities," expenditures for which would entitle the provider to a tax deduction or tax credit. This approach would ignore whether the organizational status of the provider was for-profit or nonprofit; instead, it would reward specific behavior with specific tax benefits. To accommodate regional differences, Crimm would form a community based certification panel that "would be responsible for developing and disseminating . . . community/regional medical plans . . . to outline the medical needs, availability of medical care and resources, medical goals of the particular locale, and determinations of the best means of allocating existing and potential medical resources to achieve a level of health care considered sufficient." Activities of local providers certified by this board as being in compliance with the plan would be eligible for tax-favored treatment (either a deduction or credit) according to a federally set sliding scale based on a "broad range of weights based on general societal priorities."

While Professor Crimm's approach certainly solves the problem of exemption having a weak connection to socially desirable behavior, even she admits that the system would be extremely complex. Moreover, although she defends this system as providing considerable flexibility in responding both to local need and to the ever-changing demands of health care, in practice this flexibility is likely to be severely limited by the multiple layers of bureaucracy necessary to administer it. Individual service changes by hospitals desiring exemption would need approval of the local administrative board; if the changes were outside the preset federal weighting guidelines, some federal process would be needed to change the guidelines. Finally, I would simply ask whether going through this much trouble and administrative complexity to use tax breaks as health care incentives is

\[122\] Crimm, supra note 95.
\[123\] Id. at 107.
\[124\] Id. at 107.
\[125\] Id. at 110.
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worth it: one wonders if the effort would be better spent on direct implementation of health care initiatives funded directly by the federal government and/or the states.

2. An Access-Based Test

To recap the previous discussion, the original formulation of community benefit in Revenue Ruling 69-545 has proven essentially useless as a legal test for exemption or as a recognition of behavioral differences between nonprofit and for-profit health care providers. As a result, the IRS, federal courts and state legislatures and courts have increasingly turned to charity care as the measurable behavioral distinction that would justify exemption. The best behavioral defense to date of continued use of the community benefit test is Jill Horwitz’s empirical data that tends to show that nonprofit hospitals engage in more unprofitable services than for-profit counterparts. But her own data shows that government-owned hospitals are far more likely to provide these unprofitable services, indicating that the direct application of health policy via government intervention is more likely to produce changes in provider behavior than indirect incentives such as exempt status. Ultimately, Professor Horwitz’s defense of exemption rests on the claim that we should not tinker with exemption because it may be a source of incentive for private nonprofit hospitals to engage in socially desirable behavior (more unprofitable services).

On the other hand, current alternatives to the community benefit formulation are not that great either. After all, Professor Horwitz and others who have made similar points might be right: eliminating the community benefit test and returning to a strict charity care standard for exemption might result in the loss of other socially-desirable behavioral differences between nonprofit and for-profit health care providers. Thus the “be careful what you wish for” theme sounded by her and echoed by Professor Karns and other community-benefit supporters is certainly worth thinking about. Implementing a system of rewarding specific behavior as suggested by Professor Crimm, however, would appear administratively difficult and to some degree would suffer from the same lack of flexibility as a strict charity care test.

Perhaps a better approach, then, is to try to find ground in the middle, and to formulate a test of exemption that ties exemption, at least in part, to specific, verifiable behavior but permits wider latitude in that behavior than either a strict charity care standard or Professor Crimm’s strict behavioral reward approach (as well as avoiding the considerable administrative overhead of such an approach). In a recent article, I examined the possibility of using a doctrinal test of exemption tied to “enhancing access” in cases in which services pro-
vided by a nonprofit organization were similar to those provided by for-profit organizations.\(^{126}\) This enhanced access could occur on one or both of two fronts: either by providing commercially-available services to previously underserved populations ignored by for-profit or government providers, or by providing the general population with services that neither the private market nor government otherwise would provide.\(^{127}\) The basic doctrinal elements of this test would be two-fold. First, drawing on past process-based suggestions made by community benefit supporters,\(^{128}\) an organization seeking exemption would have to observe certain procedural formalities, including a written policy statement that details exactly how the organization would execute its “enhancing access” mission.\(^{129}\) Second, the organization in question would have to show that its outputs in fact accomplish this mission.\(^{130}\) If the organization wants to predicate exemption on providing enhanced access for underserved populations, for example, it would need to identify in its mission statement the specific underserved population and its plan for bringing services to that population, then show (perhaps via an annual report) that it had in fact dedicated a significant portion of its resources to implementing that mission. This outputs-based test would require, at a minimum, that the organization show it was doing substantially more to address the access mission it identifies than competing for-profit providers. In the health care context, for example, if free care for the poor was the organization’s chosen access mission, then it would have to prove that it provided substantially more such care than is provided by for-profits in the form of bad debt write-offs.

Such a test might mesh well with the empirical evidence on behavioral differences presented by Professor Horwitz’s recent research. If a nonprofit organization dedicates itself to a mission of providing services for the general population that otherwise are undersupplied (e.g., unprofitable services), then such a mission (if actually executed) should support exemption. What this approach does that current law lacks, however, is require a direct connection between exempt status and the desirable social behavior. It is a variation of the old “drill sergeant” theme, requiring a nonprofit seeking exemption to “tell us


\(^{127}\) Id. at 371-72.

\(^{128}\) E.g., Seay, supra note 97 (suggesting that the community benefit standard requires voluntary non-profit institutions to actively attempt to evaluate community needs, carry out objectively verifiable measures to satisfy those needs, and publicly report the resources dedicated to such measures).

\(^{129}\) Colombo, supra note 126, at 371.

\(^{130}\) Id. at 372.
what you are going to do, tell us how you are doing it, and then tell us how you did it.” Thus it avoids to a considerable degree the inherent imprecision in the original community benefit formulation. By requiring that the enhancing access mission supporting exemption be one not currently undersupplied by the private market, the test also eliminates from the community benefit formulation certain behaviors that have commercial appeal (e.g., the outreach program that funnels patients into the sponsoring hospital). At the same time, by broadly defining “enhancing access” and permitting individual organizations to tailor their mission to specific access needs that may or may not involve large amounts of charity care, the access test is far more flexible than a strict charity care approach while avoiding the complex bureaucracy associated with Nina Crimm’s specific-behavior-reward system.\(^{131}\)

**V. SUMMARY**

Though proponents of tax exemption for health care providers continue to extol the virtues of the community-benefit test, Part II of this article illustrates that the train pretty much has already left the station on this front. Both the federal government and the states increasingly look to uncompensated care as the touchstone of exemption for health care providers. To a great extent, this transition back to a “relief of the poor” standard for exemption is the result of the inherent lack of precision in community benefit standards, along with the general trend of empirical evidence that nonprofit health care providers behave similarly to their for-profit counterparts. Faced with this situation, federal and state policymakers naturally have focused on charity care as the one quantifiable behavioral difference to justify exemption.

Nevertheless, some empirical evidence suggests that nonprofits may engage in socially desirable behavior other than simply free care for the poor, and the arguments that a mixed ownership system provides the best overall health care model cannot be dismissed out of hand. Thus, despite my past criticisms of the community benefit formulation, I have come to the view that we should seriously consider the options available beyond complete repeal of the community benefit test or a return to a strict charity-care exemption standard. I continue to believe that we should demand a fairly high level of “accountability” from exemption, however, and that exemption should

\(^{131}\) As I explain in more detail in the cited article, the test is also more consistent with current IRS ruling positions than the community-benefit test. In fact, one could say that the IRS already has adopted “enhancing access” as the key component of exemption for health care providers; the agency simply hasn’t officially recognized their positions as incorporating this standard. Colombo, supra note 126, at 347-58.
have some direct causal connection to whatever socially-desirable behavior we are seeking. While one option along these lines is to adopt Nina Crimm’s approach of rewarding specific behaviors through a deduction or credit system, using “enhancing access” as a test of exemption may provide the best combination of flexibility and verifiable behavioral differences to support continued exemption for health care providers.